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: 02 (Month) 04 (Day) 2020 (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: 2/18/2020

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: 1 Hours _____ Days

7. Remarks: bleeding after MAB
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

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

Date 2/18/20

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

Prescribed 8/--/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 (Month) 8 (Day) 2020 (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 prior 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) _____

6. Duration of event: 24 Hours _____ Days

7. Remarks:
uncomplicated D:E

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature _____ M.D. / D.O.

Date 6/10/20

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

MEDICAL BOARD
JUN 23 2020

Prescribed by ORC 2919.123, 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 (Month) 24 (Day) 2020 (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 most RU-486 complication began: 5/26/2020

5. Event: (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 MAB

6. Duration of event: 4 Hours ___ Days

7. Remarks:
uncomplicated D:E

8. a. Name of physician who provided RU-486: Catherine Romanos

8. b. Physician's signature: [signature] M.D. / D.O.

Date 5/27/20

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

MEDICAL BOARD
JUN 09 2020

Prescribed [illegible] (3/13/12)

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: 04 (Month) 29 (Day) 2020 (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 (failed) ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
Dilation and Suction

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 5/15/20

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

MEDICAL BOARD
MAY 27 2020

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 (Month) 30 (Day) 2020 (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 (failed) ___ 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:
dilation suction

8. a. Name of physician who provided RU-486 Ramanos

8. b. Physician's signature _____ MD DO

Date 5/14/20

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

MEDICAL BOARD
MAY 18 2020

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 (Month) 8 (Day) 2020 (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: 9/2/2020

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 MAB

6. Duration of event: 3 Hours _____ Days

7. Remarks:
D: E

8. a. Name of physician who provided RU-486 Catherine Romanos, MD

8. b. Physician's signature _____ MD/DO

Date 9/3/20

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

MEDICAL BOARD
SEP 09 2020

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: 7 (Month) 24 (Day) 2020 (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: 10/12/20

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 m+b

6. Duration of event: 24 Hours _____ Days

7. Remarks:
uncomplicated D: E

8. a. Name of physician who provided RU-486 Catherine Romanos

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

Date 10/15/20

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

MEDICAL BOARD
OCT 26 2020

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 (Month) 13 (Day) 2020 (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: 8-17-2020

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

___ Incomplete abortion (medical) ___ 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:
D & S - uncomplicated

8. a. Name of physician who provided RU-486 Dr. Catherine Romanos

8. b. Physician's signature _____ MD DO

Date 8/19/20

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

MEDICAL BOARD
AUG 24 2020

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: 10 (Month) 9 (Day) 2020 (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: 10/16/20

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) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks:

8. a. Name of physician who provided ~~RU-486~~ Catherine Romanos

8. b. Physician's signature _____ MD/DO

Date 10/22/20

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

MEDICAL BOARD
NOV 12 2020

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: 11 (Month) 20 (Day) 20 (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: 11/24/20

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) _____

6. Duration of event: ___1___ Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Dr. Catherine Kenanos

8. b. Physician's signature _____ MD/DO

Date 12/3/20

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

MEDICAL BOARD
DEC 09 2020

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

MEDICAL BOARD

JAN 27 2021

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) 11 (Day) 2020 (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: 01-12-2021

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) Continuing pregnancy

6. Duration of event: 1 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature [signature] MD / D.O.

Date 1/14/21

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

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: 12 (Month) 17 (Day) 2020 (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:
12-19-20

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) _____

6. Duration of event: 24 Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486 Catherine Romanos MD

8. b. Physician's signature _____ MD DO

Date 12/23/20

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

MEDICAL BOARD
JAN 04 2021

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: 12 (Month) 23 (Day) 20 (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: 12/28/20

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) _____

6. Duration of event: 1 Hours _____ Days

7. Remarks:
uncomplicated suction

8. a. Name of physician who provided RU-486: Catherine Romeros

8. b. Physician's signature _____ M.D./D.O.

Date 1/12/21

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

MEDICAL BOARD
JAN 14 2021

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