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: [illegible] Month [illegible] Day [illegible] 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: [illegible]

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: 7 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 [illegible] MD

8. b. Physician's signature R. Ilan MD/DO

Date 5/15/18

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

MEDICAL BOARD
MAY 21 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: July (Month) 19 (Day) 2018 (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: 8/8/18

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: ___ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Joyce Horn

8. b. Physician's signature Joyce Horn M.D. / D.O.

Date 8/8/18

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Columbus, OH 43215-6127

MEDICAL BOARD
AUG 14 2018

Prescribed 6/--/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: 12 (Month) 14 (Day) 18 (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):

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

___ Patient received a transfusion ___ Severe bleeding

___ 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 Remanus, MD

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

Date 1/10/19

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

MEDICAL BOARD
JAN 22 2019

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