


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

MAR 26 2024
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	<u>Feb</u>	<u>12</u>	<u>2024</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Your Choice Healthcare LLC</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Karl Road Columbus OH 43229</u>		
4. Date post RU-486 complication began:	<u>2-26-24</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete ^{failed} abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized		
	<input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding		
	<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>1</u> Hours	<u>0</u> Days	
7. Remarks:	<u>pt did not continue protocol after misoprostol. pregnancy remains viable; pt electing to continue pregnancy.</u>		
8. a. Name of physician who provided RU-486	<u>William Nassar MD</u>		
8. b. Physician's signature	 <u>MD/D.O</u>		
	Date	<u>3.8.24</u>	

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor Columbus,
OH 43215-6127

YCH, LLC
6721 Karl Rd.
Cols., Oh 43229

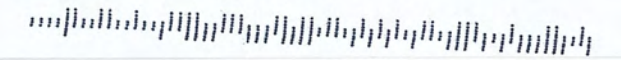
COLUMBUS OH 430
22 MAR 2024 PM 4 L



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

MAR 26 2024
STATE MEDICAL BOARD OF OHIO

43215-612799



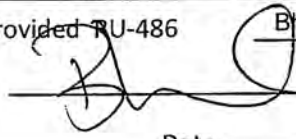
MAR 19 2024
STATE MEDICAL BOARD OF OHIO



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

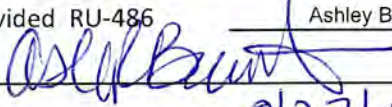
1. Date RU-486 was provided:	02	15	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 3/2/24			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: MAB procedure initiated per FHD regimen on 2/15/24. Follow up ultrasound performed on 3/2/24 revealed continuing pregnancy. Pt opted for second dose of MAB medications.			
8. a. Name of physician who provided RU-486 <u>Bhavik Kumar</u>			
8. b. Physician's signature  <u>M.D./D.O.</u>			
Date <u>3/13/2024</u>			

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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:	12/19/23	
	Month Day Year	
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio	
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Road, Bedford Heights, Ohio, 44146	
4. Date post RU-486 complication began:	2/26/24	
5. Event(s) (Please check all that apply):		
<input type="checkbox"/> Incomplete abortion	<input type="checkbox"/> Adverse reaction to RU-486	<input type="checkbox"/> Patient hospitalized
<input type="checkbox"/> Patient received a transfusion	<input type="checkbox"/> Severe bleeding	
<input checked="" type="checkbox"/> Other serious event (specify)	failed abortion	
6. Duration of event:	1 Hours	Days
7. Remarks:	Patient had positive HSPT >5 weeks post-MAB. MAB follow-up ultrasound showed continued pregnancy 20.1 weeks with desire to continue pregnancy	
8. a. Name of physician who provided RU-486	Ashley Brant	
8. b. Physician's signature		M.D. / D.O.
	Date	2/27/24

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MAR 11 2024
STATE MEDICAL BOARD OF OHIO



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: 11 / 20 / 23
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
 Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
 25350 Rockside Road, Bedford Heights, Ohio, 44146

4. Date post RU-486 complication began: 11/20/2023

5. Event(s) (Please check all that apply):

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

Patient received a transfusion Severe bleeding

Other serious event (specify) Failed medication abortion

6. Duration* of event: 1 Hours 0 Days

7. Remarks: MAB proced we initiated per FDA regimen on 09/27/2023. Follow up US performed on 11/13 showing continuing pregnancy. Surgical Aspiration performed on 11/20/23.

8. a. Name of physician who provided RU-486 Kate Turner

8. b. Physician's signature [Signature] MD (M.D./D.O)

Date 1

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MAR 11 2024
 STATE MEDICAL BOARD OF OHIO



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:	12	27	2023
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 1/11/24			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input checked="" type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u> 1 </u> Hours <u> </u> Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 12/27/23. FU appt 1/11/24 noted a hgb of 6.8 and pt was symptomatic. FU US 1/11/24 revealed incomplete MAB. Pt sent directly to ED for transfusion and given a second dose of misoprostol to take after transfusion to resolve incomplete MAB			
8. a. Name of physician who provided RU-486 <u>Bhavit Kumar</u>			
8. b. Physician's signature _____ M.D./D.O.			
Date <u>2/14/24</u>			

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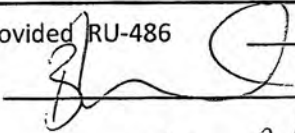
MAR 11 2024
STATE MEDICAL BOARD OF OHIO



