

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>2</u> Month <u>24</u> Day <u>18</u> Year
2. Name of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
4. Date post RU-486 complication began:	<u>4/12/18</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:	_____ Hours <u>2</u> Days
7. Remarks:	<i>Pt took single aspirin rather than being given a 2nd dose of Miso. Dose 5 days later & normal discharge</i>
8. a. Name of physician who provided RU-486	<u>J. M. Watson, MD</u>
8. b. Physician's signature	<u>[Signature]</u> <u>MD / DO</u>
Date	<u>4/17/18</u>

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

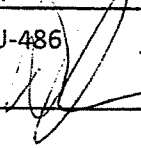
MEDICAL BOARD

APR 17 2018

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>4</u> / <u>29</u> / <u>18</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	
3. Address of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223	
4. Date post RU-486 complication began:	
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: _____ Hours _____ Days	
7. Remarks: PT had stable low level HCG Did Suction D.C on 4/28/18. Mink small ant of bleeding	
8. a. Name of physician who provided RU-486	Jennifer Watson, MD
8. b. Physician's signature	
Date <u>4/29/18</u> MB / DO	

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JUL 02 2018