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-00123

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 [illegible]

8. a. Name of physician who provided RU-486 Christine Slotta, M.D.

8. b. Physician's signature [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 03 2019

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