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:	12/27/23
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Road, Bedford Heights, Ohio, 44146
4. Date post RU-486 complication began:	2/6/24
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	1 Hours _____ Days
7. Remarks:	MAB initiated per FDA regimen on 12/27/23. Patient had MAB follow up for positive HSPT on 2/6/24. Ultrasound showed possible retained products of conception. Patient had uterine aspiration procedure on 2/12/24. Patient did well post-op
8. a. Name of physician who provided RU-486	Bhavik Kumar
8. b. Physician's signature	 M.D. / D.O.
	Date 2/14/24

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MAR 11 2024
STATE MEDICAL BOARD OF OHIO



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:	12	18	23
	Month	Day	Year

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Road, Bedford Heights, Ohio, 44146

4. Date post RU-486 complication began: 12/23/23

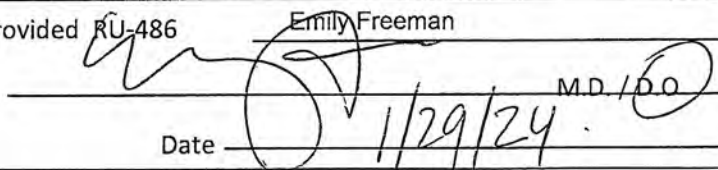
5. Event(s) (Please check all that apply):

Incomplete abortion
 Adverse reaction to RU-486
 Patient hospitalized
 Patient received a transfusion
 Severe bleeding
 Other serious event (specify) Failed Abortion

6. Duration of event: 1 Hours _____ Days

7. Remarks:
MAB initiated, per FDA regimen on 12/18/23. Continued pregnancy shown on ultrasound 12/23/23

8. a. Name of physician who provided RU-486 Emily Freeman

8. b. Physician's signature  M.D./D.O.

Date 1/29/24

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Columbus, OH 43215-6127

MAR 11 2024
STATE MEDICAL BOARD OF OHIO

PP041
25350 Rutside Rd
Bedford Hts., OH 44146

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

MAR 11 2024
STATE MEDICAL BOARD OF OHIO

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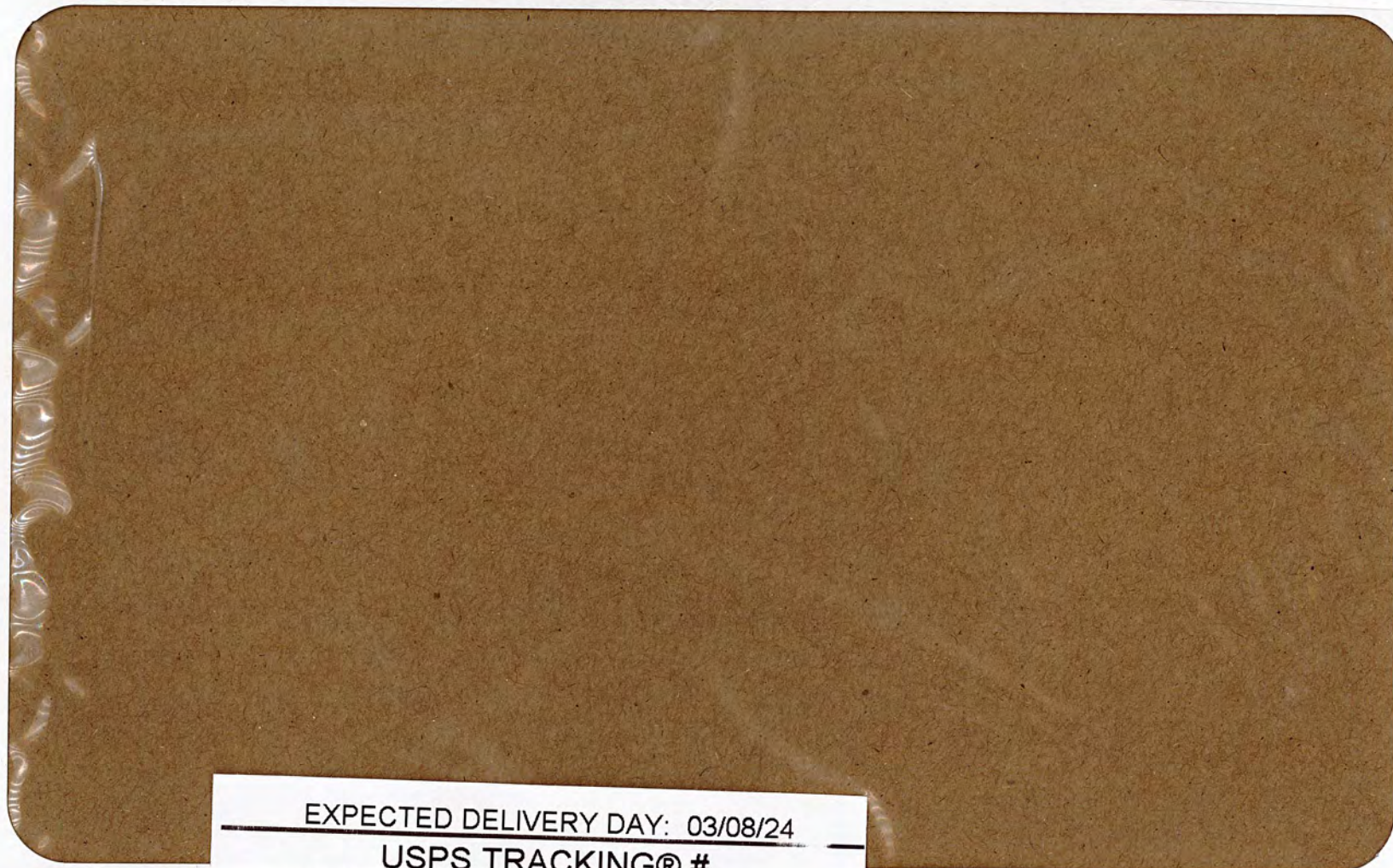
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MAR 11 2024

