



# 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	6	2014
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <b>NORTHEAST OHIO WOMENS CENTER LLC</b>			
2127 STATE RD CUYAHOGA FALLS, OH 44223			
NORTHEAST OHIO WOMENS CENTER LLC CUYAHOGA FALLS, OH 44223			
3. Address of medical practice or facility at which RU-486 was provided:			
CUYAHOGA FALLS, OH 44223			
4. Date post RU-486 complication began:			
10/30/16			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized  <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding  <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks: <i>AS had D&amp;C at our facility on 10/31/16 without complication</i>			
8. a. Name of physician who provided RU-486: <i>David M. Bunkens, MD</i>			
8. b. Physician's signature: _____ M.D./D.O.			
Date: <i>11/17/16</i>			

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

**MEDICAL BOARD**  
 NOV 10 2016

# 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's Ctr

3. Address of medical practice or facility at which RU-486 was provided:  
21249 S. White Rd  
Cuyahoga Falls, OH 44723

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

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

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized JUN 28 2016

Patient received a transfusion       Severe bleeding

Other serious event (specify) \_\_\_\_\_

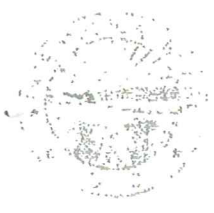
6. Duration of event: 1 Hours \_\_\_\_\_ Days

7. Remarks: pt called in little bleed after Mife/miso  
US showed sac still present through smalles  
decided to have surgery at which time report MISO

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

8. b. Physician's signature \_\_\_\_\_ MD/DO  
 Date 6/27/16

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Columbus, OH 43215-6127



# 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	29	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Northeast Ohio Women's Center</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>2127 State Rd Cuyahoga Falls, Ohio 44223</i>			
4. Date post RU-486 complication began: <i>2/10/16</i>			
5. Event(s) (Please check all that apply):			
<input checked="" type="checkbox"/> Incomplete abortion		<b>MEDICAL BOARD</b>	
<input type="checkbox"/> Adverse reaction to RU-486		MAR 7 2016	
<input type="checkbox"/> Patient hospitalized			
<input type="checkbox"/> Patient received a transfusion		<input type="checkbox"/> Severe bleeding	
<input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ Hours <i>10</i> Days			
7. Remarks: <i>Pt had persistent but smaller size elevated HCG a P/E was done on 2/10/16 in completion of abx</i>			
8. a. Name of physician who provided RU-486 <i>David Burkens, M.D.</i>			
8. b. Physician's signature _____ M.D./D.O.			
Date <i>2/15/16</i>			

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