



# 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 / 20 / 23  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
 Planned Parenthood of Greater Ohio

3. Address of medical practice or facility at which RU-486 was provided:  
 25350 Rockside Road, Bedford Heights, Ohio, 44146

4. Date post RU-486 complication began: 11/20/2023

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: 1 Hours 0 Days

7. Remarks: MAB proced we initiated per FDA regimen on 09/27/2023. Follow up US performed on 11/13 showing continuing pregnancy. Surgical Aspiration performed on 11/20/23.

8. a. Name of physician who provided RU-486 Kate Turner

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

Date 1

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

MAR 11 2024  
 STATE MEDICAL BOARD OF OHIO