## 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

	Date RU-486 was provided:	80	04	2016
		Month	Day	Year
2.	1243 Ea Columbi	omen's Health Cer st Broad Street us, Ohio 43205		
		) 251-1800		
3.	. Address of medical practice or facility	y at which RU-486 <b>See</b> വ	was provided:	
4.	Date post RU-486 complication begai	n: 08	-210-16	
5.	Event(s) (Please check all that apply):			
X	Lincomplete abortionAdve	erse reaction to RU-486	Patient hospitalized	
	Patient received a transfusionSevere bleedOther serious event (specify)	ling		
6.	Duration of event: 4 Hours	Days		
7.	Remarks: D+C procedure, POC			
	Diagnosis: Necrotic vil	litacidua Co	nastanti nonu	iable Pregnancy
8.	a. Name of physician who provided R	U-486 <b>Ka</b> y	d Schaeffe	er MD
_	b. Physician's signature	e Schae	16	(M.D)/D.O

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

NO. 93 2017

## 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:	08	18	2014	
2. Name of medical practice or facility at whi	Month	Day	Year	
2. Name of medical practice of facility at will	cu ko-400 was bijovit	<b>160.</b>		
THE FOUNDER'S Women's	Health Cent	er		
3. Address of medical practice or facility	at which RU-486 v	was provided:		
1243 E BROOD ST	COL DH	43205		
4. Date post RU-486 complication began	າ:			
	9-01-14			
5. Event(s) (Please check all that apply):				
Incomplete abortionAdve	erse reaction to RU-486	Patient hospitaliz	ed.	
Patient received a transfusion Severe bleed	ding			
		~0.vs		
Other serious event (specify)	ris in ute	- ROS	· · · · · · · · · · · · · · · · · · ·	
			······································	
6. Duration of event: Hours	Days			
7 D				<u> </u>
7. Remarks: Uterine Contents s				• •
Sent to Pathology 1	ab Diagnos	is=Necrotic V Consist	ivi therectic Deciont z nonviable	plearany
8. a. Name of physician who provided R	U-486 Ka	rl Schaef	fer md	
•	1 Schaet			
8. b. Physician's signature	~ .	0-21-17	(M.D)D.O	
	Date	10.21.(1		

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

NOV 03 2017

## 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:	09	01	2014	
	Month	Day	Year	
2. Name of medical practice or facility at wh	ich RU-486 was provid	ded:		
	11 A+10	(0 to 10)		
The Founders Wo	mens Health.	) wrus		
2. Address of modical practice or facility	hich DU 486	idad.		
3. Address of medical practice or facilit	y at Willell NO-480 t	was provided.		
1243 E Broad S	t Col E	4 4 3205		
4. Date post RU-486 complication bega				
	9-15-16			
5. Event(s) (Please check all that apply)				
Adv	verse reaction to RU-486	Patient hospitalize	<b>.d</b>	
Patient received a transfusion Severe blee	ding			
Other serious event (specify)				
6. Duration of event: 4 Hours 1	Ø Davs			
7. Remarks: Pregnancy Stu	u Intact		*	
S t				
8. a. Name of physician who provided F	RU-486 <u>Kar</u>			
8. b. Physician's signature	L Schoop	ser, me	)	
	Data 10-31-	-17		

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

NOV 03 2017

## 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:	11	10.	2016
	Month	Day	Year
2. Name of medical practice or facility at which R	, ,		
The Founder's Women's	Health len	ter	
3. Address of medical practice or facility at	which RU-486 v	vas provided:	
1243 E BROad St		•	4
4. Date post RU-486 complication began:	11-28-201	6	
5. Event(s) (Please check all that apply):		•	
Incomplete abortionAdverse r	eaction to RU-486	Patient hospitalized	
Patient received a transfusion Severe bleeding			
Other serious event (specify) Reto	wied POC	D+C	**************************************
6. Duration of event: 41 Hours 2 I	Days		
7. Remarks:			
			·
8. a. Name of physician who provided RU-4		Schaeffer	m D
8. b. Physician's signature <u>Kau</u>	10.3	Her, weD	N_D/D.O
	Date		
Send completed forms to:	State Medical	Board of Ohio	
Legal D	epartment		
30 E. B	road St., 3 <sup>rd</sup> Floo	or	MEDICAL BOAR

Columbus, OH 43215-6127

NOV 03 2017