


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>20</u> <u>FEB</u> <u>14</u> <u>2020</u> Month Day Year
2. Name of medical practice or facility at which RU-486 was provided:	<u>Your Choice Healthcare</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>6721 Karl Road, Columbus, OH 43229</u>
4. Date post RU-486 complication began:	<u>2/28/20</u>
5. Event(s) (Please check all that apply):	<input type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input checked="" 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>Parenteral antibiotics for presumed PID.</u>
8. a. Name of physician who provided RU-486	<u>WILLIAM RODDICK MD</u>
8. b. Physician's signature	<u></u> <u>(M.D./D.O.)</u>
Date	<u>3.31.20</u>


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

MEDICAL BOARD

APR 13 2020

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:	Aug	14	2020
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Youv Choice Healthcare		
3. Address of medical practice or facility at which RU-486 was provided:	6721 Kowl Road Cols OH 43229		
4. Date post RU-486 complication began:	Aug 26, 2020		
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:	0 Hours 2 Days		
7. Remarks:	Persistent clots. Ref'd to another facility for D&C.		
8. a. Name of physician who provided RU-486	WILLIAM RODDICK, MD		
8. b. Physician's signature			
Date	Aug 28, 2020		
	M.D./D.O.		

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MEDICAL BOARD

OCT 28 2020

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:	Aug	21	2020
Month Day Year			
2. Name of medical practice or facility at which RU-486 was provided:	Your Unique Healthcare,		
3. Address of medical practice or facility at which RU-486 was provided:	6921 Karl Rd. Cols OH 43229		
4. Date post RU-486 complication began:	Aug 28 2020		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion Failed mab <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:	1	Hours	0 Days
7. Remarks:	Failed mab → continuing pregnancy. Ref'd to other clinic for surgical AB.		
8. a. Name of physician who provided RU-486	William Modrow MD		
8. b. Physician's signature	 M.D./D.O.		
Date	Aug 28 2020		

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OCT 28 2020