



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	17	2014
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood Southwest Ohio</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>12/30/14</i>			
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:			
8. a. Name of physician who provided RU-486 <i>Sageon Kim</i>			
8. b. Physician's signature _____ M.D./D.O.			
Date <i>2/18/15</i>			

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

MEDICAL BOARD
FEB 23 2015