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

To be completed by the physician who provided RU-486

FEB 2 1 2024

STATE MEDICAL ROARD OF OHIO

1. Date RU-486 was provid	led:	Jon	ر۲	rory
		Month	Day	Year
2. Name of medical practi		*	ded:	
Your Chris	e Multhane U	LC 意		
3. Address of medical prac				
6721 Kaul	Hoad Columb	us of u	zus	
4. Date post RU-486 comp	lication began:			
	Sa	n er zoe	4	
5. Event(s) (Please check a	I that apply):			
	Adverse re	eaction to RU-486	Patient hospitalize	ed
Dadfant was bred a truck of city				
Patient received a transfusion	on Severe blee	eding		
Other and a second for the				
Other serious event (specify	Market and the control of the contro			- ASSESSED AND ADDRESS AND ADD
			Market	
6. Duration of event:/	Hours	_ Days		
7. Remarks: Netril	Times Rebus	end for	D&C.	
VICTORY	(V)VOC			
3. a. Name of physician who	provided RU-486	Whaik	r Roomen	· M
3. b. Physician's signature	•	11	L ROOMEN	D.O.
	Date -	2.12.00		
end completed forms to:	State Medical Board o	of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd Flo	or Columbus,		
	OH 43215-6127			

(Required pursuant to R.C. 2919.123)

FEB 2 1 2024

STATE MEDICAL BOARD OF OIRO

To be completed by the physician who provided RU-486

1. Date RU-486 was provided	1:	Jan	19	2024
		Month	Day	Year
2. Name of medical practice	or facility at which R	U-486 was provid	led:	
You arouse	Halthine 10	ic 🖟 "		
3. Address of medical practice	·	RU-486 was prov	ided:	
6721 Kaul 12	d·	Ę		
		* * *		
4. Date post RU-486 complica	ition began: San 25	2024		
5. Event(s) (Please check all ti	nat apply):			
@Incomplete abortion	Adverse re	action to RU-486	Patient hospitalize	d
,		i		
Patient received a transfusion	Severe blee	ding		
Other serious event (specify) _				
		***************************************		**************************************
6. Duration of event:	HoursO	Days		
7. Remarks: Retain	tissue. Ref	d to OBO	Cayn for Da	is.
8. a. Name of physician who p	rovided RU-486	WILLIAM	n Ropown	w
	/)		***
8. b. Physician's signature	· · · · · · · · · · · · · · · · · · ·		MD/	D.O
	Date -	۵ . 8	·wy	
Send completed forms to: S	tate Medical Board o	of Ohio		
·, L	egal Department			
3	0 E. Broad St., 3 rd Flo	or Columbus,		
	N /2015_6107			

(Required pursuant to R.C. 2919.123)

FEB 2 1 20124

To be completed by the physician who provided RU-486

STATE MEDICAL BOARD OF ONLO

1. Date RU-486 was provided:	Jan	3	0	lozy
	Month		Day	Year
2. Name of medical practice or faci		provided:		
3. Address of medical practice or fac	cility at which RU-486 wa	as provided:		
6721 Kan Rd Co	larbys 04 4322	19 1		
4. Date post RU-486 complication be	egan: 2/5/2024			
5. Event(s) (Please check all that app	oly):	a para 2000 and 1900		ту до је ту је у учено брене и не осе достого добо не постоја на пред се остоја на постоја на постоја на постој
P Incomplete abortion	Adverse reaction to RU	-486 Patien	thospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event: Ho	urs Days	u a sana na pandahan kana kana sa		
7. Remarks: Failed MAB.	Pt apring to	contine	pungning.	
8. a. Name of physician who provide	d RU-486	Wu.ru	novome no	
8. b. Physician's signature	/((AD/D.O	
	Date	2.9.2029		
Send completed forms to: State M	ledical Board of Ohio			
Legal D	epartment			
30 E. Br	oad St., 3 rd Floor Columl	ous,		
OH 432	215-6127			

