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: 1 (Month) 24 (Day) 20 (Year)

2. Name of medical practice or facility at which RU-486 was provided: Northeast Ohio Women's 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: 2/24/20

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 Med Ab

6. Duration of event: _____ Hours _____ Days

7. Remarks: Med AB @ 8wks 3 days - post failed Med AB @ 13.3. Suction- Pt had a positive pregnancy test post Med AB came in for follow up and preg. was viable

8. a. Name of physician who provided RU-486 Jennifer Walker

8. b. Physician's signature X JWalker M.D./D.O

Date 2/22/20

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

MEDICAL BOARD
FEB 27 2020

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