State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 02 (Month) 28 (Day) 17 (Year)

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

Capital Care Network Toledo

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

1100 W Sylvania Ave
Toledo, OH 43612

4. Date post RU-486 complication began:

3/9/17

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 1 Days

7. Remarks:

Pt in for surgical suction after incomplete Medical. Ø complications (D+C)

8. a. Name of physician who provided RU-486 Dr. David Burkons MAA1224

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

Date 03/09/18

Send completed forms to:

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

MEDICAL BOARD