

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:	<u>01</u>	<u>26</u>	<u>2018</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Capital Care Network Toledo</u>			
3. Address of medical practice or facility at which RU-486 was provided: <u>1160 W. Sylvan Ave. Toledo, OH 43612</u>			
4. Date post RU-486 complication began: <u>02/20/2018</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>4</u> Hours <u>0</u> Days			
7. Remarks: <u>Incomplete med. AB. D&C completed. No complications.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. L. Ann Nunnally</u>			
8. b. Physician's signature <u>L. Ann Nunnally MD</u> <u>(M.D./D.O.)</u>			
Date <u>02/20/2018</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 13 2018

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: 02 / 22 / 18
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvan Ave
Toledo, OH 43612

4. Date post RU-486 complication began:
3/9/19

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

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

Patient received a transfusion Severe bleeding

Other serious event (specify) _____

6. Duration of event: _____ Hours 1 Days

7. Remarks:
Plan for suction after incomplete Med AB. complications
(D+C)

8. a. Name of physician who provided RU-486 Dr. David Burkens MAA1224

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

Date 03/09/18

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MEDICAL BOARD

31 178

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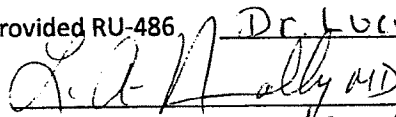
1. Date RU-486 was provided:	04	27	2018
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Capital Core Network of Toledo			
3. Address of medical practice or facility at which RU-486 was provided: 1160 W. Sylvania Ave.			
4. Date post RU-486 complication began: 06-02-18			
5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized ___ Patient received a transfusion ___ Severe bleeding ___ Other serious event (specify) _____			
6. Duration of event: 5 Hours ___ Days			
7. Remarks: Incomplete med ab. pt requests d+e. D+e completed, & complications WFK0819			
8. a. Name of physician who provided RU-486			
8. b. Physician's signature <u>L. A. Nally MD</u> (M.D./D.O.)			
Date <u>06/02/18</u>			

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MEDICAL BOARD
JUN 11 2018

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>05</u> Month	<u>10</u> Day	<u>2018</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Capital Care Network Toledo</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>1160 W. Sylvania Ave Toledo OH 43612</u>		
4. Date post RU-486 complication began:	<u>05/23/2018</u>		
5. Event(s) (Please check all that apply):	<input 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 checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medical Abortion</u>		
6. Duration of event:	____ Hours <u>2</u> Days		
7. Remarks:	<u>Surgical abortion completed on 05/25/2018.</u> GUK0730		
8. a. Name of physician who provided RU-486:	<u>Dr. Lucy Ann Nunnally</u>		
8. b. Physician's signature		<u>MD</u>	<input checked="" type="checkbox"/> (M.D./D.O.)
	Date	<u>5/25/18</u>	

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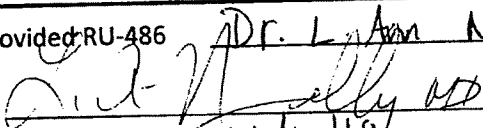
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MEDICAL BOARD

JUN 11 2018

State Medical Board of Ohio Report of RU-486 Event

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1. Date RU-486 was provided:	05	07	18
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Capital Care Network of Toledo		
3. Address of medical practice or facility at which RU-486 was provided:	1160 W. Sylvania Ave. Toledo, OH 43612		
4. Date post RU-486 complication began:	06/12/18		
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:	2	Hours	____ Days
7. Remarks:	Incomplete Med. AB . DTC completed. & complications NOA 0927		
8. a. Name of physician who provided RU-486	Dr. L. Ann Nunnally		
8. b. Physician's signature	 (M.D./D.O.)		
	Date 06/12/18		

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JUN 26 2018