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) 25 (Day) 2019 (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:
10/25/2019

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: ________ Hours 2 Days

7. Remarks:
Failed med ab, pt was out of town + sought care

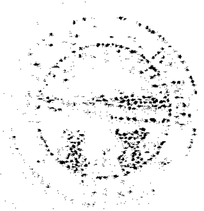
8. a. Name of physician who provided RU-486 Dr. Kelly

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

Date 1/29/2020

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

MEDICAL BOARD
FEB 04 2020



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)	4 (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:
12/4/19

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: ________ Hours 2 Days of treatment.

7. Remarks:
completed surgically.

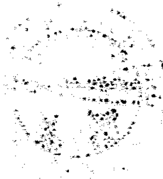
8. a. Name of physician who provided RU-486 Dr. Lim

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

Date 12/17/19

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

MEDICAL BOARD
DEC 23 2019



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	27 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: 12/10/19			
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 w/o incident			
8. a. Name of physician who provided RU-486 [illegible] 8. b. Physician's signature [signature] MD/DO Date 12/12/19			

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

MEDICAL BOARD
DEC 20 2019

Appendix III

Post Abortion Care Report For Complications

Ohio Department of Heath
(Required Pursuant to O.A.C. 3701-47-03
To be completed by the physician providing post-abortion care

State Use Only

1. Facility where post-abortion care was provided: Planned Parenthood SW Ohio

2. Street or Post Number: 2314 Auburn Ave. City: Cincinnati State: OH Zip: 45219

3. Date of Abortion: Month Day Year 2 / 15 / 19

4. Weeks of Gestation: 10

5A. Facility where Abortion was performed: Planned Parenthood SW Ohio

5B. Address of Facility: Street or Post Number: 2314 Auburn Ave. City: Cincinnati State: OH Zip: 45219

6. Date Post Abortion Care Begin: Month Day Year 2 / 21 / 19

7. Patient Number 0/0/0/0/ 2/4/2/5/3/3/

8. Complication (s) (Please check all that apply):

- ✓ Hemorrhage
- __ Anesthetic
- __ Hematometra
- __ Perforation of Uterus
- __ Failure of Amniotic Fluid Ex
- __ RH Incompatibility
- __ Cervical Laceration
- __ Failed Abortion
- __ Infection
- __ Incomplete Abortion
- __ Death
- ✓ Other (Specify) endometritis

9. Duration of treatment: (Indicate number of hours or days) (7)

____ Hours 14 ~~ Days

10. Remarks

pt. tx empirically with antibiotics due to pain but pain could have been residual from recent heavy bleeding that resolved on its own.

11A. Physician's Name providing care (Type or print) [signature]

11.B Physicians Signature: M.D. D.O. Date: 3/14/19

Send Completed Forms to: Ohio Department of Health
Confidential Reports A
PO Box 118
Columbus, Ohio 43216

2019 MAR 15 AM 10: 26
STATE MEDICAL BOARD OF OHIO

HEA 1806 Rev. 4/96

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) 30 (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:
2/13/19

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) Failed medication abortion

6. Duration of event: 2 Hours ______ Days

7. Remarks:
Completed surgically.

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

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

Date 2/14/19

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:	1 (Month) 29 (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:	2/12/19

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) Failed medical abortion

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 [signature] MD/DO

Date 2/12/19

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) 13 (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:	11/23/19
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:	2 Hours ____ Days
7. Remarks:	completed surgically
8. a. Name of physician who provided RU-486	Dr. Liu
8. b. Physician's signature	[signature] M.D./D.O.
Date	12/3/19

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

MEDICAL BOARD
DEC 1 6 2019