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

MAR 2 6 2024 STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided:	Feb	12	2074
	Month	Day	Year
2. Name of medical practice or facility at which Your Chaice Kealthone WC	ch RU-486 was provid	ed:	
3. Address of medical practice or facility at wh		ded:	
6721 Karl Rad Columns	OH 43219		
4. Date post RU-486 complication began: フ・	-76·24		
5. Event(s) (Please check all that apply):			
Incomplete abortion Adver			
Incomplete abortion Adver	se reaction to RU-486 _	Patient hospitalize	ed
Patient received a transfusion Severe	e bleeding		
Other serious event (specify)			
6. Duration of event: Hours(
7. Remarks: Po did not contin	ie protecul o	etter milepu	yere.
7. Remarks: Pr did not court	le; preleting	to curare	wiling.
8. a. Name of physician who provided RU-486		An Rossine	
8. b. Physician's signature		MD/	0.0
D	ate3. &	.24	
Send completed forms to: State Medical Bo	ard of Ohio		
Legal Departmen	t		
30 E. Broad St., 3	rd 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:	<u>Fer</u>	12	2024
	Month	Day	Year
2. Name of medical practice or facility at which		ovided:	
3. Address of medical practice or facility at whicl	h RU-486 was p	rovided:	
6721 Koul Rd Colub.	7 04 4	3229	
4. Date post RU-486 complication began:	19.24		
5. Event(s) (Please check all that apply):			
Adverse	reaction to RU-48	5 Patient hospitali	æd
Patient received a transfusion Severe bl	eeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: PT & revent Time. Refld In Dec	Now n	on-meder prog	~ >.
8. a. Name of physician who provided RU-486	Wile	Am roonuc	w
8. b. Physician's signature		(MD	⟨D, O
, <u> </u>	e <u>3</u> .	20.2.4	<i></i>
Send completed forms to: State Medical Board	d of Ohio		
Legal Department			. 6 6001
30 E. Broad St., 3 rd F	loor Columbus		APR 19 2024
OH 43215-6127		STAT	E MEDICAL BOARD OF OHIO

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

	s provided:	_April	(6	2014
2. Name of modical		Month		
Jour	practice or facility at w Choic Ker(tha	hich RU-486 was provided	d:	Year
	Talina	m uc		
3. Address of medica	practice or facility at a	which RU-486 was provide		
6761 Ka	nd Md Colubry	OH 4326	ed:	
4. Date post RU-486 c	omnlication has			
_	emplication began:	4/23/14		
5. Event(s) (Please che	ock all the second	11021-4		
fail et	ck all that apply):			
P Incomplete abortion	Adve	rse reaction to but to		
	, , , , , , ,	rse reaction to RU-486 P	atient hospitalized	
Patient received a trans	fusion Severe	*		
		. Meeding		
Other serious event (spe	anie A			
- Too event (spe	echy)			
Duration of event:	Hours 0	Davs		

Remarks				
Remarks		return for sugar	AB.	
Remarks		return for sayor	AB.	
Remarks: Faul	ind MAN. PT	retained for Enger	e AB.	
Remarks: Faul	ind MAN. PT			
Remarks: Faul	lud MA4. PT ho provided RU-486	retained for Enger		
Remarks: Faul	lud MA4. PT ho provided RU-486			
Remarks: Faul . Name of physician wi . Physician's signature	lud MA4. pT ho provided RU-486		roxam y	
Remarks: Faul	lud MA#. pT ho provided RU-486 ————————————————————————————————————	William 4.24.24	roxam y	
Remarks: Faul . Name of physician wi . Physician's signature	ho provided RU-486 Date State Medical Board	William 4.24.24	roxam y	
Remarks: Faul . Name of physician wi . Physician's signature	ho provided RU-486 Date State Medical Board Legal Department	William Yizyizy of Ohio	roxam y	
Remarks: Faul . Name of physician wi . Physician's signature	ho provided RU-486 Date State Medical Board	William Yizyizy of Ohio	roxam y	

MAY 13 7074

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Apr	29	2027
	Month	Day	Year
2. Name of medical practice or facility at which	n RU-486 was i	provided:	
Your Chien Hulteric UC			
3. Address of medical practice or facility at which	 ch RU-486 wa:	provided:	
670 Kan Rd Count		•	
4. Date post RU-486 complication began:			
5. Event(s) (Please check all that apply):			
Language Adverse	e reaction to RU-4	486 Patient hospita	lized
Patient received a transfusion Severe b	oleeding		
Other serious event (specify)			
6. Duration of event: Hours0	Days		
7. Remarks: Fouled MAB,	7 (surs	od Felice .	ιφ.
8. a. Name of physician who provided RU-486	Wil	1.Am Nosque	. <i>N</i> >
8. b. Physician's signature		MO	j
Dat	te S		
Send completed forms to: State Medical Boar		t	
Legal Department			
30 E. Broad St., 3 rd	Floor Columbi	ıs,	JUN 0 4 2024
OH 43215-6127			JOH O J YOYA