STATE MEDICAL BOARD OF OHIO



EXPECTED DELIVERY DAY: 03/08/24

USPS TRACKING® #



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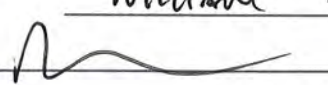
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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

FEB 21 2024
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	<u>Jan</u>	<u>19</u>	<u>2024</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Yow Choice Healthcare LLC</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Karl Rd.</u>		
4. Date post RU-486 complication began:	<u>Jan 25 2024</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>1</u> Hours	<u>0</u> Days	
7. Remarks:	<u>Retained tissue. Ref'd to OBGYN for D&E.</u>		
8. a. Name of physician who provided RU-486	<u>William Rooden M.D.</u>		
8. b. Physician's signature	<u></u> <u>M.D./D.O.</u>		
	Date	<u>2.8.2024</u>	

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Legal Department
30 E. Broad St., 3rd Floor Columbus,
OH 43215-6127

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

FEB 21 2024

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	<u>Jan</u>	<u>30</u>	<u>2024</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Your Choice Healthcare LLC</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Kant Rd Columbus OH 43229</u>		
4. Date post RU-486 complication began:	<u>2/5/2024</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete ^{failed} abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>1</u> Hours	<u>0</u> Days	
7. Remarks:	<u>Failed MAB. Pt opting to continue pregnancy.</u>		
8. a. Name of physician who provided RU-486	<u>William Lee Woodruff MD</u>		
8. b. Physician's signature	<u>[Signature]</u> <u>MD/D.O.</u>		
	Date	<u>2.9.2024</u>	

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor Columbus,
OH 43215-6127

YCH, LLC
6721 Karl Rd
Columbus, OH
43229

COLUMBUS OH 430
16 FEB 2024 PM 3 L



State Medical Board of Ohio
Legal Dept.
30 E. Broad St. 3rd floor
Columbus, OH 43215-6127

FEB 21 2024
STATE MEDICAL BOARD OF OHIO

43215-612799

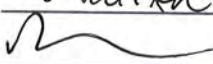


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

FEB 21 2024
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	Jan	15	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	You Choice Healthcare LLC		
3. Address of medical practice or facility at which RU-486 was provided:	6721 Karl Road Columbus OH 43229		
4. Date post RU-486 complication began:	Jan 22 2024		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	1	Hours	0 Days
7. Remarks:	Retinal tissue returned for D&C.		
8. a. Name of physician who provided RU-486	Wanda Roshan M.D.		
8. b. Physician's signature	 M.D./D.O.		
	Date 2-12-24		

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Legal Department
30 E. Broad St., 3rd Floor Columbus,
OH 43215-6127

YCH, LLC
6721 Karl Rd
Columbus, OH 43229

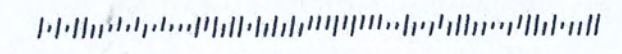
COLUMBUS OH 430
16 FEB 2024 PM 3 L



State Medical Board of Ohio
Legal Dept.
30 E. Broad St., 3rd floor
Columbus, OH 43215-6127

