## 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-488

1. Date RU-486 was provided	:	05	16	20/2		
		Month	Day	Year		
2. Name of medical practice or facility at which RU-486 was provided:						
1 GNTRAK	DAID	Womas's	(Varya)			
	01.10	Williams	C499C			
3. Address of medical practice or facility at which RU-486 was provided:						
3/55 E. MA	IN STILE	et Cohui	ribus, ONO	43213		
4. Date post RU-486 event beg	gan:					
04-04-12						
5. Event(s) (Please check all that apply):						
Incomplete abortion	Advers	e reaction to RU-486	Patient hos	pitalized		
Patient received a transfusion	Severe	bleeding				
Other serious event (specify)						
				and the same and t		
6. Duration of event:	Hours	Days				
7. Remarks:						
		Cuth		1/212		
8. a. Name of physician who pr	rovided RU-4	86	TIME CAL	Brus MI		
8. b. Physician's signature		11000	>	M.D. / D.O		
	Da	te(p	11/12	·		
Send completed forms to:	State Medi	cal Board of Ohio				
	Legal Dep	artment	MEDIC	GAL BOARD		
		d St., 3rd Floor				
		OH 43215-6127	JU	N 18 2012		

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	d:	Maych Month	Day	2012 Year			
2. Name of medical practice	or facility at w	hich RU-486 was p	provided:				
Central Onio W.	omen's Ce	nter					
3. Address of medical practice	e or facility at	which RU-486 was	provided:				
,							
		Columbus, o	H				
4. Date post RU-486 event be	egan:						
5. Event(s) (Please check all	that apply):						
Incomplete abortion	Adver	se reaction to RU-486	Patie	nt hospitalized			
Patient received a transfusion	Sever	e bleeding					
,							
Other serious event (specify)							
		-					
6. Duration of event:	Hours	Days					
7. Remarks:	en fersette filmen til ster fra former men för sik sik på set til behalde. Han en ett gillet til der filmler en getter men sen eller ett til ster filmler sik sen film ster sik set til s						
7. Hemarks:							
8. a. Name of physician who p	provided RU-	486 COHOU	rue a	nsuo			
8. b. Physician's signature	(1	Mode		M.D. / D.O			
o. b. r riyololari o olgilataro	D	ate5	114/12	W.D. / D.O			
Cond complete 15		and the same are not as the same of the sa					
Send completed forms to:		State Medical Board of Ohio					
	Legal Dep	ad St., 3 <sup>rd</sup> Floor		MEDICAL DUALL			
	Columbus	s, OH 43215-6127		MAY 2 4 2012			