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) 28 (Day) 2016 (Year)

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

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

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