(Required pursuant to R.C. 2919.123)

MAR 2 6 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

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30 E. Broad St., 3<sup>rd</sup> Floor Columbus,

OH 43215-6127

YCH, LLC 16721 Karl Rd. Cols., Oh 43229



State Medical Board

Of Ohio

STATE MEDICAL BOARD OF OHIO

30 E. Broad St., 3rd Floor

Cols., Oh 43215-10127

43215-612799

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	02	15	2024
	Month	Day	Year
Name of medical practice or facility at w     Planned Parenthood of Grea		ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
25350 Rockside Road, Bed	dford Heights, Ohio, 44146		
4. Date post RU-486 complication began: 3/2/24			
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	lverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	eding		
X Other serious event (specify) Failed Abortio	n		
6. Duration of event:1 Hours	Days		
7. Remarks:			
MAB procedure initiated per FHD regimen of continuing pregnancy. Pt opted for second	on 2/15/24. Follow up ultr dose of MAB medications	rasound preformed s.	on 3/2/24 revealed
8. a. Name of physician who provided 70-4	186 Bhavik Kuma	ar	
8. b. Physician's signature	Date 3 1/3 1	2024 2024	/ D.O
	Date 3 / 13 / 1	-	

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12/19/23		
	Month	Day	Year
Name of medical practice or facilit     Planned Parenthood of		ed:	
3. Address of medical practice or facil	ity at which RU-486 was provi	ded:	
4. Date post RU-486 complication beg			
5. Event(s) (Please check all that apply	y):		
Incomplete abortion	Adverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Seve	re bleeding		
X Other serious event (specify)	ortion		
6. Duration of event:1 Hou	rs Days		
7. Remarks: Patient had positive HSPT weeks with desire to continu	>5 weeks post-MAB. MAB follow-up ue pregnancy	ultrasound showed co	ontinued pregnancy 20.1
8. a. Name of physician who provided 8. b. Physician's signature	Selleur	m.D.,	/ D.O
	tate Medical Board of Ohio		
- 1.5700 A	partment pad St., 3 <sup>rd</sup> Floor		

Columbus, OH 43215-6127

MAR 1 J 2024 STATÉ MEDICAL BOARD O



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11/20/23
	Month Day Year
Name of medical practice or facility at v     Planned Parenthood of Great	
3. Address of medical practice or facility at 25350 Rockside Road, Be	t which RU-486 was provided: edford Heights, Ohio, 44146
4. Date post RU-486 complication began:	11/2023
5. Event(s) (Please check all that apply): Incomplete abortionAddPatient received a transfusion Severe blee Other serious event (specify) Failed	1.
7. Remarks: MAB proced we ini Foliow up us performed on 1  Susical Aspiration pe	D Days  Ticked per FDA regimen on 09/27/2023  1/13 showing continuing pregnancy.  er formed on 11/20/23.
3. a. Name of physician who provided RU-4	
end completed forms to: State N  Legal Departm  30 E. Broad St.	

Columbus, OH 43215-6127

STATE MEDICAL BOARD OF OHIO



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	12	27	2023
		Month	Day	Year
2. Name of medical praction Planned Par	ce or facility at which Renthood of Greater Ohi		led:	
3. Address of medical pract	cice or facility at which		ided:	
4. Date post RU-486 compl 1/11/24	ication began:			
5. Event(s) (Please check al	l that apply):			
X Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalize	d
6. Duration of event:	Hours	_ Days		
7. Remarks:  MAB procedure was initiat symptomatic. FU US 1/11/dose of misoprostol to take	24 revealed incomplete	MAB. Pt sent dire	ctly to ED for transfi	b of 6.8 and pt was usion and given a secon
3. a. Name of physician who	provided RU-488	Bhavily Kuma	ır	
3. b. Physician's signature	Date	2/14/24	M.D. /	D.O
send completed forms to:	State Medica	l Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Fl	oor		
1	Columbus, OH 4321	5-6127	into	4 4 000

Prescribed: 5/--/2011, Rev. 12/13/12

MAR 1 1 2024

STATE MEDICAL BOARD OF DE



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12/27/23		
	Month	Day	Year
Name of medical practice or facility at v     Planned Parenthood of Great		ed:	
3. Address of medical practice or facility at		ded:	
25350 Rockside Road, Be	edford Heights, Ohio, 44146		
4. Date post RU-486 complication began:	2/6/24		
5. Event(s) (Please check all that apply):			
x Incomplete abortionA	dverse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe ble	eding		
Other serious event (specify)			
6. Duration of event:1 Hours	Days		
7. Remarks:  MAB initiated per FDA regimen on 12/27/23. Patie	ent had MAB follow up for positi	ve HSPT on 2/6/24. U	Jitrasound showed possible
retained products of conception. Patient had uteri	ne aspiration procedure on 2/12	2/24. Patient did well	post-op
B. a. Name of physician who provided RU-	486 Bhavik Ku	mar	
8. b. Physician's signature	Date 2/14/24	M.D./	<u> </u>
Send completed forms to: State	Medical Board of Ohio		
Legal Departr	ment		

