Rept # 12

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 provided:	missement it in the contract of the contract o	Luf	<u> </u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:			
	Women's	Center	
3. Address of medical practice or facility at which RU-486 was provided:			
3. Address of Medical practice of	a di		43213
4. Date post RU-486 event begar	4-12-12		and the second s
5. Event(s) (Please check all that	apply):	etal general projecti, consider in infrae de la constantina del constantina del constantina de la constantina del constantin	
XIncomplete abortion	Adverse reaction to RU	J-486 Patient ho	ospitalized
Patient received a transfusion	Severe bleeding		
Other serious event (specify)			
6. Duration of event:	Hours 14 Days		
7. Remarks:	and the state of t	s t dia pharmacha mandra mandria pasti injundus dia insulati na mandra mana mangrapa di melandani kini kini k	
8. a. Name of physician who provided RU-486			
8. b. Physician's signature	+ mku no	M.D. / D.O	
8. D. Physician's signature	one and the second control of the second con	(5725/12	
	Date	nere en	
Send completed forms to:	State Medical Board of	Ohio	
	Legal Department		
	30 E. Broad St., 3 rd Flor)(*	Ť 46
		bus, OH 43215-6127 MEDICAL BQ/	
	Columbus, Ort 43210-	hit to time to	

MAY 3 I 2012

Prescribed: 5/--/2011