


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	04	2020
	Month	Day	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): <input 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 checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____			
6. Duration of event: _____ 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:  MD			
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

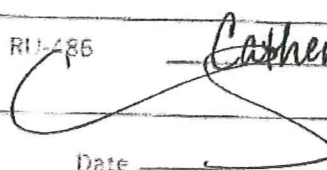
MEDICAL BOARD

FEB 27 2020

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:	<u>4</u>	<u>8</u>	<u>2020</u>
	Month	Day	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): <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: <u>24</u> Hours _____ Days			
7. Remarks: <p style="text-align: center;">uncomplicated D+E</p>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature  <u>MD, DO</u>			
Date <u>6/10/20</u>			

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

MEDICAL BOARD

JUN 23 2020

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:	<u>4</u>	<u>24</u>	<u>2020</u>
	Month	Day	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:	5/26/2020		
5. Event(s) (Please check all that apply):	<input 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): <u>failed MAB</u>		
6. Duration of event:	<u>4</u> Hours	_____ Days	
7. Remark(s):	<u>uncomplicated D+E</u>		
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>		
8. b. Physician's signature	<u>[Signature]</u>		
	Date	<u>5/27/20</u>	<u>M.D. / D.O.</u>

Send completed forms to: State Medical Board of Ohio
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Columbus, OH 43215-6127


MEDICAL BOARD

JUN 09 2020

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:	<u>04</u>	<u>29</u>	<u>2020</u>
	Month	Day	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):	<input checked="" type="checkbox"/> Incomplete abortion (failed) <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:	<u>1</u>	Hours	_____ Days
7. Remarks:	Dilation and Suction		
8. a. Name of physician who provided RU-486	Catherine Romanos		
8. b. Physician's signature	 M.D. D.O.		
	Date	<u>5/15/20</u>	

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MEDICAL BOARD

MAY 27 2020



State Medical Board of Ohio Report of RU-486 Event

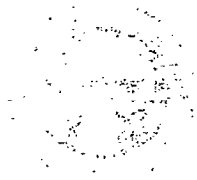
(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	4	30	2020
	Month	Day	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):			
<input checked="" type="checkbox"/> Incomplete abortion (failed) <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: _____ Hours _____ Days			
7. Remarks: dilation; sueta			
8. a. Name of physician who provided RU-486 _____ Romkowski			
8. b. Physician's signature _____ MD/DO			
Date _____ 5/19/20			

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MEDICAL BOARD
MAY 18 2020



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

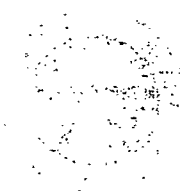
1. Date RU-486 was provided:	<u> 9 </u> Month	<u> 8 </u> Day	<u> 2020 </u> Year
2. Name of medical practice or facility at which RU-486 was provided: Women's Med Dayton			
3. Address of medical practice or facility at which RU-486 was provided: 1401 E Stroop Rd Dayton, Ohio 45429			
4. Date post RU-486 complication began: <u> 9/2/2020 </u>			
5. Event(s) (Please check all that apply):			
<input 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) <u> Failed MIB </u>			
6. Duration of event: <u> 3 </u> Hours <u> </u> Days			
7. Remarks: <u> D:E </u>			
8. a. Name of physician who provided RU-486 <u> Catherine Romanos, MD </u>			
8. b. Physician's signature <u> <i>Catherine Romanos</i> </u> MD/DO			
Date <u> 9/3/20 </u>			

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MEDICAL BOARD

SEP 09 2020



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	24	2020
	Month	Day	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):			
<input 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) <u>failed m + b</u>			
6. Duration of event: <u>24</u> Hours _____ Days			
7. Remarks: uncomplicated D+E			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature			
Date <u>10/15/20</u>			

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MEDICAL BOARD
OCT 26 2020



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	13	2020
	Month	Day	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):			
<input checked="" type="checkbox"/> Incomplete abortion (medical) <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: _____ Hours _____ Days			
7. Remarks: DS - uncomplicated			
8. a. Name of physician who provided RU-486: Dr. Catherine Romanos			
8. b. Physician's signature:			
Date: MD 8/19/20			

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MEDICAL BOARD
AUG 24 2020



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:	<u>10</u> Month	<u>9</u> Day	<u>2020</u> 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: 10/14/20			
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: _____ Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 Catherine Romanos			
8. b. Physician's signature 			
Date <u>10/22/20</u> <small>MD/DO</small>			

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MEDICAL BOARD
NOV 12 2020



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:	<u>11</u> <u>20</u> <u>20</u> Month Day 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:	<u>11/24/20</u>
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:	_____ Hours _____ Days
7. Remarks:	uncomplicated suction
8. a. Name of physician who provided RU-486	<u>Dr. Catherine Romanos</u>
8. b. Physician's signature	 _____ Date _____ M.D./D.O. <u>12/3/20</u>

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MEDICAL BOARD
DEC 09 2020

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:	<u>12</u>	<u>11</u>	<u>2020</u>
	Month	Day	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: <u>01-12-2021</u>			
5. Event(s) (Please check all that apply):			
<input 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) <u>Continuing pregnancy</u>			
6. Duration of event: <u>1</u> Hours <u> </u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/D.O.</u>			
Date <u>1/14/21</u>			

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State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

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1. Date RU-486 was provided:	12	17	2020
	Month	Day	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):			
<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: 24 Hours _____ Days			
7. Remarks: uncomplicated suction			
8. a. Name of physician who provided RU-486: Catherine Romanos MD			
8. b. Physician's signature:			
Date: MD/DO 12/23/20			

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 Legal Department
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 Columbus, OH 43215-6127

MEDICAL BOARD
 JAN 04 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	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):			
<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: 1 Hours _____ Days			
7. Remarks: uncomplicated suction.			
8. a. Name of physician who provided RU-486: Catherine Romanos			
8. b. Physician's signature: MD/DO			
Date: 1/16/21			

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