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

	Month	フ <i>リ</i>	19
2. Name of medical practice or facility at w		·	Year
. Address of medical practice or facility at v	which RU-486 was pro	RTHEAST OHIO WOT vided: LLC 2127 STATE CUYAHOGA FALLS,	
Date post RU-486 complication began:			
Event(s) (Please check all that apply):	·		
thcomplete abortion Adv	verse reaction to RU-486	Patient hospitali	zed .
Patient received a transfusion Severe bleed	ling		
Other serious event (specify)			DOTTO SECURITION OF THE SECURI
Duration of event: Hours	Days		
Remarks: HM Such	J.C 5	ceffical	Î
			<u> </u>
a. Name of physician who provided RU-44. b. Physician's signature	Date Chyis		OTTA MIN
end completed forms to: State M	ledical Board of Ohio		
Legal Departme			
30 E. Broad St., Columbus, OH		د المراد المعم معم	N, BOAR

JUN 0 9 2019

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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

			14
1. Date RU-486 was provided:	Month	// Day	Year
2. Name of medical practice or facility at which I			
FLLS, OH 44223	CUYAHOGA	NORTHEAST OHIO	WOMENS CENTED
3. Address of medical practice or facility at which	RII-486 was prov	ided: 2127 ST. CUYAHOGA FA	ATE RD
4. Date post RU-486 complication began:	3/4/19		
5. Event(s) (Please check all that apply):	•		.•
	reaction to RU-486	Patient hospitaliz	ed
Patient received a transfusion Severe bleeding	·		
Other serious event (specify)			
6. Duration of event:	Days		
7. Remarks: 1 A 1 C	3 difh	uly	·
	100	1//	
8. a. Name of physician who provided RU 486	1/-11/18	mlen	7
8. b. Physician's signature	vate 3	Intra	5/0.0
Send completed forms to: State Med	dical Board of Ohio		
Legal Departmen	nt		
30 E. Broad St., 3	1rd Floor EE :6 1/3	7 SI LYNGOZ	
Columbus, OH 4		10 de	

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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	:	Fel	10	2014
		Month	Day	Year
2. Name of medical practice	or facility at which	RU-486 was provid	ed:	
3. Address of medical practice	or facility at whic	h RU-486 was provi	ded:	
		NO	RTHEAST OHIO WO	MENS CENTER
4. Date post RU-486 complica	tion began:		2127 STATE CUYAHOGA FALLS	RD 6, OH 44223
5. Event(s) (Please check all th	nat apply):	•		
Incomplete abortion Wire Alm Per — Patient received a transfusion		reaction to RU-486 _ POSSI ME (Patient hospitaliz	ed
Other serious event (specify)				
6. Duration of event:	Hours	Days		·
7. Remarks: 17 Ld Da XIC 3	Twon, O. deffectly	ne prosod	on desir	X
8. a. Name of physician who r	rovided RU 486	DM B	when M	n
8. b. Physician's signature	Da	te 3/1/4	(M.D.	/DO
Send completed forms to:		cal Board of Ohio		
	Legal Department 30 E. Broad St., 3 rd	EE :6 ## 91	क्ष्मा श ार	
(Columbus, OH 432	215-6127		