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: 01 (Month) 21 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429 # 19733

4. Date post RU-486 complication began: 1/31/22

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) _____

6. Duration of event: _____ Hours 7 Days

7. Remarks: ongoing heavy bleeding after medication abortion. Treated with Suction D&C

8. a. Name of physician who provided RU-486 Dr. Jeanne Corwin

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

Date 01/31/2022

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

FEB 17 2022
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: 1 (Month) 24 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/2/22

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 Ø Days

7. Remarks: Patient presented with retained IUP. Underwent uncomplicated D+C.

8. a. Name of physician who provided RU-486 Keith Reisinger-Kinzie

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

Date 2/2/22

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

FEB 17 2022
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: 1 (Month) 5 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/12/22

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: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Kelley

8. b. Physician's signature [signature] MD/D.O

Date 2/8/22

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

FEB 17 2022
STATE MEDICAL BOARD OF OHIO

State Medical Board of Ohio

Report of RU-486 Event

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

1. Date RU-486 was provided: Feb (Month) 25 (Day) 2022 (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:
3.7.22

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:
continuing pregnancy on U/S. Repeated misoprostol/mifepristone.

8. a. Name of physician who provided RU-486 K. Ann Nunnally

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

Date 3.8.22

Send completed forms to:

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

MAR 16 2022
STATE MEDICAL BOARD OF OHIO

State Medical Board of Ohio

Report of RU-486 Event

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

1. Date RU-486 was provided: Feb (Month) 28 (Day) 2022 (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:

3-7-22

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: Continuing pregnancy at f/u. Repeated misoprostol/misoprostol.

8. a. Name of physician who provided RU-486 L. Ann Nunnally, MD

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

Date 3-8-22

Send completed forms to:

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

MAR 16 2022
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: 2 (Month) 10 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/17/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 3/17/22

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

MAR 21 2022
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: 01 (Month) 14 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/8/22

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 _____ Days

7. Remarks:
Suction

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 3/10/22

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

MAR 21 2022
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: Jan (Month) 26 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
3/2/22

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: _____ Hours _____ Days

7. Remarks: uncomplicated D&E

8. a. Name of physician who provided RU-486 Jeanne Corwin

8. b. Physician's signature [signature] MD / DO

Date 03/02/2022

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

MAR 21 2022
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: 1 (Month) 7 (Day) 22 (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 Rd. Bedford Hts. Ohio 44146

4. Date post RU-486 complication began:
1/11/22

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 _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 1/7/22. Pt. called on 1/10/22 with c/o continued nausea. US performed on 1/11/22 revealed incomplete abortion. Surgical aspiration was performed 1/11/22; pt. did well post op.

8. a. Name of physician who provided RU-486 Dr. Vickery

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

Date _____

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: 1 (Month) 13 (Day) 22 (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 Rd. Bedford Hts. Ohio 44146

4. Date post RU-486 complication began:
1/20/22

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 _____ Days

7. Remarks: Mab procedure was initiated per FDA regimen on 1/13/22. Pt. called on 1/20/22 with c/o little to no bleeding. US performed on 1/21/22 confirmed continuing pregnancy. Surgical aspiration was performed 1/27/22; pt. did well post op.

8. a. Name of physician who provided RU-486 Dr. Vickery

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

Date _____

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 ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: March (Month) 4 (Day) 2022 (Year)

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

Your Choice Healthcare LLC

MAR 28 2022
STATE MEDICAL BOARD OF OHIO

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:

3-21-2022

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: Patient did not complete protocol after administration of mifepristone. VTabe pregnancy noted at flw, >10wks. Referred for surgical abortion.

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

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

Date 3-22-22

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: 01 (Month) 25 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429 # 28300

4. Date post RU-486 complication began: 3/16/22

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 _____ Days

7. Remarks: Underwent uncomplicated D+E after failed MAB.

8. a. Name of physician who provided RU-486 Dr. Reisinger-Kindle

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

Date 3/16/22

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

APR 06 2022
STATE MEDICAL BOARD OF OHIO

Prescribed. 5/--/2011. Rev. 12/13/32

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: 3 (Month) 3 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
4/1/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Suction

8. a. Name of physician who provided RU-486 Romanos

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

Date 4/1/22

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

APR 06 2022
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: 3 (Month) 8 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 3/11/2022

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 _____ Days

7. Remarks: Underwent uncomplicated D+C after failed MAB.

8. a. Name of physician who provided RU-486 Keith Reisinger-Kindle

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

Date 3/11/22

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

APR 06 2022
STATE MEDICAL BOARD OF OHIO

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

State Medical Board of Ohio
Report of RU-486 Event

APR 11 2022
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 provided: 2 (Month) 23 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/8/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Kolar

