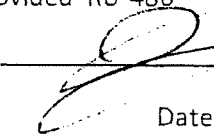


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u>	<u>28</u>	<u>2017</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Pre-term</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>12000 Shaker Blvd. Cleveland, OH 44120</u>		
4. Date post RU-486 complication began:	<u>11/11/17</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>3</u> Hours	_____ Days	
7. Remarks:			
8. a. Name of physician who provided RU-486	<u>Justin Lappen, MD</u>		
8. b. Physician's signature		<u>MD / D.O.</u>	
	Date	<u>12/12/17</u>	

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

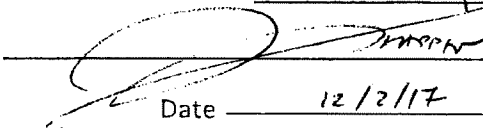
MEDICAL BOARD

DEC 07 2017

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>10</u> Month	<u>28</u> Day	<u>2017</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Preterm</u>		
3. Address of medical practice or facility at which RU-486 was provided:	<u>12000 Shaker Blvd Cleveland OH 44120</u>		
4. Date post RU-486 complication began:	<u>11/17/2017</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>2</u> Hours	_____ Days	
7. Remarks:			
8. a. Name of physician who provided RU-486	<u>Justin Lappen, MD</u>		
8. b. Physician's signature	 _____ MD/D.O.		
	Date	<u>12/2/17</u>	

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

MEDICAL BOARD

DEC 07 2017