## 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

. Date RU-486 was provided:	DA FEB	Day	2020 Year
to the second se		The second secon	Ted
2. Name of medical practice or facility at which	RU-486 was provide	ed:	
your choice Ho	ealth care		
3. Address of medical practice or facility	at which RU-486 w	as provided:	
6721 Karl Road,	Columbus	, on 432	29
4. Date post RU-486 complication began	2/28/20	)	
<ol><li>Event(s) (Please check all that apply):</li></ol>			,
Incomplete abortionAdver	se reaction to RU-486	** Patient hospitalized	
Patient received a transfusion Severe bleed	ng		
Other serious event (specify)			
6. Duration of event: Hours	_ Days		
7. Remarks: Parenteral autibiot.	ies for pies	ind PID.	
8. a. Name of physician who provided R	U-486	AM RODDICK	· MP
8. b. Physician's signature	Date_	3.31.20	
Send completed forms to:	Date		

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

## 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

Date RU-486 was provided:	July	15	2020
	Month	Day	Year
2. Name of medical practice or facility at which RU	486 was provid	led:	
Your Chaire Healt	have	·	· · · · · · · · · · · · · · · · · · ·
3. Address of medical practice or facility at w	hich RU-486 v	vas provided:	
6721 Karl Rad			
001 mbus od 43279			
4. Date post RU-486 complication began:	7 22,2	v20	
5. Event(s) (Please check all that apply):	· · · · · · · · · · · · · · · · · · ·		,
incomplete abortionAdverse re	action to RU-486	Patlent hospitalize	1
Patient received a transfusion Severe bleeding			
Other serious event (specify)	ailed 1	med AB/	Contrag Bright
6. Duration of event: Hours D	ays		
7. Remarks: Repeated med	Ag , 51	occessful wo	not incidet.
8. a. Name of physician who provided RU-48	16 <u>L. 6</u>	Inn Nunn	uz, no
8. b. Physician's signature		7:31-2020	,

Send completed forms to:

State Medical Board of Ohio

**Legal Department** 

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

MEDICAL BOARD
AUG 1 3 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

Date RU-486 was provided:	Aug	to 14	ひひ	
2. Name of medical practice or facility at which	Month -	Day	Year	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Your Choir ited				
3. Address of medical practice or facility	at which RU-486 was	provided:	A A A A A A A A A A A A A A A A A A A	
6721 Kowl Road Co	us of 43225		·	
4. Date post RU-486 complication began:	Aug 26,20	20		
5. Event(s) (Please check all that apply):				
Incomplete abortionAdvers	e reaction to RU-486	_ Patient höspitalized		
Patlent received a transfusion Severe bleedin	<b>K</b> .			
Other serious event (specify)				
6. Duration of event: 0 Hours 2	Days			
7. Remarks: Persistant clots. P	refid to anoth	ner families	AV Dec.	<u>, , , , , , , , , , , , , , , , , , , </u>
B. a. Name of physician who provided RU-	486 <u>W(</u>	HAM RODD	icue, mo	
8. b. Physician's signature	Date	Aug 20,	M.D/D.O	•
end completed forms to:	State Medical Boa	rd of Ohio		
Legal	Department			
20.5	Broad St., 3rd Floor			

Columbus, OH 43215-6127

MEDICAL BOARD 0CT 2 8 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	2000	
	Month J	Day	Year	
2. Name of medical practice or facility at which From the Healthense,	₹U-486 was pṛovic	led;		
3. Address of medical practice or facility at	which RU-486	waż nrowided:		
6721 Karl Rd. Col				
4. Date post RU-486 complication began:	lug 28 2	020		<u> </u>
5. Event(s) (Please check all that apply):		,	,	
Lincomplete abortionAdverse r	eaction to RU-486	Patlent hospitaliz	ed	
Patient received a transfusion Severe bleeding	·		•	
Other serious event (specify)			144	
6. Duration of event: Hours O	Days			
7. Remarks: Failed MAB > con Nefld to other	nowy production	guz. Surgiel	A6.	***************************************
8. a. Name of physician who provided RU-4	86W	MAM MO	some m	
8. b. Physician's signature	Date	Au 28 3	M.D/D.O_	
Send completed forms to:	State Medical I	Board of Ohio		
Legal D	epartment			

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MEDICAL BOARD

OCT 2 8 2020