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) 2 (Day) 16 (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:
12/8/16

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) ______________________

6. Duration of event: 3 Hours ______ Days

7. Remarks: completed surgically

8. a. Name of physician who provided RU-486 D. Kelsy

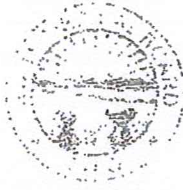
8. b. Physician's signature [signature] (M.D.)/D.O.

Date ______________________

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

MEDICAL BOARD
DEC 27 2016

Prescribed: 5/--/2011, Rev. 12/13/12



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 Month	22 Day	16 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: 12/3/16.			

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) ______________________

6. Duration of event: 2 Hours ______ Days

7. Remarks:
D+C done without incident.

8. a. Name of physician who provided RU-486 [illegible signature]

8. b. Physician's signature [signature] MD/D.O.

Date 12/7/16

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

MEDICAL BOARD

DEC 19 2016

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: 10 (Month) 25 (Day) 16 (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:
11/4/16

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: 3 Hours ______ Days

7. Remarks:
completed surgically without issue

8. a. Name of physician who provided RU-486 Dr. Pickle

8. b. Physician's signature [signature] (MD/DO)

Date 12/6/16

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

MEDICAL BOARD

DEC 12 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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:	10 Month	4 Day	16 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, 45219

4. Date post RU-486 complication began:
10/22/16

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: 2 Hours ______ Days when pt returned for surgical completion

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Pickle

8. b. Physician's signature [signature] M.D./D.O.

Date 12/6/16

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

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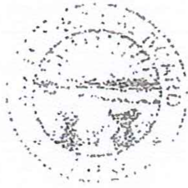
DEC 12 2016



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:	10 Month	4 Day	16 Year

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave.

4. Date post RU-486 complication began:
10/16/16

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

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 3 Hours ________ Days

7. Remarks:
completed surgically without issue

8. a. Name of physician who provided RU-486 Dr Pickle

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

Date 10/25/16

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
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Prescribed: 5/--/2011, Rev. 12/13/12

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: 8 (Month) 11 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinati OH 45219

4. Date post RU-486 complication began:
9/11/16

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 Abortion completed surgically.

6. Duration of event: ________ Hours ________ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. Kalsy

8. b. Physician's signature [signature] M.D./D.O.

Date 10/4/16

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

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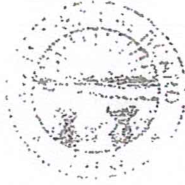
OCT 11 2016



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: 9 (Month) 9 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave, Cincinnati, OH 45219

4. Date post RU-486 complication began:
9/15/16

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) __________

6. Duration of event: 2 Hours ____ Days (plus time in ER for transfusion)

7. Remarks:

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

8. b. Physician's signature [signature] M.D./D.O.

Date 10/4/16

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

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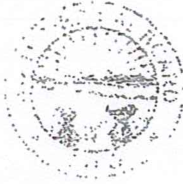
OCT 11 2016



State Medical Board of Ohio
Report of RU-486 Event

MEDICAL BOARD

SEP 23 2016

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 8 (Month) 16 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave., Cincinnati, OH 45219

4. Date post RU-486 complication began:
8/30/16

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) ______

6. Duration of event: (1) Hours ______ Days

7. Remarks:
D+C done without issue.

8. a. Name of physician who provided RU-486 Sarah Pickle.

8. b. Physician's signature [signature] M.D./D.O.

Date 9/20/16

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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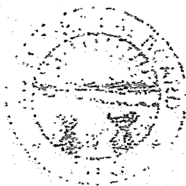

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 06 (Month) 25 (Day) 16 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave.
Cincinnati, OH 45219

4. Date post RU-486 complication began:
7/9/16

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

MEDICAL BOARD

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

AUG 12 2016

___ Patient received a transfusion ___ Severe bleeding

✓ Other serious event (specify) Failed Ab, completed with surgery

6. Duration of event: 1 Hours ________ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Sharon Liner

8. b. Physician's signature ________________ M.D./D.O.

Date 8/2/16

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Prescribed: 5/--/2011, Rev. 12/13/12

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: July 05, 2016
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   YPGOH

3. Address of medical practice or facility at which RU-486 was provided:
   3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:
   07/14/2016

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

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: 2 Hours ________ Days

7. Remarks: Failed medical abortion completed surgically

8. a. Name of physician who provided RU-486 Romanos

8. b. Physician's signature [signature] M.D./D.O.

Date 7/15/2016

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

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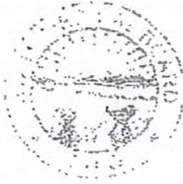
Prescribed: 5/–/2011, Rev. 12/13/12



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:	3	2	16
	Month	Day	Year

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

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave., Cincinnati, OH 45219

4. Date post RU-486 complication began:
3/23/16

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) ______________________

MEDICA[illegible] [illegible]ARD
APR 12 2016

6. Duration of event: ________ Hours 2 Days

7. Remarks:
Doing well p̄ D&C

8. a. Name of physician who provided RU-486 [illegible]

8. b. Physician's signature [signature] MD/DO

Date 4/7/16

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

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