MEDICAL BOARD
JAN 27 2017

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:	1 (Month)	3 (Day)	17 (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:
1/10/17

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) infection

6. Duration of event: ________ Hours 14 Days

7. Remarks:
responded well to antibiotics

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

8. b. Physician's signature ________ (M.D.) / D.O.

Date ________

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:	2 (Month) 28 (Day) 17 (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:	3/14/17

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 performed without incident.

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

8. b. Physician's signature [signature] (M.D.) / D.O.

Date 3/21/17.

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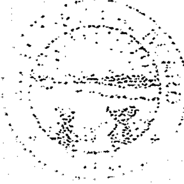

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	10 Month	17 Day	17 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: 11/10/17			
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) ongoing pregnancy			
6. Duration of event: 3 Hours ________ Days			
7. Remarks: completed surgically			
8. a. Name of physician who provided RU-486 [illegible]			
8. b. Physician's signature [signature] MD / DO (MD circled)			
Date 1/16/18			

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FEB 05 2018

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