(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

FEB 2 1 2024

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was prov	ded:	Jan	U _	rory
		Month	Day	Year
2. Name of medical pract	ice or facility at which F ie Meethane U	*	ed:	net self-planet spokkelje a li iz liki kan kapa sapa sapa sa ke kapa sapa saba saba saba saba saba saba s
3. Address of medical practical practical was a second contraction of the second contraction of	ctice or facility at which			
4. Date post RU-486 comp	olication began: ゴa	n 22 202	1	
5. Event(s) (Please check a	ıll that apply):		04-2	
	Adverse r	eaction to RU-486	Patient hospitaliz	ed
Patient received a transfusi	on Severe ble	eding		
Other serious event (specif	у)			i t
6. Duration of event:	Hours O	_ Days		
7. Remarks: Vetind	tismi Rebu	und for	D&C.	
3. a. Name of physician wh	o provided RU-486	White	Roonim	- w
3. b. Physician's signature			RODAUL MD/	D.O
	Date	2.12. W		
send completed forms to:	State Medical Board	of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	oor 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 OIHO

1. Date RU-486 was provid	ded;	Jan	19	2024
		Month	Day	Year
2. Name of medical practi	ce or facility at which R	IU-486 was prov	vided:	
You Chair	e Halthere L	oc 🖟 "		
3. Address of medical prac	•	RU-486 was pro	ovided:	
b fel caul	ra.	,	É	
4. Date post RU-486 comp	ication began: San 25			
5. Event(s) (Please check al	I that apply):			
(Pincomplete abortion	Adverse re	eaction to RU-486	Patient hospitalize	ed
Patient received a transfusio	n Severe bled	eding		
Other serious event (specify)			1 4
6. Duration of event:	Hours O	_ Days		
7. Remarks: Letail	tissue. Res	fld 20 O	Bayn Gu Di	4C2 ,
8. a. Name of physician who	provided RU-486	Nouna	m Roponne	. w)
8. b. Physician's signature	/		MD/	DO
or or a mysician s signature	Data	2.	8.2024	
Send completed forms to:	State Medical Board	of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	oor Columbus,		
	OH 43215-6127			

(Required pursuant to R.C. 2919.123)

FED 2 1 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:				And a state of the
1. Date no-486 was provided.	<u>Ja∽</u> Month	Lagrange and the second	30	
	*		Day	Year
2. Name of medical practice or facility at which		provided:		
Your Choic Kaltucae	160			
2 Address of modical products on Exciting at which	b DII 400			
3. Address of medical practice or facility at whic				
6721 Karl Rd Columbus	04 4322	25 ' 		
4. Date post RU-486 complication began: 2/	5/2024			
5. Event(s) (Please check all that apply):				
failed				
ncomplete abortion Adverse	reaction to RU	I-486 Patie	nt hospitalized	
Patient received a transfusion Severe b	leeding			
Other serious event (specify)				± .
6. Duration of event: Hours &	Days			
7. Remarks: Failed MAB. Pt go	Try to	contine	programy.	
8. a. Name of physician who provided RU-486	A	Wur.run	usosue d	<u>></u>
8. b. Physician's signature	1		MD/0.0	
	e	2.9.2029		
Send completed forms to: State Medical Board	d of Ohio			
Legal Department				
30 E. Broad St., 3 rd	Elaar Calumi	huo		
	rioor colum	uus,		
OH 43215-6127				

(Required pursuant to R.C. 2919.123)

MAR 26 2024

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided	P	Flo	12	2024
		Month	Day	Year
2. Name of medical practice of Maice Health		RU-486 was provid	ed:	
3. Address of medical practice	or facility at which	RU-486 was provi	ded:	
6721 Karl Road				
4. Date post RU-486 complica	tion began: マール	.24		
5. Event(s) (Please check all th	at apply):			
Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe ble	eding		
Other serious event (specify)				
6. Duration of event:	HoursO	_ Days		
7. Remarks: Pr did	not contine	protocul o	Her nibero	pere.
Pregny	not contine	, pr eleting	to culine	profess.
8. a. Name of physician who p	ovided RU-486	<u> </u>	on rossure	- <i>W</i> >
8. b. Physician's signature			n rosauc	D.O
	Date		.24	
Send completed forms to: S	tate Medical Board	of Ohio		
L	egal Department			
3	0 E. Broad St., 3 rd Fl	oor Columbus,		
O	H 43215-6127			