STATE MEDICAL BOARD OF DHIC

STATE MEDICAL GOARD OF OMO

AUG 0 6 2024

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	Joly	15	2024
	Month 1	Day	Year
2. Name of medical practice or facility at wh	ich RU-486 was pro	ovided:	
You Chair Hubbare	ue		
3. Address of medical practice or facility at w	hich RIL-186 was n	rovidad:	
6721 Kan red Col			
Otel Kan PA Coo	OR 9	3019	
4. Date post RU-486 complication began:	7/23/24		
5. Event(s) (Please check all that apply):	The state of the s	Arthdon (and the Matter)	
South			
<u> </u>	erse reaction to RU-486	Patient hospitalize	ed
Patient received a transfusion Sever	re bleeding		
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Failed med AB, no Redid he Sugar	ow measing	10'Y Ws.	
Red'd by Sugn	m		
8. a. Name of physician who provided RU-489	s Will	un Rodelide u	9
8. b. Physician's signature		M.D.	In o
	7.	23.14	
	Date	V I V I	
Send completed forms to: State Medical Bo	oard of Ohio		
Legal Departmen	nt		
30 E. Broad St., 3	3 rd Floor Columbus		
OH 43215-6127	1		

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	Aus	UF .	2024
		Month	Day	Year
2. Name of medical practice	•	186 was provide	ed:	
3. Address of medical practi	ca ar facility at which DLL	AOC was provide	Jad.	
	·	•		
6721 Kaul	Re Colulis	OH 4322	9	
4. Date post RU-486 complic	cation began: 8 ในใน			i
5. Event(s) (Please check all	that apply):			Application of the state of the
Lancomplete abortion	Adverse reacti	on to RU-486	Patient hospitalize	d
Patient received a transfusion	Severe bleedin	g		
Other serious event (specify)	Ministra			
6. Duration of event:	Hours O Da	ays		
7. Remarks: Pて さ よ	aird mise/miso	x2. Ref'd	alkalva for	suggest AD.
8. a. Name of physician who	provided RU-486 _	VIIIAN	Nodelich	ms
8. b. Physician's signature			M.D. / I	0.0
	Date	91.1	ruy	
,	State Medical Board of C Legal Department 30 E. Broad St., 3 rd Floor			ALCONOMIC TOTAL
	OH 43215-6127			OCT 0 4 2024

STATE MEDICAL BOARD OF OWN

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provid	led:	001	8	<i>2</i> 024
		Month	Day	Year
2. Name of medical practi	ce or facility at which R	U-486 was prov	ided:	
You Chair H	enthene UC			
3. Address of medical prac	tice or facility at which	RII-486 was nro	wided:	The manufacture of the control of th
•	red. Coll of	•	Mucu.	
701				
4. Date post RU-486 compl	ication began:	. 24		
5. Event(s) (Please check al	l that apply):	44,000,000,000,000,000,000,000,000,000,		
faulu Incomplete abortion	Adverse re	eaction to RU-486	Patient hospitalize	ed
			,	
Patient received a transfusion	on Severe blee	eding		
Other serious event (specify)			
6. Duration of event:	(Hours O	_ Days		
7. Remarks: Failul	med AB. Pro	tocol repute	d succes truly.	
8. a. Name of physician who	o provided RU-486	William	n Nordick	<i>M</i>
8. b. Physician's signature			M.D/	
	Date	10.15-1	m (-	
Send completed forms to:	State Medical Board	of Ohio	MANAGEMENT	
	Legal Department			
	30 E. Broad St., 3 rd Flo	oor Columbus,	1995 - 1995	T n & AAA
	OH 43215-6127		nuise) [**	T 2 Z 2024

STATE MEDICAL BOARD OF ONIO

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