

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>11</u>	<u>12</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:			
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 abortion</u>			
6. Duration of event: <u>7</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486			
8. b. Physician's signature <u>R. C. Case, M.D.</u>			
Date <u> </u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 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:	<u>10</u>	<u>18</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: <u>11/12/19</u>			
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 checked="" type="checkbox"/> Other serious event (specify) <u>failed abortion</u>			
6. Duration of event: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>ROSALYN KADG</u>			
8. b. Physician's signature <u>R. Kadg</u> M.D./D.O. _____			
Date <u>11/12/19</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

NOV 18 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:	8	7	19
	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: 8/8/19			
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 checked="" type="checkbox"/> Other serious event (specify) <u>failed ab</u>			
6. Duration of event: <u>7</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>R. Kade MD</u> <u>MD/DO</u>			
Date <u> </u>			

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>8</u>	<u>5</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: <u>8/13/19</u>			
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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: <u>1</u> Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>R. Kade MD</u> <u>MD/DO</u>			
Date _____			

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:	08	01	19
	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: 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 8/15/19			

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Legal Department
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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>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: <u>08/05/19</u>			
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: <u>uncomplicated dilation and suction.</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ Date <u>8/16/19</u>			

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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: <u>8/6/19</u>			
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: <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> MD/DO <u>8/16/19</u>			
Date <u>8/16/19</u>			

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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>May</u>	<u>03</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: <u>5/17/19</u>			
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> <u>MB/DO</u>			
Date <u>5/20/19</u>			

Send completed forms to: State Medical Board of Ohio

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Columbus, OH 43215-6127

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>23</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: <u>5/9/19</u>			
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 checked="" type="checkbox"/> Other serious event (specify) <u>failed mife</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade, MD</u>			
8. b. Physician's signature <u>R. Kade</u> MD/DO			
Date <u>5/9/19</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

MAY 20 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	11	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: 5/14/19			
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 M&B</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>Uncomplicated Dilatation and Curettage</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u> Date <u>5/20/19</u>			

Send completed forms to:

State Medical Board of Ohio
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Columbus, OH 43215-6127

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>1</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: <u>4/22/19</u>			
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: <u>dilation and suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature _____ Date <u>4/22/19</u>			

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Columbus, OH 43215-6127

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:	March	18	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: 3/19/19			
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: 1 Hours _____ Days			
7. Remarks: tissue removed thru curette as uncomplicated suction			
8. a. Name of physician who provided RU-486 Catherine Romanos			
8. b. Physician's signature _____ MD/DO			
Date 4/10/19			

Send completed forms to: State Medical Board of Ohio

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Columbus, OH 43215-6127

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 3/21/19			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

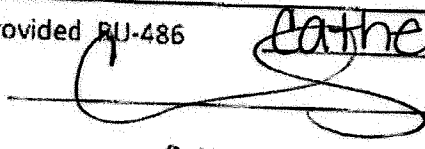
APR 01 2019

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):	<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:	suction - uncomplicated.
8. a. Name of physician who provided RU-486	Catherine Romanos M.D.
8. b. Physician's signature	
	Date 4/5/19 ^{MD/DO}

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

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): <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: 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			

Send completed forms to: State Medical Board of Ohio

Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

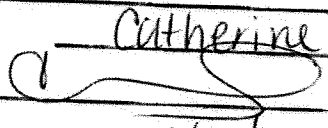
MEDICAL BOARD

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:	12 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

30 E. Broad St., 3rd Floor

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:	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) failed medication abortion			
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 1/31/19			

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:	January	21	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: 2/14/19			
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 MD/DO			

Send completed forms to:

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Legal Department
30 E. Broad St., 3rd Floor
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:	<u>January</u>	<u>11</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:			
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 checked="" type="checkbox"/> Other serious event (specify) <u>subtotal medication abortion</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks: <u>uncomplicated Dilation and Suction.</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>1/16/19</u>			

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

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:	January	09	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: 1/22/19			
5. Event(s) (Please check all that apply): <input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" 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:			
8. a. Name of physician who provided RU-486: <u>Roslyn Kade</u>			
8. b. Physician's signature: <u>[Signature]</u> MD/DO			
Date: <u>1/20/19</u>			

Send completed forms to:

State Medical Board of Ohio

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30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JAN 31 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>January</u> Month	<u>8</u> Day	<u>2019</u> 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: <u>1/17/19</u>			
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:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade M.D.</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>1/22/19</u>			

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Columbus, OH 43215-6127

MEDICAL BOARD

JAN 25 2019