

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>4</u> / <u>18</u> Month Day Year |
| 2. Name of medical practice or facility at which RU-486 was provided: | <u>Northeast Ohio Women's Center</u> |
| 3. Address of medical practice or facility at which RU-486 was provided: | <u>2125 State Rd</u> <u>Cuyahoga Falls OH 44323</u> |
| 4. Date post RU-486 complication began: | <u>8/14/14</u> |
| 5. Event(s) (Please check all that apply): | <input checked="" type="checkbox"/> <u>Fault</u> <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>pt had sudden DRE on 8/16</u> <u>in what appears to be complication</u> |
| 8. a. Name of physician who provided RU-486 | <u>David Burkhardt</u> |
| 8. b. Physician's signature | <u>[Signature]</u> MD/DO |
| | Date <u>8/27/14</u> |

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

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 / 22 / 18
Month Day 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. Sylvan Ave
Toledo, OH 43612

4. Date post RU-486 complication began:
3/9/19

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: _____ Hours 1 Days

7. Remarks:
Plan for suction after incomplete Med Ab. & complications (D+C)

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

8. b. Physician's signature [Signature] (M.D./D.O.)

Date 03/09/18

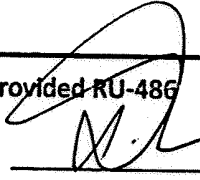
Send completed forms to:

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

MEDICAL BOARD
 178

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 | 08 | 18 |
| | Month | Day | 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): | <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 medical abortion</u> | | |
| 6. Duration of event: | ___ Hours / ___ Days | | |
| 7. Remarks: | | | |
| 8. a. Name of physician who provided RU-486 | Dr. David Burkons | | |
| 8. b. Physician's signature |  _____ | | |
| | Date | 8/17/18 | (M.D./D.O.) |

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

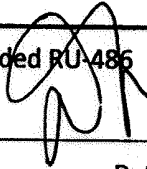
Columbus, OH 43215-6127

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: | <u>08</u> | <u>01</u> | <u>2018</u> |
| | Month | Day | Year |
| 2. Name of medical practice or facility at which RU-486 was provided: | <u>Capital Care Network of Toledo</u> | | |
| 3. Address of medical practice or facility at which RU-486 was provided: | <u>1160 W. SYLVANIA AVE.</u> <u>Toledo, OH 43612</u> | | |
| 4. Date post RU-486 complication began: | <u>08/27/2018</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 | <u>1</u> Days | |
| 7. Remarks: | <u>Incomplete med. Ab.</u> <u>Sx d+c performed. No further issues</u> | | |
| 8. a. Name of physician who provided RU-486 | <u>Dr. David Burkows</u> | | |
| 8. b. Physician's signature |  | <u>(M.D./D.O.)</u> | |
| | Date | <u>08/31/18</u> | |

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 / 19 / 2018
Month Day 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):

Incomplete abortion Adverse reaction to RU-486 Patient hospitalized

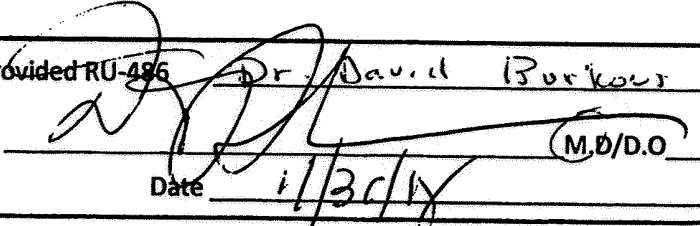
Patient received a transfusion Severe bleeding

Other serious event (specify) _____

6. Duration of event: 3 Hours _____ Days

7. Remarks: COH 0922

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

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