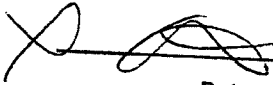


State Medical Board of Ohio Report of RU-486 Event

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

1. Date RU-486 was provided:	<u>3</u> / <u>28</u> / <u>18</u>
	Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Founders Women's 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):	<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>0</u> Hours <u>1</u> Days
7. Remarks:	Gestational sac visualized on US 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	 (M.D./D.O.)
	Date <u>4/18/18</u>

Send completed forms to:

State Medical Board of Ohio

MEDICAL BOARD

APR 18 2018

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127