# 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: 02 (Month) FEB (Month) 14 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Road, Columbus, OH 43229

4. Date post RU-486 complication began: 2/28/20

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

___ Incomplete abortion ___ Adverse reaction to RU-486 X Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: ____ Hours 1 Days

7. Remarks: Parenteral antibiotics for presumed PID.

8. a. Name of physician who provided RU-486 WILLIAM RODDICK MD

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

Date 3.31.20

Send completed forms to:

State Medical Board of Ohio
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

1. Date RU-486 was provided: July (Month) 15 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Road
Columbus OH 43229

4. Date post RU-486 complication began:
July 22, 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 med AB / continuing pregnancy

6. Duration of event: 1 Hours 0 Days

7. Remarks: Repeated med AB, successful without incident.

8. a. Name of physician who provided RU-486 L. Ann Nunnally, MD

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

Date 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 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 ~~28~~ 14 2020
   Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:
   Your Choice Healthcare

3. Address of medical practice or facility at which RU-486 was provided:
   6721 Kaul Road Cols OH 43229

4. Date post RU-486 complication began: Aug 26, 2020

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

   X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

   ___ Patient received a transfusion ___ Severe bleeding

   ___ Other serious event (specify) _____

6. Duration of event: 0 Hours 2 Days

7. Remarks:
   Persistant 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 _____ M.D./D.O.

   Date Aug 28, 2020

Send completed forms to:

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

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 (Month) 21 (Day) 2020 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Your Choice Healthcare,

3. Address of medical practice or facility at which RU-486 was provided:
6721 Karl Rd. Cols OH 43229

4. Date post RU-486 complication began: Aug 28 2020

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

X Incomplete abortion failed MAB ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ 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 Noblick MD

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

Date Aug 28 2020

Send completed forms to:

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

MEDICAL BOARD
OCT 28 2020