



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:	<u>11</u> Month	<u>23</u> Day	<u>19</u> Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood</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>12/3/19</i>			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion / <i>Failed</i> <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: <i>Completed surgically w/o incident.</i>			
8. a. Name of physician who provided RU-486 <i>Dr. D. Stupoli</i>			
8. b. Physician's signature <i>[Signature]</i> <i>MB/DO</i>			
Date <u>12/14/19</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

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