State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 3 (Month) 28 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Founders Womens Health Center

3. Address of medical practice or facility at which RU-486 was provided:
1243 E. Broad St., Columbus OH 43205

4. Date post RU-486 complication began:
4/11/18

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: 0.1 Hours _____ Days

7. Remarks:
Gestational sac visualized on U/S 4.11.18.
Managed w/ D&C. Pt tolerated well.

8. a. Name of physician who provided RU-486 Abigail Lowther, MD

8. b. Physician's signature [signature] M.D./D.O

Date 4/18/18

Send completed forms to:

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

MEDICAL BOARD
APR [illegible] 2018