

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

			•	16	
	Month	Day	- 	Үеэг	
			0		
nthood S	outhwist	Ohio	Regi	07	
or facility at which	RU-486 was pr	ovided:			
in AM.	Cinch	mati,	0#	45219	7
nat apply):					
Adverse	reaction to RU-486	Patient he	ospitalized	MED	IC
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12 Severe piceding					
***************************************				-	
Hours2	Days				
5 Dul					
provided RU-486		Marin	Li.	~/ <u></u>	
	1/2	12/16	MD/0		
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	e or facility at which A. A Ition began: Adverse Severe bleeding Hours Provided RU-486 Dat	Month or facility at which RU-486 was proved the or facility at which RU-486 was proved to represent the continuation began:	Month Day or facility at which RU-486 was provided: nthood Southwast Ohio e or facility at which RU-486 was provided: nthood Cinchnati, tion began:	Month Day or facility at which RU-486 was provided: nthood Southwast Ohio Region or facility at which RU-486 was provided: n Art., Cinchnati, Ott tion began:	Month Day Year or facility at which RU-486 was provided: NHOOD RESON er or facility at which RU-486 was provided: NAW. Cinchnat; OH U5216 tion began:

Columbus, OH 43215-6127



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1. Date RU-486 was provided:	06	25	16
	Month	Day	Year
2. Name of medical practice or facility at which R			
Planned Parenthood So	outhwest	Ohio	Region
3. Address of medical practice or facility at which a 2314 Auburn Aug. Ghannet: off 45219 4. Date post RU-486 complication began:	RU-486 was pro	vided:	
7/9/16	-		
5. Event(s) (Please check all that apply): Incomplete abortionAdverse re	eaction to RU-486	Patient hospita	MEDICAL BOAR
Patient received a transfusion Severe bleeding			AUG 12 2016
Other serious event (specify) Failed	Ab, c	ompleted	will Sarpry
6. Duration of event: Hours	_ Days		
7. Remarks:	and the second second second	green production of the second	
8. a. Name of physician who provided RU-486	_Shac	on hirel	
8. b. Physician's signature Date		MI MI	0./0.0
Send completed forms to: State Medica	l Board of Ohio		
/ Legal Department			
30 E. Broad St., 3 rd Fl	oor		
Columbus, OH 4321	5-6127		



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	11	22	16
	Month	Day	Year
2. Name of medical practice or facility at whi Planned Parenthood	ch RU-486 was pro	ovided:	
3. Address of medical practice or facility at wi	nich RU-486 was p	rovided:	
2314 Auburn Aus. C			
4. Date post RU-486 complication began:	12/3/16		
5. Event(s) (Please check all that apply): Incomplete abortion Adver	rse reaction to RU-486	6 Patient hospitalized	
Other serious event (specify)			
6. Duration of event: Hours	Days		
7. Remarks: Du (done without	incident.		
8. a. Name of physician who provided RU-486 8. b. Physician's signature	Soate —	12/11 600 10	Δ
Send completed forms to: State Me	dical Board of Ohi	0	

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-485

1. Date RU-486 was provide	d:		15	16
		Month	Day	Year
2. Name of medical practice		U-486 was prov	ded:	
3. Address of medical practic	e or facility at which	RU-486 was pro	vided:	
2314 Auburn	Au. an	a, ott	45219	
4. Date post RU-486 complica	ation began:	/3/17		
5. Event(s) (Please check all t	hat apply):			
Lincomplete abortion	Adverse rea	ection to RU-486	Patient hospitalized	
Patient received a transfusion	Severe bleeding			
Other serious event (specify)				
6. Duration of event: 2	Hours	Days		
7. Remarks:	lon without	- is su		
,				
. a. Name of physician who p	rovided RU-486		Dr. Line	
3. b. Physician's signature			M.D./D.	
	Date –		11+	
end completed forms to:	State Medical E	Board of Ohio		
L	egal Department		•	-
3	0 E. Broad St., 3 rd Floo	or		•
C	olumbus, OH 43215-	6127	j	AN (19 TOT



(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10	-a	
	Month		6 16
2. Name of medical practice or facility at which RU- Planned Parenthood		Day ided:	Year
3. Address of medical practice or facility at which RL	J-486 was pro	vided:	
2314 Auburn Aus. ana			
4. Date post RU-486 complication began:	3/17		
5. Event(s) (Please check all that apply):			
✓ Incomplete abortion Adverse react	ion to RU-486	Patient hospitalized	3
Patient received a transfusion Severe bleeding			
Other serious event (specify)			
6. Duration of event: 2 Hours Da	ays .		
7. Remarks: Completed (3) Dx (a	" that	- is ner	
3. a. Name of physician who provided RU-486		7.00 /	
3. b. Physician's signature Date —		M.D./E	0.0
end completed forms to: State Medical Bo	ard of Ohio		
Legal Department			
30 E. Broad St., 3 rd Floor			ORIOMI (ANGE)
Columbus, OH 43215-61	27	* C	property of the second of the second

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

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