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: 04 (Month) 13 (Day) 2017 (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:
3255 E. Main St, Columbus OH 43213

4. Date post RU-486 complication began:
4/28/17

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

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

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours 15 Days

7. Remarks:

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

8. b. Physician's signature A. Lowther, MD M.D./D.O

Date 5/11/17

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

MEDICAL BOARD
MAY 16 2017

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

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