State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided: May (Month) 30 (Day) 2019 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare of Columbus

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd. Columbus, Ohio 43229

4. Date post RU-486 complication began: 6-27-19

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: .1 Hours ____ Days

7. Remarks: D+C @ Northeast Ohio Womens Center

8. a. Name of physician who provided RU-486 Mary Ann Nunnally MD

8. b. Physician's signature L.A. Nunnally MD (M.D/D.O)

Date 7-15-19

Send completed forms to:

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

084 mailed 7/23/2019 — TRH RN
To md board

MEDICAL BOARD
JUL 24 2019