



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>2</u>	<u>25</u>	<u>17</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>3/11/17</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 Abortion</u>			
6. Duration of event: <u>2</u> Hours <u> </u> Days			
7. Remarks: <u>Completed Surgically without incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Kalsy</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u>			
Date <u>3/16/17</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAR 24 2017



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>2</u>	<u>28</u>	<u>17</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>3/14/17</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 performed without incident.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pickle</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u> Date <u>3/21/17</u>			

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

MEDICAL BOARD

MAR 31 2017



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>11</u>	<u>17</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:			
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 checked="" 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>Dr. Giv</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>4/5/17</u>			

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

APR 14 2017

Cincinnati
PP

Medical Board of Ohio Report of RU-486 Event

Required pursuant to R.C. 2919.123)

Completed by the physician who provided RU-486

3 29 17
Month Day Year

which RU-486 was provided:

Planned Parenthood

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:

4/18/17

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) _____

MEDICAL BOARD

6. Duration of event: 2 Hours _____ Days

MAY 12 2017

7. Remarks:

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

Dr. Kelly

8. b. Physician's signature

Kelly

MD/DO

Date

5/9/17

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:		
4	5	17
Month	Day	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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 6/27/17		
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: 2 Hours _____ Days		
7. Remarks: completed w/ D&C		
8. a. Name of physician who provided RU-486 Dr. Garschlag		
8. b. Physician's signature [Signature] (M.D. A.D.O.)		
Date 7.7.2017		

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

JUL 19 2017



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>4</u>	<u>5</u>	<u>18</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>4/11/18</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>4</u> ^{hrs} Hours _____ Days			
7. Remarks: <u>trial of medicine but needed D+C which was done with success.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. W...</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>5/16/18</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAY 21 2018



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>4</u>	<u>11</u>	<u>18</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>4/25/18</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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <u>1</u> Days			
7. Remarks: <u>pt. stable, started on iron</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lial</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>5/1/18</u>			

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

MAY 21 2018



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>4</u>	<u>28</u>	<u>18</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>5/9/18</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>Dr. Kirby</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</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
MAY 21 2018



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	28 Day	17 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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 5/5/17		
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: _____ Hours 4 Days		
7. Remarks: pt. returned for D+C as she could not stay on day this was diagnosed.		
8. a. Name of physician who provided RU-486 Dr. Lin		
8. b. Physician's signature [Signature] M.D./D.O. Date 5/9/17		

MEDICAL BOARD

MAY 12 2017

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:	<u>5</u>	<u>26</u>	<u>17</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>6/8/17</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>ongoing pregnancy</u>			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>completed surgically without issue</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lin</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____ Date <u>6/14/17</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JUN 19 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

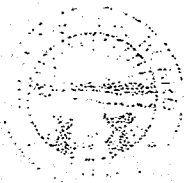
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
<u>5</u> Month	<u>31</u> Day	<u>17</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, OH 45219</u>		
4. Date post RU-486 complication began: <u>6/1/17</u>		
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: _____ Hours <u>2</u> Days		
7. Remarks: 		
8. a. Name of physician who provided RU-486 <u>Dr. Kirschenbaum</u>		
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. Date <u>6/30/2017</u>		

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

MEDICAL BOARD

JUL 10 2017



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>6</u>	<u>16</u>	<u>17</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>7/27/17</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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>2</u> Hours _____ Days			
7. Remarks: <u>Resolved w/ D+C.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Lin</u>			
8. b. Physician's signature _____ M.D./D.O. _____			
Date <u>8/3/17</u>			

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

MEDICAL BOARD



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:		
8 Month	4 Day	17 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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 8/18/17		
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: 2 Hours _____ Days		
7. Remarks: D & C performed		
8. a. Name of physician who provided RU-486 Dr. G. Schang		
8. b. Physician's signature [Signature] M.D./D.O. Date 8/18/17		

Send completed forms to: State Medical Board of Ohio

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

RECEIVED

SEP 1 2017



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 Month	20 Day	17 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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 10/04/17		
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 medical Abortion</u>		
6. Duration of event: <u>2</u> Hours _____ Days		
7. Remarks: <u>Completed surgically w/o issue</u>		
8. a. Name of physician who provided RU-486 <u>D. Lind</u>		
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>		
Date <u>10/5/17</u>		

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

OCT 12 2017



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 Month	21 Day	17 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. Cincinnati, OH 45219		
4. Date post RU-486 complication began:		
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 med Ab</u>		
6. Duration of event: <u>1</u> Hours <u>12/3/17</u> Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 <u>K. Lin</u>		
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>		
Date <u>12/3/17</u>		

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

OCT 06 2017



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>17</u> Day	<u>17</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, OH 45219</u>		
4. Date post RU-486 complication began: <u>11/10/17</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>ongoing pregnancy</u>		
6. Duration of event: <u>3</u> Hours <u> </u> Days		
7. Remarks: <u>Completed surgically</u>		
8. a. Name of physician who provided RU-486 <u>D. P. Lee</u>		
8. b. Physician's signature <u>[Signature]</u>		
Date <u>11/16/18</u>		

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

MEDICAL BOARD



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 Month	19 Day	17 Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood</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>12/1/17</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>continued pregnancy.</i>		
6. Duration of event: _____ Hours <i>2</i> Days		
7. Remarks: <i>pt. had termination completed surgically.</i>		
8. a. Name of physician who provided RU-486 <i>D. L. W.</i>		
8. b. Physician's signature <i>[Signature]</i> MD / DO _____		
Date <i>12/6/17</i>		

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 15 2017



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

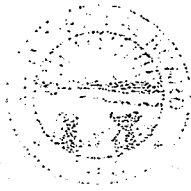
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		
11 Month	15 Day	17 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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 11/29/17		
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>on going pregnancy</u>		
6. Duration of event: <u>1</u> Hours <u> </u> Days		
7. Remarks: Completed surgically.		
8. a. Name of physician who provided RU-486 <u>Dr. Finc</u>		
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>		
Date <u>12/11/17</u>		

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

MEDICAL BOARD

DEC 15 2017



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:		
12	2	17
Month	Day	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. Cincinnati, OH 45219		
4. Date post RU-486 complication began: 12/21/17		
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 checked="" type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event: 2 Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486 _____ Dr. Luv- _____		
8. b. Physician's signature _____ MD/DO _____		
Date 12/26/17		

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

MEDICAL BOARD

JAN 09 2018



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

MEDICAL BOARD

JAN 27 2017

1. Date RU-486 was provided:	<u>1</u>	<u>3</u>	<u>17</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>1/10/17</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>infection</u>			
6. Duration of event: _____ Hours <u>14</u> Days			
7. Remarks: <u>responded well to antibiotics</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Pickle</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