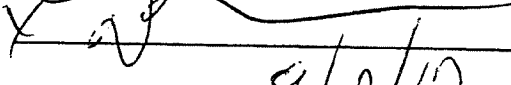


State Medical Board of Ohio Report of RU-486 Event

(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>9/7/17</u>	<u>MD/DO</u>

Send completed forms to: State Medical Board of Ohio

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

MEDICAL BOARD