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: 10 (Month) 6 (Day) 2016 (Year)

2. Name of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223

NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223

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

4. Date post RU-486 complication began: 10/30/16

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: Pt had D&C at our facility on 10/31/16 w/out complications.

8. a. Name of physician who provided RU-486: David M. Brinks, MD

8. b. Physician's signature _____ M.D. / D.O.

Date 11/7/16

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

MEDICAL BOARD
NOV 10 2016

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

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: June 1 2016
   Month Day Year

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

3. Address of medical practice or facility at which RU-486 was provided:
   2127 State Rd
   Cuyahoga Falls, Ohio 44223

4. Date post RU-486 complication began:
   6/12/16

5. Event(s) (Please check all that apply):

MEDICAL BOARD

JUN 28 2016

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: Pt called c little bleeding after Mife/Miso
   U/S showed sac still present though smaller
   Elected to have suction D&C rather than repeat Miso

8. a. Name of physician who provided RU-486 D.M. Burkons

8. b. Physician's signature [signature] M.D./D.O.

Date 6/27/16

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

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: Jan (Month) 24 (Day) 2016 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2127 State Rd
Cuyahoga Falls, Ohio 44223

4. Date post RU-486 complication began:
2/10/16

5. Event(s) (Please check all that apply):

MEDICAL BOARD
MAR 7 2016

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 10 Days

7. Remarks: pt had persistent but smaller sac i elevated HCG a D.C was done on 2/10/16 i completion of ab

8. a. Name of physician who provided RU-486 David Burkons, M.D

8. b. Physician's signature _____ MD/DO

Date 2/15/16

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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