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: [illegible] / [illegible] / [illegible]
   Month / Day / Year

2. Name of medical practice or facility at which RU-486 was provided:
   Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
   1401 E Stroop Rd
   Dayton, Ohio 45429

4. Date post RU-486 complication began: [illegible]

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: ___7___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 [illegible] MD

8. b. Physician's signature [signature] MD, DO

Date 6/15/18

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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