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MAR 1 1 2024

STATE MEDICAL BOARD OF ONIC



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	18	23
	Month	Day	Year
Name of medical practice or facility at w     Planned Parenthood of Great		ded:	
3. Address of medical practice or facility at	which RU-486 was prov	rided:	
25350 Rockside Road, Bed	ford Heights, Ohio, 44146		
4. Date post RU-486 complication began:	12/23/23		
5. Event(s) (Please check all that apply):			
Incomplete abortion Ad	verse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Severe blee	ding		
X Other serious event (specify) Failed Abortion	on		
6. Duration of event:1 Hours	Days		
7. Remarks:  MAB initiated, per FDA regimen on 1	2/18/23. Continued preg	nancy shown on ult	rasound 12/23/23
8. a. Name of physician who provided RU-4 8. b. Physician's signature	86 Emily Freen	19/24 ·	60
Send completed forms to: State N	ledical Board of Ohio		

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MAR 1 1 2024

25350 Dutsde 2d Bedford Hts., OH 44141

State Medical Econd

Legal Department

BOE Broad St. 329 Floor

Colombis OH 43215-6127

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LAT RATE ENVELOPE

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(Required pursuant to R.C. 2919.123)

FEB 2 1 2024

STATE MEDICAL BOARD OF OHIO

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		Jan	19	2024
		Month	Day	Year
2. Name of medical practice or			d:	
3. Address of medical practice o		U-486 was provid	ed:	
6721 Kaul Rd	•	1 1		
4. Date post RU-486 complication	on began: Jan 25	2024		
5. Event(s) (Please check all that	apply):			
	Adverse rea	ction to RU-486	_ Patient hospitalize	ed
Patient received a transfusion	Severe bleed	ling		
Other serious event (specify)				
5. Duration of event:l	HoursO	Days		
7. Remarks: Retail 1	sine. Ref	ld to OBCa	ge for Do	
3. a. Name of physician who prov	vided RU-486	Willam	Rooom	- wy
3. b. Physician's signature	Date -	2.8.	wy MD/	D.O
	te Medical Board o	f Ohio		
	al Department	6.1		
30 (	E. Broad St., 3 <sup>rd</sup> Floo	or Columbus,		

OH 43215-6127

(Required pursuant to R.C. 2919.123)

FEB 2 1 2024

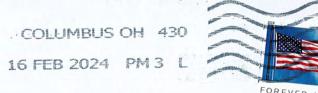
To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	Jan	30	Zozy
	Month	Day	Year
2. Name of medical practice or facility at which	1	ided:	
3. Address of medical practice or facility at wh		vided:	
4. Date post RU-486 complication began: 2	15/2024		
P Incomplete abortion Adverse Patient received a transfusion Severe Other serious event (specify)	se reaction to RU-486	Patient hospitaliz	ed
5. Duration of event:(Hours&	Days		'
7. Remarks: Failed MAB. Pt o	iping to cont	inic progra	J.
3. a. Name of physician who provided RU-486 3. b. Physician's signature	1	1200 1200	
State Medical Box Legal Department 30 E. Broad St., 3			

OH 43215-6127

40H.UC 6721 Karl Rd Cols.101 43129



State Medical Board of Ohio legal Dept. 30 E. Broad St. 3rd Hoor cols. 101 43215-4927

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STATE MEDICAL BOARD OF OHIO

43215-612799

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(Required pursuant to R.C. 2919.123)

FEB 21 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provid	led:	Jon	15	rory
		Month	Day	Year
2. Name of medical praction			vided:	
Your Chris	e Mouthane V	LC i		
2. Adduses of wedded weed	daa ay faailitu at uubiah	DI 196	المراجعة الم	
3. Address of medical pract				
67C1 (2001	hoad Columb	1 2	43007	
4. Date post RU-486 compl	ication began: Ja	n zz z	sey	
5. Event(s) (Please check al	l that apply):			
	Adverse	eaction to RIL-496	Patient hospitalize	ad
		200101110110-400	ratient nospitalize	eu
Patient received a transfusion	n Severe ble	eding		
Other serious event (specify				
				- 1
5 Duration of events /				
6. Duration of event:	Hours	_ Days		
7. Remarks:	tismi Rebu	and for	DAG	
vierny	(1)	2007		
3. a. Name of physician who	provided RU-486		to Roonin	- wy
B. b. Physician's signature		1	MD/	D.O.
	Date	2.12.		
end completed forms to:	State Medical Board	of Ohio		
	Legal Department			
	30 E. Broad St., 3 <sup>rd</sup> Flo	oor Columbus,		
	OH 42215 6127			