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

Date 4/5/22

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

APR 11 2022

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 provided: 2 (Month) / 16 (Day) / 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/1/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. K[illegible]

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

Date 4/5/22

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

Prescribed: S/--/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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 1 (Month) 5 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/12/22

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

Y 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 _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr Kelsey

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

Date 4/5/22

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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 2 (Month) 5 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/11/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

8. b. Physician's signature [signature] MD/DO

Date 4/1/22

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

Prescribed: S/--/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

APR 11 2022

STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 1 (Month) 13 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/21/22

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) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr Smyth

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

Date 4/1/22

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 ORC 2919.123)
To be completed by the physician who provided RU-486

APR 11 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: February (Month) 9th (Day) 2022 (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:

4/5/22

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed

6. Duration of event: 1 Hours 0 Days

7. Remarks:

Failed MAB., 7 pills. returned for surg.

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

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

Date 4-6-22

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: 2 (Month) 24 (Day) 2022 (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 Rd. Bedford Heights Ohio 44146

4. Date post RU-486 complication began:

2/26/2022

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 2/24/2022. Pt called on 2/26/2022 with c/o bleeding/pelvic pain. US on 3/1/2022 revealed incomplete AB. Surgical aspiration was performed on 3/1/2022 pt. did well post op.

8. a. Name of physician who provided RU-486 Dr. Vickery

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

Date 4/1/22

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: 3 (Month) 19 (Day) 22 (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 Rd. Bedford Heights, Oh. 44146

4. Date post RU-486 complication began:
3/22/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 3/19/22. Pt. called on 3/22/22 with c/o no bleeding/cramping. US revealed incomplete AB. Patient was given a repeat dose of mifeprex/misoprostol per FDA regimen, per patient's request.

8. a. Name of physician who provided RU-486 Dr. Vickery

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

Date 4/1/22

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 ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 3/8/22 — Month: 3 Day: 1 Year: 2022

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:

3255 E Main St, Columbus, Ohio 43213

4. Date post RU-486 complication began:

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks: MAB Procedure initiated per FDA regimen on 3/1/22. patient called emergency RN line 3/7/22 Reporting heavy bleeding & cramping. US revealed continuing pregnancy. Surgical aspiration performed 3/8/22.

8. a. Name of physician who provided RU-486 Dr Rivlin

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

Date 3/8/22

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: 1 (Month) 25 (Day) 2022 (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 Rd. Bedford Hts., Oh 44146

4. Date post RU-486 complication began:

1/31/2022

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

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

___ Patient received a transfusion ___ Severe bleeding

x Other serious event (specify) Intrauterine Debris

6. Duration of event: 1 Hours _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 1/25/22. Pt. called on 1/31/22 c/o pelvic pain and bleeding. US on 2/1/22 revealed intrauterine debris. Surgical aspiration was performed on 2/3/22; pt. did well post op.

8. a. Name of physician who provided RU-486 Dr. Brant

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

Date 2-15-22

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: 1 (Month) 8 (Day) 2022 (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 Rd. Bedford Hts. Ohio 44146

4. Date post RU-486 complication began:

2/7/2022

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 _____ Days

7. Remarks: MAB procedure was initiated per FDA regimen on 1/8/2022. Pt. called with + PTU on 2/7/22. Ultrasound on 2/10/22 revealed continuing pregnancy; surgical aspiration was performed 2/10/22 Pt. did well post op.

8. a. Name of physician who provided RU-486 Dr. Wilcox

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

Date 2/19/22

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

APR 25 2022
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 provided: 4 (Month) 8 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/4/22

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: Uncomplicated D+C after retained clots. No evidence of ongoing IUP on US.

8. a. Name of physician who provided RU-486 Dr. Reisinger-Kindle

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

Date 4/12/22

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

APR 25 2022
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 provided: 3 (Month) 23 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429
#29290

4. Date post RU-486 complication began:
4/5/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Suction.

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 4/7/22

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

APR 25 2022
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 provided: 3 (Month) 28 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton
#29352

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/4/22

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Treated with uncomplicated D&C

8. a. Name of physician who provided RU-486 Dr. Jeanne Corwin

8. b. Physician's signature [signature] MD DO

Date 04/04/2022

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: 3 (Month) 4 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
3/9/22

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Rita Di Napoli

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

Date 4/19/22

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

APR 29 2022
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: 2 (Month) 5 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
2/16/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Parsa

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

Date 4/1/22

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

APR 29 2022
STATE MEDICAL BOA...

