

R0000505

# 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: 2 11 14  
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 WOMEN'S CENTER, LLC  
2127 STATE RD  
CUYAHOGA FALLS, OH 44223

4. Date post RU-486 complication began: 3/6/14

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: 4 Hours \_\_\_\_\_ Days

7. Remarks: Had a.c.s difficulty

8. a. Name of physician who provided RU-486: D. Burkam

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

Date: 3/11/14

Send completed forms to:

State Medical Board of Ohio

Legal Department

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

Columbus, OH 43215-6127

WHA0831

# 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: Feb 10 2014  
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

4. Date post RU-486 complication began: 3/1/14  
 2127 STATE RD  
 CUYAHOGA FALLS, OH 44223

5. Event(s) (Please check all that apply):  
 Incomplete abortion  Adverse reaction to RU-486  Patient hospitalized  
*was term pregnancy. One passed me decent*  
 Patient received a transfusion  Severe bleeding  
 Other serious event (specify) \_\_\_\_\_

6. Duration of event: 6 Hours \_\_\_\_\_ Days

7. Remarks: *Pt had twin. One passed on decant  
 Dec & C 3 difficulty*

8. a. Name of physician who provided RU-486: D M Bushong, MD  
 8. b. Physician's signature: *[Signature]* M.D./D.O.  
 Date: 3/7/14

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