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: 6 (Month) 14 (Day) 19 (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:
7/5/19

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

✓ Incomplete abortion / failed ___ 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 surgically

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

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

Date 7/19/19

Send completed forms to:

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

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) 8 (Day) 19 (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:
1/23/19

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: D&C performed

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

8. b. Physician's signature Priya Bansal MD/DO

Date 2/7/19

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Legal Department
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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-485

1. Date RU-486 was provided: 5 (Month) 28 (Day) 19 (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:
6/11/19

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: N/A Hours _____ Days

7. Remarks:
excess blood loss w/ medication abortion, no treatment needed other than iron supplement.

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

8. b. Physician's signature _____ MD/DO

Date _____

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

MEDICAL BOARD
JUN 24 2019

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