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: 1 (Month) 14 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/18/22

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: 12 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Pinsal

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

Date 4/1/22

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

APR 29 2022
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: 4 (Month) / 1 (Day) / 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
4/12/22

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: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Broad

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

Date 5/14/22

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

MAY 16 2022
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: 4 (Month) / 19 (Day) / 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
4/27/22

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 D. Kelly

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

Date 5/17/22

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

MAY 31 2022
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: November (Month) 27 (Day) 2021 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 12/14/2021

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitchell Reider, MD

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

Date 5/25/22

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

JUN 02 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: December (Month) 11 (Day) 2021 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 1/22/2022

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date: 5/25/22

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

JUN 02 2022
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 provided: December 23 2021
   Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd
   Cleveland, OH 44120

4. Date post RU-486 complication began: 2/26/2022

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) _____

6. Duration of event: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitchell Reider, MD

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

Date 5/25/22

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

JUN 02 2022
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 provided: January (Month) 4 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: ~~2/12/2022~~ er 2/15/2022

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Miriam Cremer, MD

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

Date 5/24/22

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

JUN 02 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: January (Month) 5 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 1/14/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Mitchell Reiger, MD

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

Date 5/25/22

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

JUN 02 2022
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 provided: March (Month) 5 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd
Cleveland, OH 44120

4. Date post RU-486 complication began: 3/18/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date: 5/25/22

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

JUN 02 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: March (Month) 9 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 3/19/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 ~~Natasha~~ Mitchell Rider, MD

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

Date 5/25/22

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: March (Month) 9 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 5/10/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date: 5/25/22

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: March (Month) 23 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 5/4/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date: 5/25/22

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

JUN 02 2022
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 provided: March (Month) 26 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 4/15/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date: 5/25/22

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

JUN 02 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: May (Month) 11 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 5/14/2022

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Whitney Reider, MD

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

Date 5/25/22

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 ORC 2919.123)
To be completed by the physician who provided RU-486

JUN 23 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: May (Month) 27 (Day) 2022 (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: 6.14.22

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:

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

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

Date 6.17.22

Send completed forms to:

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

JUN 23 2022
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-485

1. Date RU-486 was provided: 5 (Month) 31 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
6/17/2022

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

___ Incomplete abortion ___ Adverse reaction to RU-485 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated D&C

8. a. Name of physician who provided RU-486 Jeanne Corwin

8. b. Physician's signature _____ MD DO

Date 06/20/2022

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

JUN 29 2022
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: 05 (Month) 23 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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: 2 Hours 0 Days

7. Remarks: IUP with cardiac activity after MAB. D+C performed - uncomplicated.

8. a. Name of physician who provided RU-486 Keith Reisinger-Kindle

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

Date 6/13/22

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

JUN 29 2022
STATE MEDICAL BOA

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: 5 (Month) 5 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 5/12/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated surgica

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____ MD DO

Date 5/12/22

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

JUN 29 2022
STATE MEDICAL BOARD OF

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: 4 (Month) 18 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429
[redacted] #29625

4. Date post RU-486 complication began: 4/22/22

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated SAB

8. a. Name of physician who provided RU-486 Dr. Jeanne Corwin

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

Date 06/07/2022

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

JUN 29 2022
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: 4 (Month) 8 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/14/2022 #15435

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) _____

6. Duration of event: _____ Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanes

8. b. Physician's signature [signature] MD/DO

Date 4/14/22

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

JUN 29 2022
STATE MEDICAL BOARD OF

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: 4 (Month) 27 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
6/22/22

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: _____ Hours _____ Days

7. Remarks: Referred out of State for care

8. a. Name of physician who provided RU-486 Jeanne Corwin MD

8. b. Physician's signature [signature] MD/DO

Date 6/22/2022

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: 6 (Month) 6 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/28/22

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

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

___ Patient received a transfusion ___ Severe bleeding failed medication abortion

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Referred out of state to complete abortion

8. a. Name of physician who provided RU-486 Jeanne Corwin

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

Date 6/28/2022

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: 6 (Month) 6 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-48 , was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
6/28/22

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

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

___ Patient received a transfusion ___ Severe bleeding failed abortion

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: Referred out of State for completion of termination

8. a. Name of physician who provided RU-486 Jeane Carwin

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

Date 6/28/2022

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: 6 (Month) 10 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
6/22/22

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romano, MD

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

Date 7/6/22

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: 5 (Month) 6 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
6/28/22

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) _____

6. Duration of event: 1 Hours 0 Days

7. Remarks: ~~Failed~~ Medication abortion
Incomplete

8. a. Name of physician who provided RU-486 ~~Catherine Ramanos MD~~

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

Date 7/6/22

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. 12/13/32

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: 5 (Month) 10 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/28/22

