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) 14 (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:
2/10/20

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

4 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 for surgery Hours _____ Days

7. Remarks:
Completed surgically.

8. a. Name of physician who provided RU-486: Dr. D. Napoli

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

Date 4/14/20

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

MEDICAL BOARD
APR 22 2020

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