

State Medical Board of Ohio  
Report of BU-486 Form

Revised 10/15/19  
To be completed by the physician or other health care provider

1. Date BU-486 was provided.	1	3	2020
2. Name of medical practice or facility at which BU-486 was provided.	Women's Med Dayton		
3. Address of medical practice or facility at which BU-486 was provided.	1401 E Stroop Rd Dayton, Ohio 45429		
4. Date post-BU-486 communication began.	1/17/2020		
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other (specify):		
6. Duration of event: _____ hours _____ min.			

7. Remarks:	
8. a. Name of physician who provided BU-486	Roslyn Kade
8. b. Physician's signature	R. Kade
	1/20/2020

Send completed form to: State Medical Board of Ohio  
Legal Department  
30 E. Broad St., 3rd Floor  
Columbus, OH 43260-1398

MEDICAL BOARD  
JAN 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>1</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: <u>1/27/2020</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 checked="" 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 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>R. Kade</u> M.D./D.O.			
Date <u>1/28/20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

MEDICAL BOARD

FEB 05 2020

State Medical Board of Ohio  
Report of RU-486 Event

(Revised version to B-1, 2019-12-31)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	1	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: 2/6/2020			
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 transfusion <input type="checkbox"/> Severe bleeding Other serious event (specify):			
6. Duration of event _____ Hours _____ Days			
7. Remarks			

8. a. Name of physician who provided RU-486: Keslyn Kade  
b. Physician's signature: [Signature] M.D.  
Date: 4/29/2020

Send completed form to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3rd Floor  
Columbus, OH 43215-6100


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:	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 mib uncomplicated suction			
8. a. Name of physician who provided RU-486 Catherine Romanos, MD			
8. b. Physician's signature 			
Date 2/18/20			

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

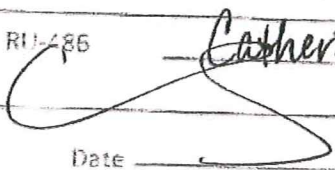
MEDICAL BOARD

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:	4	8	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 <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 D+E			
8. a. Name of physician who provided RU-486: Catherine Romanos			
8. b. Physician's signature: 			
Date: 6/10/20			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> 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 m&amp;B</u>			
6. Duration of event: <u>4</u> Hours _____ Days			
7. Remarks: <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> <u>MD/DO</u> Date <u>5/27/20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

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 <u>Catherine Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>5/15/20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

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:	<u>4</u>	<u>30</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: _____ Hours _____ Days			
7. Remarks: dilation: sueta			
8. a. Name of physician who provided RU-486 <u>Romanos</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>5/14/20</u>			

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

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>09</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 _____ 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 _____ Date <u>9/3/20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

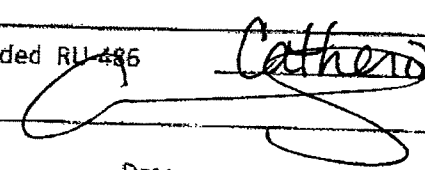
MEDICAL BOARD

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) 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  10/15/20			
Date 10/15/20			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

MEDICAL BOARD

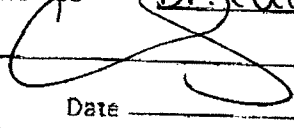
OCT 26 2020



# 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 8/19/20			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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:	9	24	20
	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: 10/15/20			
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 mife</u>			
6. Duration of event: 2 Hours _____ Days			
7. Remarks:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>R. Kade</u> (MD/DO)			
Date <u>10/28/20</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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>9</u>	<u>29</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>10/29/20</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:			
8. a. Name of physician who provided RU-486 8. b. Physician's signature <u>Roslyn Kade</u> <u>R. Kade</u> <u>MD/DO</u> Date <u>11/3/20</u>			

Send completed forms to:

State Medical Board of Ohio

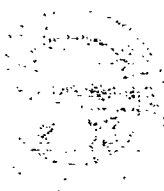
Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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:		
10	6	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: 11/2/2020		
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: _____ Hours _____ Days		
7. Remarks:		
8. a. Name of physician who provided RU-486: Roslyn Kade		
8. b. Physician's signature: <i>R. Kade</i> MD/DO		
Date: 11/3/2020		

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

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>10</u>	<u>9</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: 10/16/20			
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 10/22/20			

Send completed forms to:

State Medical Board of Ohio  
Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

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>10</u>	<u>27</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>11/2/20</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:			
8. a. Name of physician who provided RU-486 <u>Roslyn Kade</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD/DO</u>			
Date <u>11/3/20</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

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

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

DEC 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:	11	24	20
	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: 1/4/21			
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: failed medication abortion underwent uncomplicated aspiration medication abort			
8. a. Name of physician who provided RU-486: Jeanne Corwin			
8. b. Physician's signature: <i>Corwin</i> (MD/DO)			
Date: 1/4/2021			

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

MEDICAL BOARD

JAN 14 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>11</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: <u>12/1/20</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: <u>1</u> Hours <u>0</u> Days			
7. Remarks: <u>aspiration performed to complete abortion.</u> <u>No complications</u>			
8. a. Name of physician who provided RU-486 <u>Jeanne Corwin</u>			
8. b. Physician's signature <u>Corwin</u> MD/DO _____			
Date <u>12/1/2020</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

MEDICAL BOARD

DEC 09 2020

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	11	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: 01-12-2021			
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>MB/DO</u> Date <u>1/14/21</u>			

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





# 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>17</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>12-19-20</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: <u>24</u> Hours _____ Days			
7. Remarks: <u>uncomplicated suction</u>			
8. a. Name of physician who provided RU-486 <u>Catherine Romanos MD</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD</u> Date <u>12/23/20</u>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
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	23	20
	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: 12/28/20			
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 Romero			
8. b. Physician's signature: _____ Date: 1/12/21			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3<sup>rd</sup> Floor

Columbus, OH 43215-6127

MEDICAL BOARD

JAN 14 2021