


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:	<u>08</u> / <u>01</u> / <u>19</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	8/13/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion (failed) <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	uncomplicated dilation and suction
8. a. Name of physician who provided RU-486	Catherine Romanos
8. b. Physician's signature	
Date	8/15/19

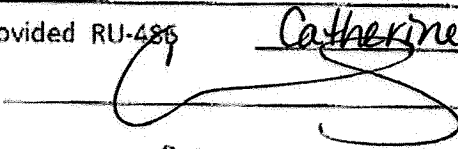
Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
AUG 26 2019

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:	<u>07</u>	<u>19</u>	<u>19</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton		
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post RU-486 complication began:	08/05/19		
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	_____ Hours	_____ Days	
7. Remarks:	uncomplicated dilation and suction.		
8. a. Name of physician who provided RU-486	Catherine Romanos		
8. b. Physician's signature			
Date	MB/DO 8/16/19		

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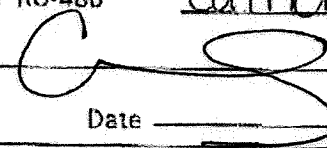
MEDICAL BOARD

AUG 26 2019

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:	<u>JULY</u> <u>15</u> <u>2019</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	8/16/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours <u> </u> Days
7. Remarks:	Uncomplicated suction.
8. a. Name of physician who provided RU-486	Catherine Romanos
8. b. Physician's signature	
	Date <u>8/16/19</u> MD/DO

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MEDICAL BOARD

AUG 26 2019

State Medical Board of Ohio Report of RU-486 Event

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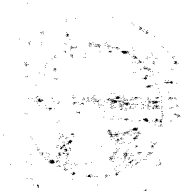
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	May	03	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton		
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post RU-486 complication began:	5/17/19		
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>retained clot</u>		
6. Duration of event:	<u>1</u> Hours <u> </u> Days		
7. Remarks:	<u>uncomplicated suction</u>		
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>		
8. b. Physician's signature	<u>[Signature]</u>		
Date	<u>5/20/19</u>		

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MEDICAL BOARD
JUN 17 2019



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:	<u>April</u> <u>11</u> <u>2019</u> <small>Month Day Year</small>
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	5/14/19
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>Failed MAB</u>
6. Duration of event:	<u>1</u> Hours _____ Days
7. Remarks:	Uncomplicated Dilatation and Curettage
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	
Date	<u>5/20/19</u>

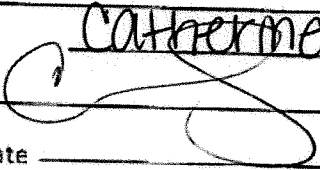
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MEDICAL BOARD
JUN 17 2019

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:	April	1	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton		
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post RU-486 complication began:	4/22/19		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	_____ Hours	_____ Days	
7. Remarks:	dilation and suction		
8. a. Name of physician who provided RU-486	Catherine Romanos		
8. b. Physician's signature			
	Date	MD/DO 4/22/19	


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MEDICAL BOARD
APR 29 2019

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:	<u>March</u> <u>18</u> <u>2019</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	3/19/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	<u>1</u> Hours _____ Days
7. Remarks:	tissue removed from cervical os uncomplicated suction
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	
Date	<u>4/10/19</u> <u>MD/DO</u>

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MEDICAL BOARD

APR 25 2019

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:	March	7	2019
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton		
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post RU-486 complication began:	3/12/19		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____		
6. Duration of event:	_____	Hours	_____ Days
7. Remarks:	uncomplicated dilation & suction		
8. a. Name of physician who provided RU-486	Catherine Romanos		
8. b. Physician's signature			
	Date	3/2/19	

Send completed forms to:

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Legal Department

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Columbus, OH 43215-6127

MEDICAL BOARD

APR 01 2019

APR 10 2019

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: February 28 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
 Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
 1401 E Stroop Rd
 Dayton, Ohio 45429

4. Date post RU-486 complication began: 4/5/19

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

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

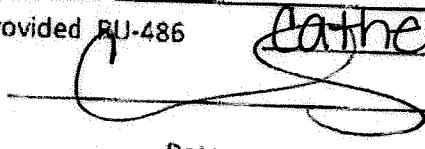
Patient received a transfusion Severe bleeding

Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
 suction - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos MD

8. b. Physician's signature  MD/DO

Date 4/5/19

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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: February 22 2019
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
Women's Med Dayton

3. Address of medical practice or facility at which RU-486 was provided:
1401 E Stroop Rd
Dayton, Ohio 45429

4. Date post RU-486 complication began: 2/27/19

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: 1 Hours _____ Days

7. Remarks: tissue removed from OS.
suction uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos
8. b. Physician's signature _____
Date 4/16/19

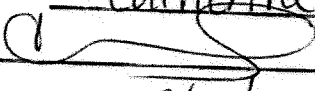
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MEDICAL BOARD
APR 25 2019

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:	February 07, 2019 Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	02/21/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	3 Hours 0 Days
7. Remarks:	uncomplicated dilation: suction
8. a. Name of physician who provided RU-486	Catherine Romanos, MD
8. b. Physician's signature	 MD/DO
Date	2/21/19

Send completed forms to:

State Medical Board of Ohio

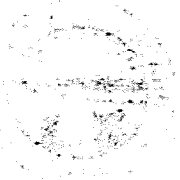
Legal Department

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Columbus, OH 43215-6127

MEDICAL BOARD

MAR 04 2019



State Medical Board of Ohio Report of RU-486 Event

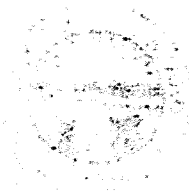
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<table style="width: 100%; border: none;"> <tr> <td style="border: none; text-align: center; width: 33%;">January</td> <td style="border: none; text-align: center; width: 33%;">25</td> <td style="border: none; text-align: center; width: 33%;">2019</td> </tr> <tr> <td style="border: none; text-align: center; font-size: small;">Month</td> <td style="border: none; text-align: center; font-size: small;">Day</td> <td style="border: none; text-align: center; font-size: small;">Year</td> </tr> </table>	January	25	2019	Month	Day	Year
January	25	2019					
Month	Day	Year					
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton						
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429						
4. Date post RU-486 complication began:	1/31/2019						
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) <u>failed medication abortion</u>						
6. Duration of event:	1 Hours _____ Days						
7. Remarks:	uncomplicated dilation and suction						
8. a. Name of physician who provided RU-486	Catherine Romanos						
8. b. Physician's signature	 MD/DO						
	Date <u>1/31/19</u>						

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

MEDICAL BOARD
 FEB 19 2019



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:	<div style="display: flex; justify-content: space-around; font-size: 1.2em;"> January 21 2019 </div> <div style="display: flex; justify-content: space-around; font-size: 0.8em; margin-top: 5px;"> Month Day Year </div>
2. Name of medical practice or facility at which RU-486 was provided:	Women's Med Dayton
3. Address of medical practice or facility at which RU-486 was provided:	1401 E Stroop Rd Dayton, Ohio 45429
4. Date post RU-486 complication began:	2/14/19
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event:	1 Hours _____ Days
7. Remarks:	uncomplicated dilation and suction
8. a. Name of physician who provided RU-486	Catherine Romanos
8. b. Physician's signature	
Date	2/14/19 M.D.

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 Columbus, OH 43215-6127

MEDICAL BOARD
MAR 04 2019

