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 / 11 / 18 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided:
Northeast Ohio Womens Center

3. Address of medical practice or facility at which RU-486 was provided:
2127 State Rd
Cuyahoga Falls OH 44223

4. Date post RU-486 complication began:
8/14/18

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

X ~~Incomplete~~ Failed abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) ______________________

6. Duration of event: ________ Hours ________ Days

7. Remarks: Pt had Suction D&C on 8/16 without difficulty or complication

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

8. b. Physician's signature [signature] MD / DO

Date 8/27/18

Send completed forms to:

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

MEDICAL BOARD
SEP 05 2018

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

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: 02 (Month) 28 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave
Toledo, OH 43612

4. Date post RU-486 complication began:
3/9/18

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: _____ Hours 1 Days

7. Remarks:
Pt in for suction after incomplete Med AB. Ø complications (D+C)

8. a. Name of physician who provided RU-486 Dr. David Burkons MAA1224

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

Date 03/09/18

Send completed forms to:

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

MEDICAL BOARD

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: 08 (Month) 08 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave Toledo, OH 43612

4. Date post RU-486 complication began:
08-15-18

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

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) failed medical abortion

6. Duration of event: ____ Hours 1 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Dr. David Burkons

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

Date 8/17/18

Send completed forms to:

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

MEDICAL BOARD

AUG 29 2018

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: 08 (Month) 01 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W. Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
08/27/2018

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: ____ Hours 1 Days

7. Remarks: Incomplete med. AB.
Sx d+c performed. No further issues

8. a. Name of physician who provided RU-486 Dr. David Burkons

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

Date 08/31/18

Send completed forms to:

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

MEDICAL BOARD
SEP 24 2018

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: 10 (Month) 19 (Day) 2018 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care Network of Toledo

3. Address of medical practice or facility at which RU-486 was provided:
1160 W Sylvania Ave.
Toledo, OH 43612

4. Date post RU-486 complication began:
11-19-18

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: 3 Hours _____ Days

7. Remarks:
COH0922

8. a. Name of physician who provided RU-486 Dr. David Burkus

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

Date 11/30/18

Send completed forms to:

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

MEDICAL BOARD
DEC 13 2018