State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

				4			
1. Date RU-486 was provide	d:	05	16	2012			
		Month	Day	Year			
2. Name of medical practice or facility at which RU-486 was provided:							
CENTICAL	0/410	Workas's	Captar				
3. Address of medical practic							
3,55 E. NO	IN STICE	T Cohui	MBUS, ONO	43213			
4. Date post RU-486 event be	egan: () 4 - 0 4 - 7	,	,				
5. Event(s) (Please check all				ka (1866-1860), Die derekters om die gewinde de Nami van die die gewinde gewinde de Verende vereinstellige gew			
Incomplete abortion	Adverse	reaction to RU-486	Patient hos	pitalized			
Patient received a transfusion	Severe	bleeding					
Other serious event (specify)				And the state of t			
6. Duration of event: Hours Days							
7. Remarks:			maniana ya pilikikan alimiddi bir Agaloo oo uu uu uu uu ahaa ahaa ahaa ahaa ah				
A Prince Control of the Control of t							
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8. a. Name of physician who p	provided RU-48	36 JULIU	nu can	Swo MD			
8. b. Physician's signature		1111		M.D. / D.O			
Parameter and Pa	Dat	e	11/12				
Send completed forms to:	State Medic	cal Board of Ohio	<u>- — — — — — — — — — — — — — — — — — — —</u>				
	Legal Depa	ırtment	MEDI	BALBOARD -			
	30 E. Broad	d St., 3 rd Floor					
	Columbus	OH 43215-6127	ş ¹ ;; ³	V IS WILL			

Rept#7

State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provide	ed:	March	19 Day	2012
2. Name of medical practice	or facility at v			Year
Central Onio W		-		W. Marie
3. Address of medical practic	e or facility at	which RU-486 was	provided:	
3755 East Mo 4. Date post RU-486 event b	egan:	Columbus, 01	4	
5. Event(s) (Please check all	that apply):		The state of the s	
Incomplete abortion	Adve	rse reaction to RU-486	Pati	ent hospitalized
Patient received a transfusion	Seve	re bleeding		
Other serious event (specify)	MANAGAMAN AND AND AND AND AND AND AND AND AND A			
6. Duration of event:	Hours	Days	F	
7. Remarks:				
		•		
8. a. Name of physician who	provided RU-	486 <u>COHAL</u>	rue C	
B. b. Physician's signature		ate5/	14/12	M.D. / D.O
Send completed forms to:		dical Board of Ohio		
	Legal De	partment	A.F'' . 3. 2	
	30 E. Bro	Broad St., 3 [™] Floor MEDICAL C		MEDICAL DUAL
	Columbu	s, OH 43215-6127		MAY 2 4 2012