



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>1</u> Month	<u>5</u> Day	<u>18</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>1/19/18</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: _____ Hours <u>6</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Dr. Kowalczuk</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O. _____			
Date <u>1/19/2018</u>			

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

MEDICAL BOARD

FEB 26 2018