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: 3/ March (Month) 16 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Northeast Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided: 2120 State Rd Cuyahoga Falls Ohio 44223

4. Date post RU-486 complication began: 4/15/17

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: 3 Hours _____ Days

7. Remarks: It had D&C without complications

8. a. Name of physician who provided RU-486 J. M. Watson, MD

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

Date 5/18/17

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

MEDICAL BOARD
MAY 26 2017

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

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: October (Month) 21 (Day) 2017 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Northeast Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided: 2177 State Rt Cuyahoga Falls, Ohio 44223

4. Date post RU-486 complication began: 11/16/17

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

X ~~Incomplete~~ Failed 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: a suction D&C was performed 11/16/17 without difficulty

8. a. Name of physician who provided RU-486 Jennifer Watson

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

Date 11/18/17

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