

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

4 6					
1. Date RU-486 was prov	vided:	_2	25	17	
2. Name of medical prac		Month U-486 was prov	Day vided:	Year	
3. Address of medical pra	ctice or facility at which	RU-486 was pro	ovided:		
2314 Aubur	n Au. an	a, of	45219		
4. Date post RU-486 com	olication began: 3/11/H				
5. Event(s) (Please check a					- 1 V.
Incomplete abortion	Adverse re	action to RU-486	Patient hospitalized		
Patient received a transfus	ionSevere bleeding				
₩ Other serious event (specif	v) Foiled	Mostion		-	
6. Duration of event:	2_Hours	Days			
7. Remarks: Campleted	Surgically w	ithout,	n cident.		
8. a. Name of physician wh	o provided RU-486	.)	r Velva		
8. b. Physician's signature		1.23	MOIN		
	Date –	21,1	1/2	<u></u>	
send completed forms to:	State Medical I	Board of Ohio			
	Legal Department				
	30 E. Broad St., 3 rd Floo	or .	MEDICAL BON	3 15	
	Columbus, OH 43215-	6127	MAD 6 4 2012		

Cincinnati

Medical Board of Ohio t 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
01 1 0	wh	nich RU-486 was prov	vided:	
Planned Par	unthood			
3. Address of medical pra	ctice or facility at w	vhich RU-486 was pro	ovided:	
2314 Aubur				
4. Date post RU-486 com	plication began:			
5. Event(s) (Please check a	all that apply):			
Incomplete abortion	Adve	erse reaction to RU-486	Patient hospitalized	
Patient received a transfus	ion Severe bleedi	ng		
Other serious event (specif	y)			_MEDICAL BO
6. Duration of event:	Hours	Days		MAY 1 2 201
7. Remarks:				
3. a. Name of physician wh	o provided DIL 405		N 1/ 1/-	
	o provided RU-486	Maly	Dr. Killsy	
3. b. Physician's signature	D	ate 5/9/17		
end completed forms to:	State Med	dical Board of Ohio		
	Legal Departmen			
	30 E. Broad St., 3			
	Columbus, OH 43	3215-6127		



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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:		//	20	. 0
		Month	2 {	Y Y
2. Name of medical practice or the Planned Parent		J-486 was provi		160)
3. Address of medical practice or	r facility at which	RU-486 was pro	vided:	
2314 Auburn	Ave. Cin	a, ot	4.5219	
4. Date post RU-486 complicatio	n began:			
5. Event(s) (Please check all that	apply):			
Incomplete abortion	Adverse re	action to RU-486	Patient hospitaliz	red
Patient received a transfusion	_ Severe bleeding			
Other serious event (specify)				
6. Duration of event: 3	Hours	_ Days		
7. Remarks: completed su	july	***************************************		
8. a. Name of physician who pro	vided RU-486	d)1.	Kibi-	
8. b. Physician's signature	M	ally	MD	/D.O.
	Date			
Send completed forms to:	State Medica	Board of Ohio		
Leg	al Department			- 0 A DD
30	E. Broad St., 3 rd Fl	oor	MED	ICAL BOARD
Col	umbus, OH 4321	5-6127		MAY 2 1 2018