



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:	<u>12</u>	<u>2</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began:	<u>12/8/16</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>3</u> Hours	_____ Days	
7. Remarks:	<u>completed surgically</u>		
8. a. Name of physician who provided RU-486	<u>D. Kelsy</u>		
8. b. Physician's signature	<u>[Signature]</u>	<u>(M.D./D.O.)</u>	
	Date	_____	

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

DEC 27 2016



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:	<u>11</u>	<u>22</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began:	<u>12/3/16</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>2</u> Hours	_____ Days	
7. Remarks:	<u>D+C done without incident.</u>		
8. a. Name of physician who provided RU-486	<u>Sharon West</u>		
8. b. Physician's signature	<u>[Signature]</u>	<u>M.D./D.O.</u>	
	Date	<u>12/3/16</u>	

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MEDICAL BOARD

DEC 13 2016



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:	<u>10</u> <u>25</u> <u>16</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>
4. Date post RU-486 complication began:	<u>11/4/16</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medication Abortion</u>
6. Duration of event:	<u>3</u> Hours _____ Days
7. Remarks:	<u>Completed surgically without issue</u>
8. a. Name of physician who provided RU-486	<u>Dr. Pickle</u>
8. b. Physician's signature	<u>[Signature]</u> <u>(MD/DO)</u>
	Date <u>12/6/16</u>

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MEDICAL BOARD

DEC 12 2016



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:	<u>10</u> Month	<u>4</u> Day	<u>16</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave, Cincinnati, 45219</u>			
4. Date post RU-486 complication began: <u>10/22/16</u>			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <u>Failed medication Abortion</u>			
6. Duration of event: <u>2</u> Hours _____ Days <u>when pt returned for surgical completion</u>			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. Pickle</u>			
8. b. Physician's signature <u>[Signature]</u> <u>(MD/DO)</u>			
Date <u>12/6/16</u>			

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MEDICAL BOARD

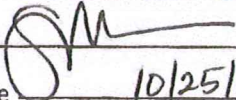
DEC 12 2016



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:	<u>10</u>	<u>4</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood Southwest Ohio</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Av.</u>		
4. Date post RU-486 complication began:	<u>10/16/16</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	<u>3</u> Hours	_____ Days	
7. Remarks:	<u>Completed surgically without issue</u>		
8. a. Name of physician who provided RU-486	<u>Dr. Pickle</u>		
8. b. Physician's signature		<u>(M.D./D.O.)</u>	
Date	<u>10/25/16</u>		

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MEDICAL BOARD

NOV 07 2016



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:	9	11	16
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood South West Ohio</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>2314 Auburn Ave. Cincinnati OH 45219</i>			
4. Date post RU-486 complication began: <i>9/11/16</i>			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input checked="" type="checkbox"/> Other serious event (specify) <i>Failed Abortion, completed surgically.</i>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <i>Dr. Kalsy</i>			
8. b. Physician's signature <i>[Signature]</i> M.D./D.O.			
Date <i>10/4/16</i>			

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MEDICAL BOARD

OCT 11 2016



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: 9 / 9 / 16
Month Day Year

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

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

4. Date post RU-486 complication began:
9/15/16

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) _____

6. Duration of event: 2 Hours _____ Days (plus time in ER for transfusion)

7. Remarks:

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

8. b. Physician's signature [Signature] M.D./D.O. _____
 Date 10/4/16

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 Columbus, OH 43215-6127

MEDICAL BOARD

OCT 11 2016



State Medical Board of Ohio Report of RU-486 Event

MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

SEP 23 2016

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	8	16	16
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood Southwest Ohio Region			
3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave., Cincinnati, OH 45219			
4. Date post RU-486 complication began: 8/30/16			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: ① Hours _____ Days			
7. Remarks: D+C done without issue.			
8. a. Name of physician who provided RU-486 Sarah Pickle.			
8. b. Physician's signature M.D./D.O.			
Date 9/20/16			

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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:	<u>06</u> <u>25</u> <u>16</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood Southwest Ohio Region</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>
4. Date post RU-486 complication began:	<u>9/9/16</u>
5. Event(s) (Please check all that apply):	<p style="text-align: right;">MEDICAL BOARD AUG 12 2016</p> <p><input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding</p> <p><input checked="" type="checkbox"/> Other serious event (specify) <u>Failed Ab, completed with surgery</u></p>
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	
8. a. Name of physician who provided RU-486	<u>Sharon Winer</u>
8. b. Physician's signature	<u>[Signature]</u> M.D./D.O.
	Date <u>9/2/16</u>

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: July 05, 2016
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
VP601

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

4. Date post RU-486 complication began:
07/14/2016

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: Failed medical abortion completed surgically

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

8. b. Physician's signature: [Signature] M.D./D.O.
 Date: 7/15/2016

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MEDICAL BOARD
JUL 18 2016



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:	<u>3</u>	<u>2</u>	<u>16</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood Southwest Ohio Region</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave., Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>3/23/16</u>			
5. Event(s) (Please check all that apply):			
<input type="checkbox"/> Incomplete abortion		<input type="checkbox"/> Adverse reaction to RU-486	
<input type="checkbox"/> Patient received a transfusion		<input type="checkbox"/> Patient hospitalized	
<input checked="" type="checkbox"/> Severe bleeding			
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>2</u> Days			
7. Remarks: <u>Doing well p D&L</u>			
8. a. Name of physician who provided RU-486 <u>Sharon Liner</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O.			
Date <u>4/2/16</u>			

MEDICAL BOARD
APR 12 2016

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