



# 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>2</u>	<u>26</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began:	<u>3/13/20</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion/failed <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:	<u>Completed surgically</u>		
8. a. Name of physician who provided RU-486	<u>Dr. Eusebio</u>		
8. b. Physician's signature	<u>[Signature]</u>	M.D./D.O.	
	Date	<u>4/17/20</u>	

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

APR 24 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:	4	16	20	
	Month	Day	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>5/21/20</i>				
5. Event(s) (Please check all that apply):				
<input checked="" type="checkbox"/> Incomplete abortion <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: <i>2</i> Hours _____ Days				
7. Remarks: <i>OK w/o incident</i>				
8. a. Name of physician who provided RU-486 <i>Low Schamy</i>				
8. b. Physician's signature <i>Miyajima</i> M.D./D.O.				
Date <i>6/9/2020</i>				

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 Columbus, OH 43215-6127

MEDICAL BOARD

JUL 10 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:	<u>4</u>	<u>23</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2314 Auburn Ave. Cincinnati, OH 45219</u>		
4. Date post RU-486 complication began:	<u>5/15/20</u>		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <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:	<u>DnC w/o incident</u>		
8. a. Name of physician who provided RU-486	<u>Corschaney</u>		
8. b. Physician's signature	<u>[Signature]</u>	M.D./D.O.	
	Date	<u>6/9/2020</u>	

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MEDICAL BOARD

JUL 10 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:	<u>6</u>	<u>16</u>	<u>20</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>2314 Auburn Ave. Cincinnati, OH 45219</u>			
4. Date post RU-486 complication began: <u>6/25/20</u>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <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: <u>Completed surgically</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Gurselny</u>			
8. b. Physician's signature <u>[Signature]</u> M.D./D.O.			
Date <u>7/21/2020</u>			

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Columbus, OH 43215-6127

**MEDICAL BOARD**

**JUL 30 2020**