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: 8 (Month) 15 (Day) 2024 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
CLEVELAND CLINIC BEACHWOOD FAMILY HEALTH CENTER

3. Address of medical practice or facility at which RU-486 was provided:
26900 CEDAR RD, BEACHWOOD, OH 44122

4. Date post RU-486 complication began: 8/29/24

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: 1 Hours _____ Days

7. Remarks:
UNDERWENT UNCOMPLICATED UTERINE ASPIRATION.

8. a. Name of physician who provided RU-486 ERICA BISHOP, MD

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

Date 9/11/24

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

Prescribed 5/../2011 Rev. 12/13/12

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: 11 / 21 / 24 (Month / Day / Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
26900 CEDAR RD BEACHWOOD, OH 44122

4. Date post RU-486 complication began: 12/18/24

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: 1 Hours 0 Days

7. Remarks: PATIENT UNDERWENT UNCOMPLICATED UTERINE ASPIRATION

8. a. Name of physician who provided RU-486 ERICA BISHOP

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

Date 12/19/24

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OH 43215-6127

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