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: 7 (Month) 10 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
2127 State Rd Cuyahoga Falls Ohio 44223

4. Date post RU-486 complication began:
7/27/17

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: _____ Hours _____ Days

7. Remarks: post med AB patient had a remaining gestational Sac w/ no fetal pole developed or remaining. patient had D&C on 7/27/17 to Complete her process.

8. a. Name of physician who provided RU-486 Dr. DAVID Burkons

8. b. Physician's signature X _____ MD/DO

Date 9/7/17

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

MEDICAL BOARD
SEP 15 2017

Prescribed: 5/--/2011, Rev. 12/13/12