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: 2 (Month) 5 (Day) 18 (Year)

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

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

4. Date post RU-486 complication began: 3/5/18

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

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

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) Failed med ab

6. Duration of event: ________ Hours ________ Days

7. Remarks:

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

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

Date 3/5/18

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

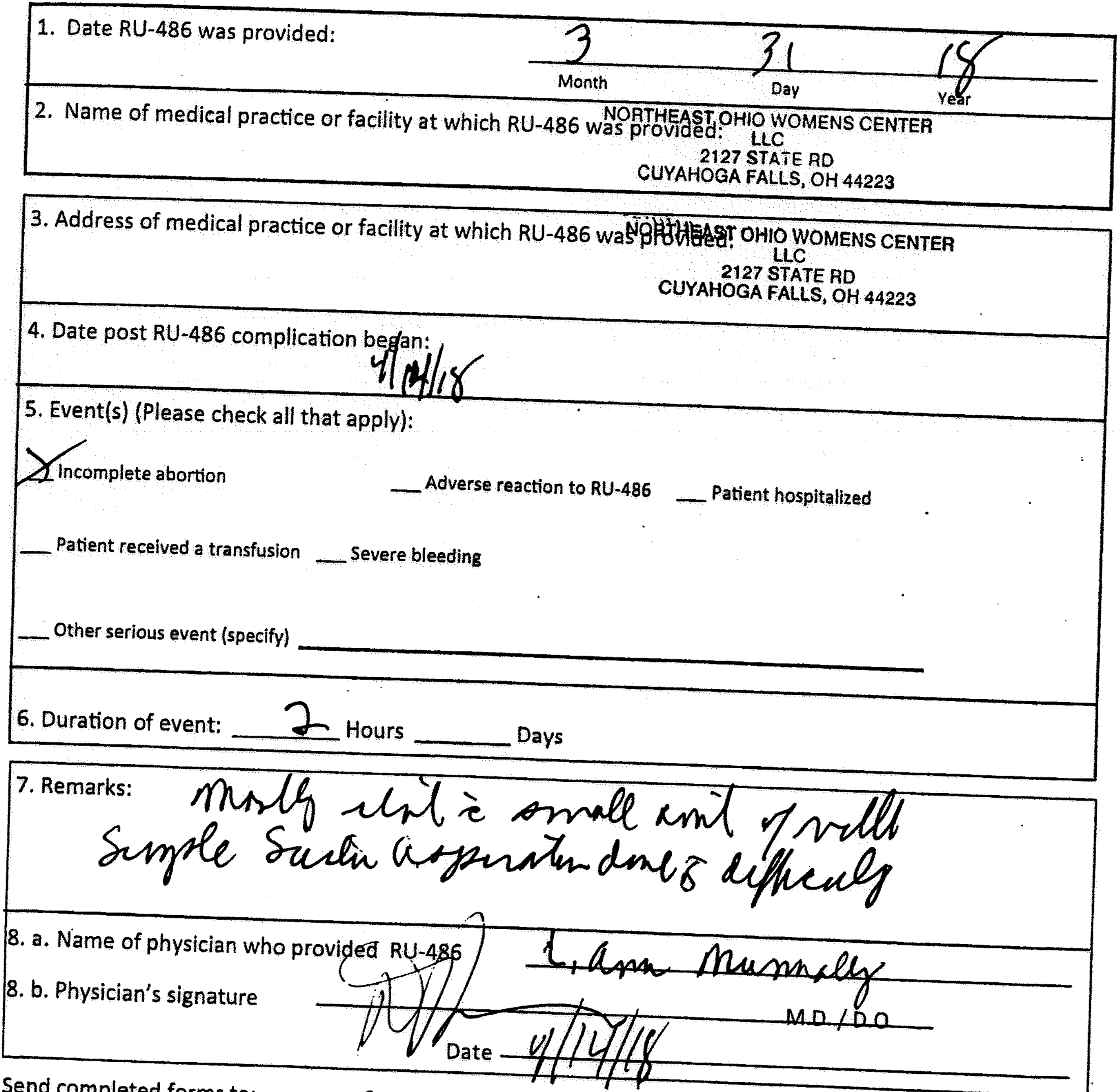
MEDICAL BOARD

State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486



1. Date RU-486 was provided: 3 (Month) 31 (Day) 18 (Year)

2. Name of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC
2127 STATE RD
CUYAHOGA FALLS, OH 44223

3. Address of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC
2127 STATE RD
CUYAHOGA FALLS, OH 44223

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

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: 2 Hours ___ Days

7. Remarks: Mostly clot c̄ small amt of villi Simple Suction Aspiration done w/o difficulty

8. a. Name of physician who provided RU-486 L. Ann Munnelly

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

Date 4/14/18

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

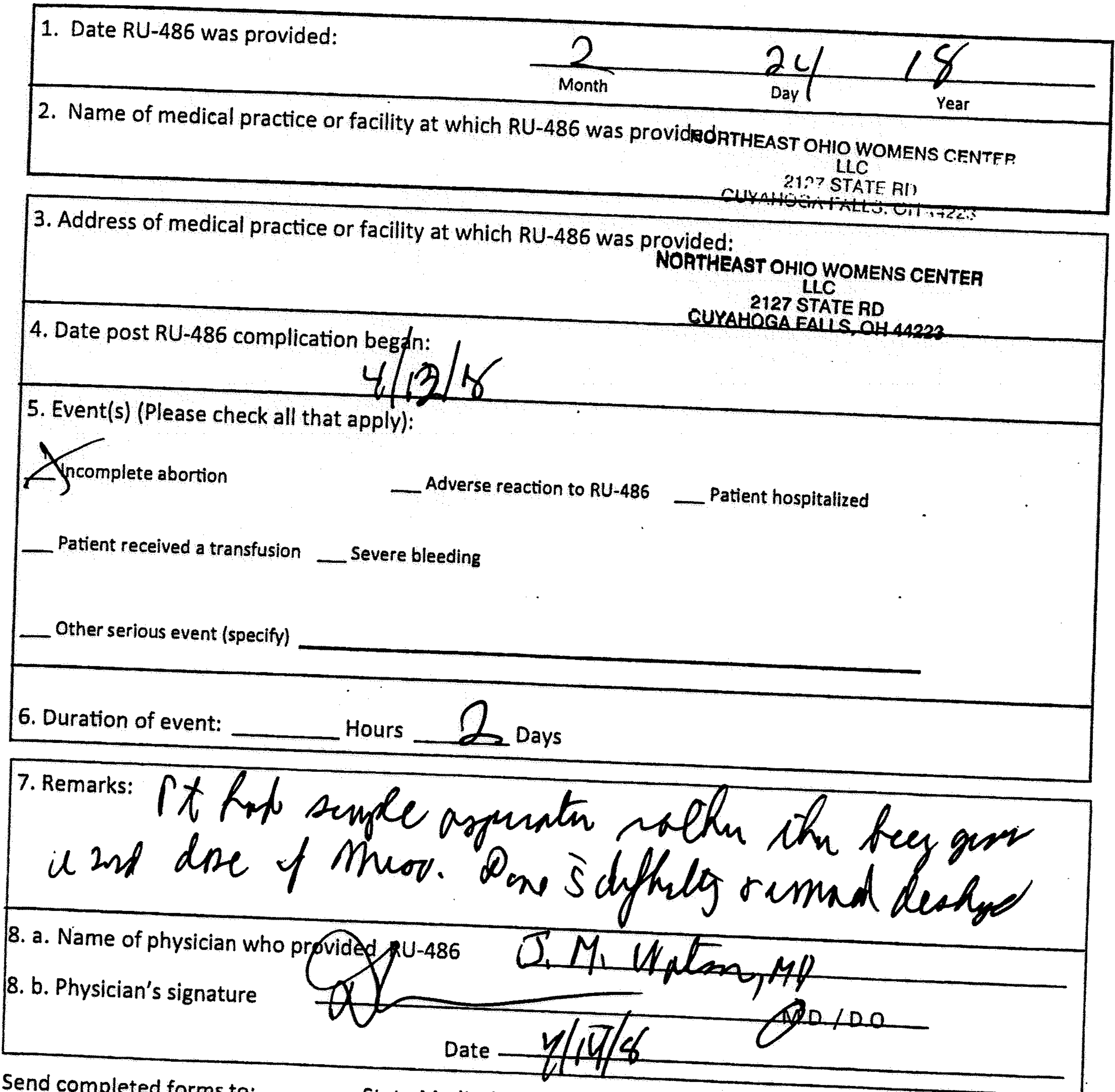
MEDICAL BOARD

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

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: 2 / 24 / 18 (Month / Day / Year)

2. Name of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223

3. Address of medical practice or facility at which RU-486 was provided: NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223

4. Date post RU-486 complication began: 4/13/18

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 2 Days

7. Remarks: Pt had simple aspiration rather than being given 2nd dose of Miso. Done ō difficulty & normal discharge

8. a. Name of physician who provided RU-486 J. M. Weston, MD

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

Date 4/14/18

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD

APR 2018

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

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:	4 / 29 / 18 (Month / Day / Year)
2. Name of medical practice or facility at which RU-486 was provided:	
3. Address of medical practice or facility at which RU-486 was provided:	NORTHEAST OHIO WOMENS CENTER LLC 2127 STATE RD CUYAHOGA FALLS, OH 44223
4. Date post RU-486 complication began:	

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 ________ Days

7. Remarks: Pt had stable low level HCG Did suction D+C on 4/28/18. Mild small amt of decidua

8. a. Name of physician who provided RU-486 Jennifer Wilton, MD

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

Date 4/23/18

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

MEDICAL BOARD
JUL 02 2018

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

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 Early ~~Incomplete~~ 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

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