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) 04 (Day) 2015 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood SW 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:
11/20/15

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 performed w/o incident.

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

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

Date 12/4/15

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

MEDICAL BOARD
DEC 09 2015

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: 6 (Month) 2 (Day) 15 (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:
6/18/15

MEDICAL BOARD
AUG 3

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: _____ Hours 30 Days Follow up period after meds

7. Remarks:
pt. elected to attempt completion with second dose of miso prostol, had D+C on 7/21/15 without problem

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

8. b. Physician's signature _____ MD / DO

Date 7/24/15

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Prescribed: S/--/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: 2 (Month) 17 (Day) 2015 (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.

4. Date post RU-486 complication began:
3/6/15

MEDICAL BOARD
AUG 3 2015

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: _____ Hours 14 Days Follow up period after mtb.

7. Remarks:
Pt. did well with second dose of misoprostol

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

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

Date _____

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