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: 05 (Month) 20 (Day) 21 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Capital Care of Toledo, Oh LLC

3. Address of medical practice or facility at which RU-486 was provided:

4. Date post RU-486 complication began: 5/20/21

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 medical

6. Duration of event: _____ Hours 13 Days

7. Remarks:

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

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

Date _____

Send completed forms to:

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

NOV 02 2021
MEDICAL BOARD OF OHIO