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 (Month) 15 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your 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):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Retained tissue Returned for D&C.

8. a. Name of physician who provided RU-486 William Rodriguez MD

8. b. Physician's signature _____ (M.D./D.O)

Date 2.12.24

Send completed forms to: State Medical Board of Ohio
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

1. Date RU-486 was provided: Jan (Month) 19 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd.

4. Date post RU-486 complication began:
Jan 25 2024

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

(X) Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Retained tissue. Ref'd to OBGyn for D&C.

8. a. Name of physician who provided RU-486 William Roderman MD

8. b. Physician's signature _____ (M.D./D.O)

Date 2.8.2024

Send completed forms to: State Medical Board of Ohio
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

1. Date RU-486 was provided: Jan (Month) 30 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began:
2/5/2024

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

- [x] Incomplete abortion (failed)
- [ ] Adverse reaction to RU-486
- [ ] Patient hospitalized
- [ ] Patient received a transfusion
- [ ] Severe bleeding
- [ ] Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. Pt opting to continue pregnancy.

8. a. Name of physician who provided RU-486 William Rodarte MD

8. b. Physician's signature _____ (M.D./D.O)

Date 2.9.2024

Send completed forms to: State Medical Board of Ohio
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

MAR 26 2024
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: Feb (Month) 12 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your 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: 2-26-24

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

~~X~~ failed Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Pt did not continue protocol after misoprostol.
Pregnancy remains viable; pt electing to continue pregnancy.

8. a. Name of physician who provided RU-486 William Noonan MD

8. b. Physician's signature _____ MD/DO

Date 3.8.24

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

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: Feb (Month) 12 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began: 3.19.24

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

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks:
Pt c retained tissue. Now non-viable pregnancy.
Ref'd for D&C

8. a. Name of physician who provided RU-486 William Roorick MD

8. b. Physician's signature _____ MD/DO

Date 3.20.24

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

APR 19 2024
STATE 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: April (Month) 16 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided: 6761 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began: 4/23/24

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

failed
p Incomplete abortion

___ Adverse reaction to RU-486

___ Patient hospitalized

___ Patient received a transfusion

___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB. pt returned for surgical AB.

8. a. Name of physician who provided RU-486 William Roberts

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

Date 4.24.24

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

MAY 13 2024
STATE 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: Apr (Month) 29 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6771 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began:
5/9/24

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

X Incomplete abortion (failed) ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: Failed MAB, >10 wks at follow-up. Pt given resources for SCAP.

8. a. Name of physician who provided RU-486 William Roadman MD

8. b. Physician's signature _____ MD/D.O

Date 5-9-24

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

JUN 04 2024
STATE 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: July (Month) 15 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Yow Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began: 7/23/24

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

Y Incomplete abortion (Suited)
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks:
Failed med AB, now nearing 10 wks.
Rec'd for surgery

8. a. Name of physician who provided RU-486 William Rodelick MD

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

Date 7.23.24

Send completed forms to: State Medical Board of Ohio
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

1. Date RU-486 was provided: Aug (Month) 25 (Day) 2024 (Year)

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

Your Choice Medicine LLC

3. Address of medical practice or facility at which RU-486 was provided:

6721 Karl Rd Columbus OH 43229

4. Date post RU-486 complication began:

8/26/24

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

X Incomplete abortion failed ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks:

Pt c failed mife/miso x2. Ref'd alternative for surgical AB.

8. a. Name of physician who provided RU-486 William Roderick MD

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

Date 9.5.24

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

OCT 04 2024

STATE 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: OCT (Month) 8 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare LLC

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd. Colu OH 43229

4. Date post RU-486 complication began:
10.11.24

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

X Incomplete abortion (failed) ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: (Hours 0 Days

7. Remarks: Failed med AB. Protocol repeated successfully.

8. a. Name of physician who provided RU-486 William Roddick MD

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

Date 10.15.24

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

OCT 22 2024
STATE MEDICAL BOARD OF OHIO

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