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: 3 (Month) 2 (Day) 16 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave., Cincinnati, OH 45219

4. Date post RU-486 complication began:
3/23/16

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) ____________

6. Duration of event: ______ Hours 2 Days

7. Remarks:
Doing well p̄ D&C

8. a. Name of physician who provided RU-486 Sharon Liner

8. b. Physician's signature [illegible] MD/DO

Date 4/7/16

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

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

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: 06 (Month) 25 (Day) 16 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave.
Cincinnati, OH 45219

4. Date post RU-486 complication began:
7/9/16

5. Event(s) (Please check all that apply):

MEDICAL BOARD
AUG 12 2016

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

✓ Other serious event (specify) Failed Ab, completed with surgery

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sharon Lin

8. b. Physician's signature _____ M.D./D.O.

Date 8/2/16

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

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

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) 22 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
12/3/16

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) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
D+C done without incident.

8. a. Name of physician who provided RU-486 [illegible]

8. b. Physician's signature [illegible] MD / D.O

Date 12/3/16

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

MEDICAL BOARD

DEC 19 2016

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

3

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 (Month) 15 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided: 2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began: 1/3/17

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) ____________

6. Duration of event: 2 Hours ______ Days

7. Remarks: D&C done without issue

8. a. Name of physician who provided RU-486 Dr. Linn

8. b. Physician's signature ____________ M.D./D.O.

Date 1/4/17

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

JAN 09 '17

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

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 (Month) 18 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cinci, OH 45219

4. Date post RU-486 complication began:
1/3/17

5. Event(s) (Please check all that apply):

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
Completed w/ Dx C without issue

8. a. Name of physician who provided RU-486 Aaron Linn

8. b. Physician's signature _____ M.D./D.O.

Date 1/4/17

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

MEDICAL BOARD OF OHIO
JAN 09 2017

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