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: MARCH (Month) 13 (Day) 2018 (Year)

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

Founder's Women's Health Center

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

1243 E Broad St, Columbus OH 43205

4. Date post RU-486 complication began:

March 30, 2018

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: 2.5 Hours _____ Days

7. Remarks:

Incomplete medication abortion. Confirmed by ultrasound. D and C performed, no complications. Pt tolerated well.

8. a. Name of physician who provided RU-486 Karl Schaeffer, MD

8. b. Physician's signature Karl Schaeffer M.D/D.O

Date 3-30-18

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 05 2018

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