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 (Month) 23 (Day) 2021 (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:
1160 W Sylvania Ave Toledo, Oh 43606

4. Date post RU-486 complication began: 6/23/2

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) missed/failed

6. Duration of event: ____ Hours 7 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 [signature] M.D/D.O

Date 6/30/21

Send completed forms to:

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

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STATE MEDICAL BOARD OF OHIO

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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 [signature] M.D./D.O.

Date

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