YCH, LLC 10721 Karl Rd Cols, Oh 43229

COLUMBUS OH 430 16 FEB 2024 PM 3 L



State Medical Board of Ohio Legal Dept. 30 E. Broad St., 3rd Floor Cols, Oh 43215-6127

STATE MEDICAL BOARD OF OHIO

49215-612799

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		Dec	()	2023
		Month	Day	Year
2. Name of medical practice or f	acility at which RU	J-486 was prov	ded:	
Your Choice	Healthan U	.c .t	ű,	
		100	W. F.	
3. Address of medical practice or b 721 kml md	facility at which F Country Of	RU-486 was pro	vided:	
4. Date post RU-486 complication	n began: 12/(	8/23		
5. Event(s) (Please check all that	apply):			
X. Incomplete abortion	Adverse rea	action to RU-486	Patient hospitalize	ed
- Arthur and Arthur and Arthur		X session de Via Talago		
Patient received a transfusion	Severe bleed	ding		
	,	+		
Other serious event (specify)				
Other serious event (specify)				
6. Duration of event:	Hours	Days		
7. Remarks: Pt did not	complete pr	otoral after	misepusane .	resitay
in retains	non whe pu	yuz. Ref	y wher of	s for date
3. a. Name of physician who prov	ided RU-486	- will	IAM ROOM	L M
8. b. Physician's signature		1	MD.	/ D.O
	Data	1-2	6.24	
ACCRECATE TO THE	Date -			
Send completed forms to: Stat	e Medical Board o	of Ohio		
Lega	l Department			
30 E	. Broad St., 3 <sup>rd</sup> Flo	or Columbus,	F	EB 05 2024
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30 E. Broadst 35d Floor

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STATE MEDICAL BOARD OF CHIO

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

B . Bu 400	11	4	2023
1. Date RU-486 was provided:	Month	Day	Year
Name of medical practice or facility at which     Planned Parenthood of Greater C	RU-486 was provi	, , , , , , , , , , , , , , , , , , ,	166)
3. Address of medical practice or facility at which 25350 Rockside Road, Bedford	1		
4. Date post RU-486 complication began: 12/18/23		\$	
5. Event(s) (Please check all that apply):			
Incomplete abortion Adverse	reaction to RU-486	Patient hospitalized	l ,
Patient received a transfusion Severe bleeding	,	<i>I.</i>	
X Other serious event (specify) hematometra			<del></del>
6. Duration of event: Hours	Days		* 1
7. Remarks:  MAB initiated per FDA regimen 11/4/23. Follow Pt opted for second dose of misoprostol to reso	up ultrasound prefo ve hematometra.	ormed on 12/18/23 rev	realed hématometra.
8. a. Name of physician who provided RU-486 8. b. Physician's signature Da	Zeyvidah Vick	(ery , M.D.*/	D.O
Sella completer forms to i	ical Board of Ohio	1   1	
Legal Department	J		
30 E. Broad St., 3 <sup>rd</sup>	•		
Columbus, OH 43	XT3-0T5\		

JAN 23 2024

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EXPECTED DELIVERY DAY: 01/20/24

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(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

Date RU-486 was provided:	nhow	, 14	2023	
	Month	Day	Year	
2. Name of medical practice or facility at w Low/ Curin Hallhu	rhich RU-486 was prov	ided:	1.	
	\$1			Action 10 September 10
3. Address of medical practice or facil		was provided:		
4. Date post RU-486 complication beg	ran	· ·	the same of the sa	water the state of
11/27/23 12/3/23		Ī		
5. Event(s) (Please check all that apply		+	and the second s	
	dverse reaction to RU-486	Patient höspitali	ized	
	•			
Patient received a transfusion 🗡 Severe ble	eeding	2.8		*
		3		
Other serious event (specify)				
5. Duration of event; Hours	O Days		7 B 400	
7. Remarks:		The second secon		· ·
Pt related to	to fur full	in muying		
		4		1.
. a. Name of physician who provided	DIL 495 / 41/	MAM Ro	DONY 10	, ,
. a. Name of physician who provided	NO-480	ang w	Olived 12	The state of the s
3. b. Physician's signature			O.O	7 .
	Date	11/23	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
nd completed forms to:				4.6
na completea ionna to:	State Medical	Board of Ohio	Š.	14 atr.
Le	gal Department	* *	el.	1
ac	F. Broad St. 3rd Flo	or	+,	

