

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-485

1. Date RU-486 was provided:	
Tear .	
2. Name of medical practice or facility at which RU-486 was provided:	
Planned Parenthood South West Ohio	
3. Address of medical practice or facility at which RU-486 was provided:	
2314 Auburn Ave. Cincinati Ott 4521	9
4. Date post RU-486 complication began: 9/1///	
5. Event(s) (Please check all that apply):	
Incomplete abortionAdverse reaction to RU-486 Patient hospitalized	Terpendenseason
Patient received a transfusion Severe bleeding	e e e e e e e e e e e e e e e e e e e
L'Other serious event (specify) Failed Abortion completed Surgicall	y.
6. Duration of event: Hours Days	
7. Remarks:	
8. a. Name of physician who provided RU-486 Dc. Kclsg.	
8. b. Physician's signature MD/DO	
8. a. Name of physician who provided RU-486 8. b. Physician's signature Date Date	
Send completed forms to: State Medical Board of Ohio	
Legal Department	
30 E. Broad St., 3 rd Floor	BUARD

Columbus, OH 43215-6127

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-485

1. Date RU-486 was provide	ded:	9	9	16
		Month	Day	Year
2. Name of medical practi	ce or facility at which I	RU-486 was provi	ided:	
Planned Pa	renthood !	South wes	+ Ohio	
3. Address of medical prac	tice or facility at which	RU-486 was pro	vided:	
2314 Au	burn Ave,	ancio	rati, 0	H 45219
4. Date post RU-486 comp				
5. Event(s) (Please check a	Il that apply):		:	
Incomplete abortion	Adverse r	eaction to RU-486	Patient hospitalize	ed
Patient received a transfusion	on Severe bleeding			
Other serious event (specify	v)			
6. Duration of event:6	2Hours	_Days (pla	us time in	ER for transfusion
7. Remarks:				
				1
	`.			
8. a. Name of physician wh	o provided RU-486	4	Dr. Kalsy	
8. b. Physician's signature	- VII	alin 10/	, M.D.	/D.O
	Date	10/	4416	
Send completed forms to:		al Board of Ohio		
	Legal Department			
	30 E. Broad St., 3 rd F	loor	MEDICAL BOA	
Columbus, OH 43215-6127				
				OCT 11 2016

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



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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	12	2	
	Month	Day	Year
2. Name of medical practice or faci Planned Parentho.	/	vided:	
3. Address of medical practice or face 2314 Auburn Au			
4. Date post RU-486 complication be	egan:		
5. Event(s) (Please check all that appunction	oly):Adverse reaction to RU-486	Patient hospitalized	
Patient received a transfusion Sev	vere bleeding		
Other serious event (specify)			·
6. Duration of event:	ours Days		
7. Remarks: Completed	Surgically		
· · · · · · · · · · · · · · · · · · ·			
8. a. Name of physician who provide	d RU-486	D. Kels	9
8. b. Physician's signature	Maly	(M.D) D.	0
	Date		
Send completed forms to:	State Medical Board of Ohio		
Legal D	epartment	MEDIC	TAT DO
30 E. Br	oad St., 3 rd Floor	MEDIC	AL BOARD
Columb	ous, OH 43215-6127	DEC	2 7 2016

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