Report 43

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: 05 (Month) 22 (Day) 2013 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Central Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided: 3255 E. MAIN STREET Cols., OHIO 43213

4. Date post RU-486 complication began: 6/7/13

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: 1 Hours _____ Days

7. Remarks: D&C done.

8. a. Name of physician who provided RU-486 DR. Kuder

8. b. Physician's signature MK (M.D./D.O)

Date 6/26/13

MEDICAL BOARD
JUL 9 - 2013

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

Prescribed: 5/--/2011, Rev. 12/13/12