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	<u>Fef</u>	/ L	20 M
	Month	Day	Year
2. Name of medical practice or facility at which	RU-486 was pro	vided:	
You Choic Hastman LL	_		
3. Address of medical practice or facility at which	h RU-486 was pr	ovided:	
6721 Koul Rd Colub	y OH 4)	125	
4. Date post RU-486 complication began:	19.24		
5. Event(s) (Please check all that apply):			
<u>✓</u> Incomplete abortion Adverse	reaction to RU-486	Patient hospital	ized
Patient received a transfusion Severe b	leeding		
Other serious event (specify)			
6. Duration of event: HoursO	Days		
7. Remarks: PT & reveal Time Refld In D&C	. New n	en-mile per	yms.
3. a. Name of physician who provided RU-486	Wicork	m roonue	W
3. b. Physician's signature		— (MD	
Dat	e <u>3:l</u>	0.2.4	
end completed forms to: State Medical Board	d of Ohio		
Legal Department			
30 E. Broad St., 3 rd	Floor Columbus,		APR 19 2024
OH 43215-6127		STA	TE MEDICAL BOARD OF OHI

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was	brovided:	_April	(6	2014
2. Name of medical	Oractice and	Month		Year
Jane 1	practice or facility at whi	ch RU-486 was provide	d:	i eat
[POV	Choir Kerthan	· Uc		
3. Address of medical	practice or facility at wh			
6711 Ka	I M Colubry	iich RU-486 was provide	ed:	
		Ch 43705		
4. Date post RU-486 co	omplication began:			
	4	123/m		
5. Event(s) (Please che	ck all that apply).			
12W 09	mat apply).			
P Incomplete abortion	Adverse	reaction to RU-486	Dari	
Dotton		100	Patient hospitalized	
Patient received a trans	usion Severe b	leeding		
Other serious event (spe	cify)			
				
Duration of event	1			
overit.	Hours 0	_ Days		
Remarks:				
Faul	ud MAG. PT r	etand for some	1 AG	
		800		
. Name of physician wh	10 Drovided PLL Age			
. Physician's signature	7. 5. 6. MGCG 14.0-486	Muchon	roxam of	
· · · · · · · · · · · · · · · · · · ·			MOLDO	
	Date -	4.24.24		
completed forms to:	State Medical Board o			
		Unio		
	Legal Department			
	30 E. Broad St., 3 rd Floo	or Columbus,		
	OH 43215-6127			
			MAY 13 2	024

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provi	ded:	Apr	29	2027
		Month	Day	Year
2. Name of medical practi	ce or facility at which RU	-486 was provi	ded:	
Your Chein	tularic UC			
3. Address of medical prac				
6711 Kan	Rd Colubus	0 F U3-	reg	
4. Date post RU-486 comp 写/4 レ				
5. Event(s) (Please check a	l that apply):			
failed				
L Incomplete abortion	Adverse read	tion to RU-486	Patient hospitalize	d
Patient received a transfusion	on Severe bleedi	ng		
Other serious event (specify)			
6. Duration of event:	Hours 2	Days'		
7. Remarks: Foul co	d MAB, 7	Jums a	of Folise up.	
	for given rema	us for	SCAP.	
8. a. Name of physician who	provided RU-486	William	1 Nosque	<i>M</i> >
8. b. Physician's signature				D.O
	Date —	5-9.7		
end completed forms to:	State Medical Board of	Ohio		
and completed forms to	Legal Department	- inv		
	30 E. Broad St., 3 rd Floo	n Calumber		
		i Columbus,	J	UN 0 4 2024
	OH 43215-6127		STATE MI	EDICAL BOARD OF OHIC

