State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 09 (Month) 21 (Day) 17 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
The Founder's Women's Health Center
1243 East Broad Street
Columbus, Ohio 43205

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

4. Date post RU-486 complication began: 9-25-17, 10-12-17

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: 41 Hours 0 Days

7. Remarks: Multiple pregnancy, failed medical Suction aspiration treatment.

8. a. Name of physician who provided RU-486: DR Blank MD

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

Date 11-11-17

Send completed forms to:

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

MEDICAL BOARD
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1. Date RU-486 was provided: 11 (Month) 25 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St. Columbus, Ohio 43205

4. Date post RU-486 complication began:
12.9.17

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: Moderate tissue

8. a. Name of physician who provided RU-486 Harley Blank MD

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

Date 12.9.17

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Columbus, OH 43215-6127

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