FEB 21 2024
STATE MEDICAL BOARD OF OHIO


43215-6127



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:	<u>Dec</u>	<u>11</u>	<u>2023</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Your Choice Healthcare LLC</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Kant Rd Columbus OH 43229</u>		
4. Date post RU-486 complication began:	<u>12/18/23</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>1</u> Hours	<u>0</u> Days	
7. Remarks:	<u>PT did not complete protocol after mifepristone resulting in retained non-viable pregnancy. Ref'd to her OB for D&C</u>		
8. a. Name of physician who provided RU-486	<u>William Roemer MD</u>		
8. b. Physician's signature	 <u>MD / D.O</u>		
	Date	<u>1-26-24</u>	

Send completed forms to: State Medical Board of Ohio
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OH 43215-6127

FEB 05 2024
STATE MEDICAL BOARD OF OHIO

YCH, LLC
6721 Karla Rd
Cols., Oh 43229

COLUMBUS OH 430

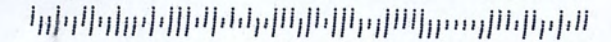
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State Medical Board of Ohio
Legal Dept.

30 E. Broad St. 3rd Floor
Cols., Oh 43215-6127

43215-612799



FEB 05 2024
STATE MEDICAL BOARD OF OHIO



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:	11	4	2023
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 12/18/23			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>hematometra</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: MAB initiated per FDA regimen 11/4/23. Follow up ultrasound performed on 12/18/23 revealed hematometra. Pt opted for second dose of misoprostol to resolve hematometra.			
8. a. Name of physician who provided RU-486 <u>Zevidah Vickery</u>			
8. b. Physician's signature <u></u> M.D. / D.O.			
Date <u>1/6/24</u>			

Send completed forms to: State Medical Board of Ohio
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 30 E. Broad St., 3rd Floor
 Columbus, OH 43215-6127

JAN 23 2024
 STATE MEDICAL BOARD OF OHIO

99011
28350 Rockside
Bedford Hts, OH 44146

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43215

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Legal Dept
30 E. Broad St, 3rd Floor
Columbus, OH 43215-4157

EXPECTED DELIVERY DAY: 01/20/24

USPS TRACKING® #



9505 5800 4018 7837 73

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.323)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>Nov</u> / <u>14</u> / <u>2023</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Yost Anne Kalkren LLC</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Karl Rd Columbus OH 43229</u>
4. Date post RU-486 complication began:	<u>11/27/23</u> <u>12/7/23</u> <u>BR</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u>0</u> Days
7. Remarks:	<u>Pt referred to ED for further management.</u>
8. a. Name of physician who provided RU-486	<u>William Noorani MD</u>
8. b. Physician's signature	<u>[Signature]</u> <u>M.D./D.O.</u>
Date	<u>12/11/23</u>

Send completed forms to:

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

JAN 22 2024
STATE MEDICAL BOARD OF OHIO

6721 Karl Rd
Cols., Oh 43229

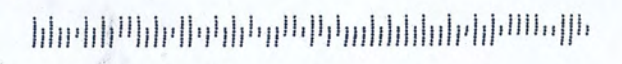
COLUMBUS OH 430
16 JAN 2024 PM 2 L



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Cols., Oh 43215

JAN 22 2024
STATE MEDICAL BOARD OF OHIO

43215-612799





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:	11	16	2023
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 25350 Rockside Road, Bedford Heights, Ohio, 44146			
4. Date post RU-486 complication began: 11/17/23			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed, ectopic</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: US preformed on 11/16/23 unknown location of pregnancy noted. Pt had MAB per FDA regimen on 11/16/23 with FU hcg quants and ectopic precautions. Hcg quant results 11/17/23 showed concern for ectopic pregnancy. Pt referred to ED 11/17/23. 11/17/23 ED US found left tubal ectopic and pt underwent LS left salpingectomy.			
8. a. Name of physician who provided RU-486 <u>Bhavik Kumar</u>			
8. b. Physician's signature M.D./D.O.			
Date <u>12/27/23</u>			

Send completed forms to: State Medical Board of Ohio
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 Columbus, OH 43215-6127

JAN 08 2024
STATE MEDICAL BOARD OF OHIO



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:	10/18/2023
	<div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood of Greater Ohio
3. Address of medical practice or facility at which RU-486 was provided:	25350 Rockside Road, Bedford Heights, Ohio, 44146
4. Date post RU-486 complication began:	10/27/2023
5. Event(s) (Please check all that apply):	<div style="display: flex; justify-content: space-between; font-size: small;"> <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding </div> <div style="display: flex; justify-content: space-between; font-size: small; margin-top: 5px;"> <input checked="" type="checkbox"/> Other serious event (specify) Failed abortion </div>
6. Duration of event:	<div style="display: flex; align-items: center; font-size: small;"> <u> 1 </u> Hours <u> </u> Days </div>
7. Remarks:	<p style="font-size: x-small;">RU-486 was administered on 10/18/23 per FDA regimen. Patient had MAB follow-up visit, at this appointment Ultrasound showed continued pregnancy. Patient proceeded with uterine aspiration. Patient did well post-op.</p>
8. a. Name of physician who provided RU-486	Bhavik Kumar
8. b. Physician's signature	<div style="text-align: center;"> </div>
	<div style="display: flex; align-items: center; justify-content: center;"> M.D./D.O. </div>
	<div style="display: flex; align-items: center; justify-content: center;"> Date <u> 12/27/2023 </u> </div>

