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: 10 (Month) 28 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Preterm

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland, OH 44120

4. Date post RU-486 complication began:
11/11/17

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Justin Lapper, MD

8. b. Physician's signature _____ M.D. / D.O.

Date 12/2/17

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

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

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12000 Shaker Blvd Cleveland OH 44120

4. Date post RU-486 complication began:
11/17/2017

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Justin Lappen, MD

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

Date 12/2/17

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