



# 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     | 7   | 20   |  |
|   | Month | Day | Year |  |
| 2. Name of medical practice or facility at which RU-486 was provided:<br><i>Planned Parenthood</i>  |       |     |      |  |
| 3. Address of medical practice or facility at which RU-486 was provided:<br><i>2314 Auburn Ave. Cincinnati, OH 45219</i>  |       |     |      |  |
| 4. Date post RU-486 complication began:   |       |     |      |  |
| 5. Event(s) (Please check all that apply):  |       |     |      |  |
| <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized<br><br><input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding<br><br><input type="checkbox"/> Other serious event (specify) _____ |       |     |      |  |
| 6. Duration of event: <i>2</i> Hours _____ Days   |       |     |      |  |
| 7. Remarks:   |       |     |      |  |
| 8. a. Name of physician who provided RU-486 <i>Dr. P. [Signature]</i>   |       |     |      |  |
| 8. b. Physician's signature _____ M.D./D.O. _____   |       |     |      |  |
| Date <i>[Signature]</i> <i>4.28.20</i>  |       |     |      |  |

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**

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(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

|   |           |          |           |
|---|-----------|----------|-----------|
| 1. Date RU-486 was provided:  | <u>10</u> | <u>6</u> | <u>20</u> |
|   | Month     | Day      | Year      |
| 2. Name of medical practice or facility at which RU-486 was provided:<br><u>Planned Parenthood</u>  |           |          |           |
| 3. Address of medical practice or facility at which RU-486 was provided:<br><u>2314 Auburn Ave. Cincinnati, OH 45219</u>  |           |          |           |
| 4. Date post RU-486 complication began:<br><u>not on 11/12/20</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<br><input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding<br><input type="checkbox"/> Other serious event (specify) _____ |           |          |           |
| 6. Duration of event: <u>2</u> Hours _____ Days   |           |          |           |
| 7. Remarks:   |           |          |           |
| 8. a. Name of physician who provided RU-486   |           |          |           |
| 8. b. Physician's signature <u>Dr. P. [Signature]</u>   |           |          |           |
| Date <u>12/1/2020</u> <u>MD/DO</u>  |           |          |           |

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