

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:	<u>3/</u> <u>March</u> <u>16</u> <u>2017</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2127 State Rd</u> <u>Cuyahoga Falls Ohio 44203</u>
4. Date post RU-486 complication began:	<u>4/15/17</u>
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>3</u> Hours _____ Days
7. Remarks:	<u>PT had D+E without complications</u>
8. a. Name of physician who provided RU-486	<u>J. M. Wilson, MD</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO
Date	<u>5/18/17</u>

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD

MAY 20 2017

State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>March 27 2017</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>21249 State Rd Cuyahoga Falls, Ohio 44223</u>
4. Date post RU-486 complication began:	<u>4/28/17</u>
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>3</u> Hours _____ Days
7. Remarks:	<u>It had D+E without complications</u>
8. a. Name of physician who provided RU-486	<u>L. Ann Nunally</u>
8. b. Physician's signature	<u>[Signature]</u> MD/DO
Date	<u>5/24/17</u>

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MEDICAL BOARD

MAY 30 2017

State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>7</u>	<u>13</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Center</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2127 State Rd Cuyahoga Falls 44223</u>		
4. Date post RU-486 complication began:	<u>8/12/17</u>		
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:	_____ Hours	_____ Days	
7. Remarks:	<u>pt. had (+) ptu post medication Abortion. She had heavy bleeding and on ultrasound there was remaining tissue but pregnancy was resolved. pt had a PEC on 8/22/17</u>		
8. a. Name of physician who provided RU-486,	<u>Dr. L.A. Nunnally</u>		
8. b. Physician's signature	<u>[Signature]</u> MD/DO		
	Date	<u>9/7/17</u>	

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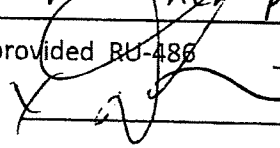
MEDICAL BOARD

SEP 15 2017

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:	<u>7</u>	<u>10</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Northeast Ohio Women's Center</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>2127 State Rd Cuyahoga Falls Ohio 44223</u>		
4. Date post RU-486 complication began:	<u>7/27/17</u>		
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: _____ Hours _____ Days			
7. Remarks:	<u>post med AB patient had a remaining gestational sac w/ no fetal pole developed or remaining. patient had DEC on 7/27/17 to complete her process.</u>		
8. a. Name of physician who provided RU-486	<u>Dr. DAVID Burkons</u>		
8. b. Physician's signature			
Date	<u>9/2/17</u>	<u>MD/DO</u>	

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MEDICAL BOARD

State Medical Board of Ohio Report of RU-486 Event

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>October</u> <u>21</u> <u>2017</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>North east Ohio Women's Center</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>2127 State St</u> <u>Cuyahoga Falls, Ohio 44223</u>
4. Date post RU-486 complication began:	<u>11/16/17</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> <u>Failed</u> 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>2</u> Hours _____ Days
7. Remarks:	<u>a suction D & C was performed on 11/16/17</u> <u>without difficulty</u>
8. a. Name of physician who provided RU-486	<u>Jennifer Watson</u>
8. b. Physician's signature	<u>J. Watson</u> MD / DO
	Date <u>11/18/17</u>

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NOV 27 2017