

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>09</u> / <u>21</u> / <u>17</u> Month Day 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:	<i>See above</i>
4. Date post RU-486 complication began:	<u>9-25-17</u> , <u>10-12-17</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:	<u>41</u> Hours <u>0</u> Days
7. Remarks:	<i>Multiple pregnancy, failed medical Suction aspirative treatment.</i>
8. a. Name of physician who provided RU-486	<u>DR. Blank MD</u>
8. b. Physician's signature	<u><i>[Signature]</i></u> (M.D./D.O.)
	Date <u>11-11-17</u>

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>11</u> Month	<u>25</u> Day	<u>17</u> 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):	<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:	Moderate tissue		
8. a. Name of physician who provided RU-486	Harley Blank MD		
8. b. Physician's signature	<u>[Signature]</u>	M.D./D.O. <u>MD</u>	
	Date	<u>12.9.17</u>	

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