



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 10 / 28 / 2016
Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 11/8/16

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 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Islay

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

Date 11/18/16

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

MEDICAL BOARD
NOV 21 2016