



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>5</u> Month	<u>19th</u> Day	<u>22</u> 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>5/19/22</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: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: <u>Dr. DiNayak</u>			
8. b. Physician's signature: <u>[Signature]</u> <u>MD/DO</u>			
Date: <u>8/12/22</u>			

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

AUG 17 2022
 STATE MEDICAL BOARD OF OHIO



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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>5</u>	<u>6</u>	<u>22</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>6/8/22</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:			
8. a. Name of physician who provided RU-486	<u>Dr. Pindapelli</u>		
8. b. Physician's signature	<u>[Signature]</u>	<u>MD/DO</u>	
	Date	<u>8/12/22</u>	

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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>3</u>	<u>30</u>	<u>22</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>6/21/22</u>		
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 <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	_____ Hours	<u>1</u> Days	
7. Remarks:			
8. a. Name of physician who provided RU-486	<u>Dr. P. Napoli</u>		
8. b. Physician's signature	<u>[Signature]</u>		
	<u>MD/DO</u>		
	Date <u>8/12/22</u>		

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