# 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) 17 (Day) 2014 (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: 12/30/14

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:

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

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

Date 2/18/15

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

MEDICAL BOARD
FEB 23 2015

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