State Medical Board of Ohio

Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 Month 20 Day 21 Year

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

NORTHEAST OHIO WOMENS CENTER

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

2127 STATE RD
CUYAHOGA FALLS, OH 44223

4. Date post RU-486 complication began: 6/22

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) ______________________

6. Duration of event: ________ Hours ________ Days

7. Remarks:

8. a. Name of physician who provided RU-486 David M Barkans

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

Date 6/26/21

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

MEDICAL BOARD
JUL 06 2021

Prescribed: 5/--/2011, Rev. 12/13/12