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: _____ Hours _____ Days

7. Remarks:
Patient failed MAB with delay in seeking follow up. Was 17 weeks at presentation, referred out of state.

8. a. Name of physician who provided RU-486 Keith Reisinger-Thindle, DO

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

Date 6/28/22

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

JUL 19 2022
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: 07 (Month) 14 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Northeast Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
2127 State Road, Cuyahoga Falls Ohio 44223

4. Date post RU-486 complication began:
7/19/2022

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed AB

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. DAVID Burkons

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

Date 7/20/22

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: 06 (Month) 09 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
7/5/2022

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

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

JUL 25 2022
STATE MEDICAL BOARD OF OHIO

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
referred out

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 7/20/22

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

Prescribed. 5/--/2011. Rev. 12/13/22

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: 6 (Month) 07 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 6/23/22

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

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

___ Patient received a transfusion ___ Severe bleeding

JUL 25 2022
STATE MEDICAL BOARD OF OHIO

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: uncomplicated D&C

8. a. Name of physician who provided RU-486 CORWIN

8. b. Physician's signature [signature] MD/DO

Date 06/23/2022

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

JUL 25 2022
STATE MEDICAL BOARD OF OHIO

1. Date RU-486 was provided: 07 (Month) 15 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:
7/18/22

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
dilation and suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 7/20/22

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: 6 (Month) 22 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 7/27/22

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: _____ Hours _____ Days

7. Remarks: failed medication abortion

8. a. Name of physician who provided RU-486 Dr. Jeane Corwin, MD

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

Date 07/27/2022

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

AUG 09 2022
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: _____
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began:

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 _____

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

Date _____

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

AUG 09 2022
STATE MEDICAL BOARD OF OHIO

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

State Medical Board of Ohio
Report of RU-486 Event

AUG 11 2022
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 provided: 5 (Month) 3 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
5/12/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Kelsey

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

Date 7/20/22

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

AUG 11 2022
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 provided: 4 (Month) 29 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
5/12/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Ponsak

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

Date 8/5/22

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

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

State Medical Board of Ohio
Report of RU-486 Event

AUG 11 2022
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 provided: 6 (Month) 18 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/24/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Ponsoti

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

Date 8/5/22

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

AUG 11 2022
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 provided: 4 (Month) 20 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/2/22

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: _____ Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Talbot

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

Date 7/19/22

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

AUG 11 2022
STATE MEDICAL BOARD OF

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 5 (Month) 28 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
7/13/22

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: _____ Hours 2 Days

7. Remarks:

8. a. Name of physician who provided RU-486 J. Lin

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

Date 7/19/22

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

AUG 11 2022
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 provided: 5 (Month) 24 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
7/1/22

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) pt. tx in ER for bluding, not severe.

6. Duration of event: _____ Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. [illegible]

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

Date 7/19/22

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: 5 (Month) 19 (Day) 22 (Year) — 06

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
5/19/22

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. DiNapoli

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

Date 8/12/22

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

AUG 17 2022
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: 5 (Month) 6 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/8/22

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Pinyopich

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

Date 6/12/22

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: 3 (Month) 30 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
6/21/22

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) _____

6. Duration of event: _____ Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Pignatello

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

Date 8/12/22

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

AUG 17 2022
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: 6 (Month) 24 (Day) 22 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 8/11/22

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: _____ Hours _____ Days

7. Remarks:
Referred out of State for termination

8. a. Name of physician who provided RU-486 Jeanne Cowin

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

Date 08/22/2022

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

SEP 30 2022
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: Sept (Month) 09 (Day) 2022 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 9/12/22

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 _____ Days

7. Remarks:
suction

8. a. Name of physician who provided RU-485 Dr. Catherine Romanos

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

Date 9/12/22

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

SEP 30 2022
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: 04 (Month) 26 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 05/25/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Miriam Cremer MD

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

Date 9/27/22

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OCT 03 2022
STATE MEDICAL

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: 04 (Month) 29 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 06/11/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 MR Mitchell Reider MD

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

Date 9/23/22

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

OCT 03 2022
STATE MEDICAL BOARD OF OH

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: 07 (Month) 19 (Day) 22 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 08/02/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider MD

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

Date: 9/23/22

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Columbus, OH 43215-6127

OCT 03 2022
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: 08 (Month) 12 (Day) 2022 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 12000 Shaker Blvd Cleveland, OH 44120

4. Date post RU-486 complication began: 08/17/22

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: 4 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider MD

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

Date: 9/23/22

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