Columbus, OH 43215-6127

JAN 2 2 2024 STATE MEDICAL BOARD OF OHIO 6721 Karl Rd cols., Oh 43229

COLUMBUS OH 430 16 JAN 2024 PM 2 L



State Medical Board of Ohio Legal Dept. 30 E. Broad St., 3rd Floor Cols., Oh 43215

JAN 2 2 2024

STATE MEDICAL BOARD OF OHIO

43215-612799



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provi	ided:	11	16	2023
and the second second second second		Month	Day	Year
2. Name of medical pract Planned Pa	ice or facility at which arenthood of Greater Oh		ovided:	
3. Address of medical prace	ctice or facility at which			
4. Date post RU-486 comp 11/17/23	olication began:		4	
5. Event(s) (Please check a	all that apply):			
Incomplete abortion  Patient received a transfus		reaction to RU-486	Patient hospi	talized
X Other serious event (specified)  6. Duration of event:	1	Days	,	
7. Remarks:	unknown location of pre	results 11/17/23	3 showed concern	OA regimen on 11/16/23 with for ectopic pregnancy. Pt S left salpingectomy.
8. a. Name of physician wl	Sh	Bhavik K	M	D/D.O
Send completed forms to:	State Medic Legal Department 30 E. Broad St., 3 <sup>rd</sup> I Columbus, OH 432			JAN 08 2024 TE MEDICAL BOARD OF OHIO



Prescribed: 5/--/2011, Rev. 12/13/12

# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	77.	10/18/2023			
		Ionth	Day	Year	
Name of medical practice or facility at which     Planned Parenthood of Greater 0		86 was pro	vided:		
3. Address of medical practice or facility at which					
4. Date post RU-486 complication began: 10/	27/2023		v ~		
5. Event(s) (Please check all that apply):					
Incomplete abortion Adverse Adverse Patient received a transfusion Severe bleeding Failed abortion	1	n to RU-486	Patient hospitaliz	ed	
x_ Other serious event (specify)	Da	ys	· · · · · · · · · · · · · · · · · · ·	1 1	
7. Remarks:  RU-486 was administered on 10/18/23 per FDA regime continued pregnancy. Patient proceeded with uterine a	nen. Pati	ent had MAE n. Patient di	g well post-op.	pointment Ultrsound shower	
8. a. Name of physician who provided RN-486 8. b. Physician's signature Da	te —	Bhavik Kum		/D.O **-	
Send completed forms to:  State Medi  Legal Department  30 E. Broad St., 3 <sup>rd</sup> Columbus, OH 432	Floor		JA	N 0 8 2024 DICAL BOARD OF OHIO	

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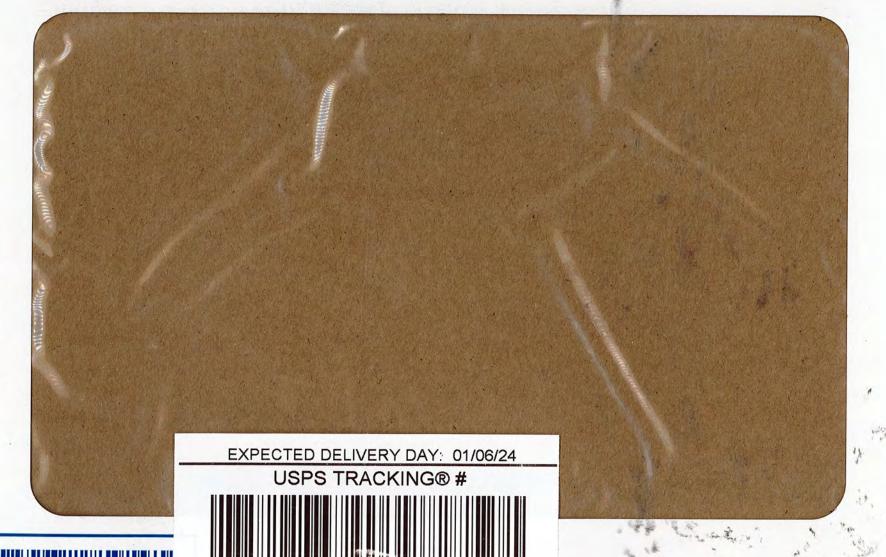
SOLON, OH 44139 JAN 04, 2024

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> JAN U 8 2024 STATE MEDICAL BOARD OF OHIO

State Medical Board of Onro Legal Department 30 E. Beood St., 3rd Floor Columbus, OH 43215-6127