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 (Month) 24 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1600 W. Sylvania Ave
Toledo OH 43612

4. Date post RU-486 complication began:
10/01/19

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: _____ Hours _____ Days N/A

7. Remarks:
Pt reported to clinic for standard f/up Sono, Sono shows pregnancy retained.

8. a. Name of physician who provided RU-486 David Burkons MD

8. b. Physician's signature _____ M.D/D.O

Date 10/1/19

Send completed forms to:

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

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: 9 (Month) 10 (Day) 2019 (Year)

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

Capital Care Toledo

3. Address of medical practice or facility at which RU-486 was provided:

1160 W. Sylvania
Toledo, OH 43612

4. Date post RU-486 complication began:

9/14/19

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

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: N/A Hours N/A Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. David Burkons

8. b. Physician's signature _____ M.D/D.O___

Date 10/11/19

Send completed forms to:

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

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 (Month) 27 (Day) 19 (Year)

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

Capital Care of Toledo

3. Address of medical practice or facility at which RU-486 was provided:

Capital Care of Toledo
1160 W. Sylvania Ave Toledo OH 43612

4. Date post RU-486 complication began:

10/01/19

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: ~~N/A~~ Hours ____ Days

7. Remarks: pt reported to clinic for sono four weeks post med ab, sono confirms pregnancy retained. pt to other clinic for surgical f/up care.

8. a. Name of physician who provided RU-486 David Burkons M.D.

8. b. Physician's signature _____ M.D./D.O.

Date 10/11/19

Send completed forms to:

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

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: 7/20/19 — 7 (Month) 20 (Day) 19 (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:

4. Date post RU-486 complication began: This was a failed Med Ab

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

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed Med Ab

6. Duration of event: ________ Hours ________ Days

7. Remarks: Pt was entailed several time to do a Preg test and come in for F/u. None of which she did

8. a. Name of physician who provided RU-486 D. M Burkons

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

Date 10/7/19

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

She was referred to Preterm

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

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: 03 (Month) 26 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave
Toledo, OH 43612

4. Date post RU-486 complication began:

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

✓ Incomplete abortion
___ Adverse reaction to RU-486
___ Patient hospitalized
___ Patient received a transfusion
___ Severe bleeding
___ Other serious event (specify) ______________________

6. Duration of event: 0 Hours 1 Days

7. Remarks: Incomplete medical ABORTION.
D&C completed w/ Ø complications.

8. a. Name of physician who provided RU-486 D M Burkons MD

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

Date 4/7/19

Send completed forms to:

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

MEDICAL BOARD
MAY 13 2019

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: February (Month) 19 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave. Toledo, OH 43612

4. Date post RU-486 complication began:
February 26, 2019

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 Hours 2 Days

7. Remarks: Failed medical abortion, D&C completed with no complications.

8. a. Name of physician who provided RU-486 Dr. David Burkons MD.

8. b. Physician's signature _____ M.D/D.O___

Date 03/01/2019

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127