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

MEMA-0023

1. Date RU-486 was provided: 5 (Month) 24 (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: NORTHEAST OHIO WOMENS CENTER LLC
2127 STATE RD
CUYAHOGA FALLS, OH 44223

4. Date post RU-486 complication began: 6/1/19

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: 4 Hours _____ Days

7. Remarks: Had Suction D+C Successfully

8. a. Name of physician who provided RU-486 Christine Stotts, MD

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

Date 6/1/19

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

MEDICAL BOARD
JUN 0 3 2019

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

RCC0005

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 (Month) 11 (Day) 14 (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: 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 D.C.S difficulty

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

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

Date 3/11/14

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

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

WHH0831

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 (Month) 10 (Day) 2014 (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: 3/4/14

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

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized
Was twin pregnancy. One passed one detect
___ 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 detect
Dx IC 3 days

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

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

Date 3/7/14

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

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