STATE MEDICAL GOARD OF ORIO

AUG 0 0 2024

(Required pursuant to R.C. 2919,123)

1. Date RU-486 was provided	1:	John		5	2024
		Month		Day	Year
2. Name of medical practice	or facility at which RU-	486 was p	rovided:		
You Choin	Hubblane uc	-			
	r 48.				
3. Address of medical practice	·		•		
6721 Kan re	id colubis	OR	43229		
4. Date post RU-486 complica	ition began: 7/23/	'ey			
5. Event(s) (Please check all tl	nat apply):				
Incomplete abortion	Adverse react	Han to Dil A	ac Dotto	nt beautalized	1
r Ingomplete abortion	Adverse react	non to NO-4	oo rane	nt nospitalizeu	=
Patient received a transfusion	Severe bleedi	ng			
Other serious event (specify) _					36 2
6. Duration of event:(Hours D)ays	Herbildheide van de verster van de v	euronakon (s. e. 11712) en	
7. Remarks: Failed M	ed AB, now no sugary	reasmy	10.4 4	~ \$.	
Relld	he sugary				
8. a. Name of physician who p	rovided RU-486	Wil	lun Re	delide ms	
8. b. Physician's signature				0.0 (0.M	successiva'
	Date —	7.	23.14		
Send completed forms to:	State Medical Board of				
·	egal Department	4 1110			
	30 E. Broad St., 3 rd Floo	r Columbi	ıs		
	OH 43215-6127		-~,		

(Required pursuant to R.C. 2919.123)

1. Date RU-486 was provided:	Aug	UF	2024
	Month	Day	Year
2. Name of medical practice or facility at which RU-	486 was	provided:	
Your Choice fredering UC	_		
3. Address of medical practice or facility at which RU	J-486 was	provided:	
6721 Koul Re Colley	OH	43229	
4. Date post RU-486 complication began: 8ルル			
5. Event(s) (Please check all that apply):			
Lawl Incomplete abortion Adverse react	tion to RU-4	186 Patient hosp	pitalized
Patient received a transfusion Severe bleedi	ng		
Other serious event (specify)			
6. Duration of event: Hours OD	ays		
7. Remarks: PT à failed mise/miso	×2. k	lef'd alkulve	for surgical AD.
8. a. Name of physician who provided RU-486	V	Muito Roddin	in my
8. b. Physician's signature			I.D. / D.O
Date —		a)· F· Ly	
Send completed forms to: State Medical Board of	Ohio		
Legal Department			
30 E. Broad St., 3 rd Floor	Columbu	ıs.	
OH 43215-6127		•	OCT 0 4 2024

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	061	8	८०२५
		Month	Day	Year
2. Name of medical praction	ce or facility at which	RU-486 was provid	led:	
You Chair H	interne UC			
3. Address of medical pract	•	•	ided:	
6721 Kml	red. Coll of	म पउरर १		
4. Date post RU-486 compl	ication began:	1 14		
	10.1	1.09		
5. Event(s) (Please check al	l that apply):			
forward Incomplete abortion	Adverse i	reaction to RU-486	Patient hospitalize	d
			,	
Patient received a transfusio	on Severe blo	eeding		
Other serious event (specify			None of the Association of the Contract of the	

6. Duration of event:	(HoursO	Days		
			·	
7. Remarks: Failal	med AB. Pr	stacel regulat	success truly.	
8. a. Name of physician who	provided RU-486	William	Noldick	15
8. b. Physician's signature	Λ	The state of the s	M.D./	D.O.
o. D. I Hysician s signature		10 15.10	(
	Date	e		
Send completed forms to:	State Medical Board	d of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd F	loor Columbus,	no.	2 2 2024
	OH 43215-6127		UU	L V C VOX 4

STATE MEDICAL BOARD OF ONO