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

JAN 08 2024
STATE MEDICAL BOARD OF OHIO

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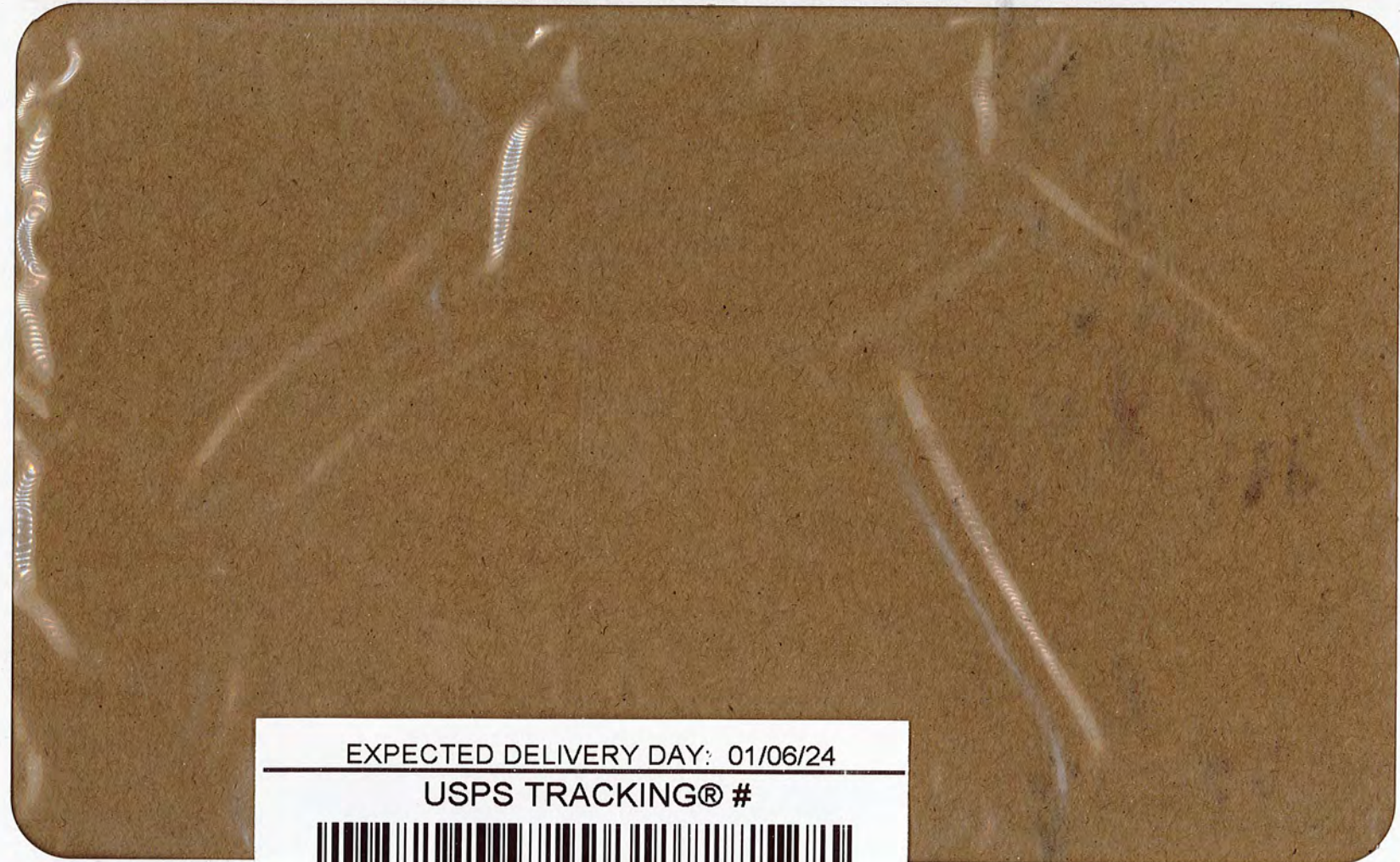
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