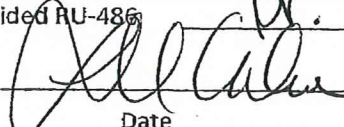


State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	June 23 2021
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:	1160 W SYLVANIA AVE TOLEDO, OH 43606
4. Date post RU-486 complication began:	6/23/21
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 checked="" type="checkbox"/> Other serious event (specify) <u>missed/failed</u>
6. Duration of event:	____ Hours <u>7</u> Days
7. Remarks:	Ongoing viable pregnancy after medication abortion
8. a. Name of physician who provided RU-486	Dr. Sarah Calabrese
8. b. Physician's signature	
Date	6/30/21 M.D./D.O.

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

NOV 02 2021

STATE MEDICAL BOARD OF OHIO

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:	<u>05</u>	<u>20</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Capital Care of Toledo, Oh LLC</u>			
3. Address of medical practice or facility at which RU-486 was provided:			
4. Date post RU-486 complication began: <u>5/20/21</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 checked="" type="checkbox"/> Other serious event (specify)	<u>failed medical</u>		
6. Duration of event: _____ Hours <u>13</u> Days			
7. Remarks:			
8. a. Name of physician who provided RU-486: <u>DR. BRITTANY</u>			
8. b. Physician's signature: <u>[Signature]</u> M.D./D.O.			
Date: _____			

Send completed forms to:

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MEDICAL BOARD OF OHIO