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: 3 (Month) 11 (Day) 24 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Northeast Ohio Women's Center

3. Address of medical practice or facility at which RU-486 was provided:
2167 State Rd, Cuyahoga Falls OH, 44223

4. Date post RU-486 complication began:
3/13/24

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: Med AB on 3/11/24 - failed
Readministered on 3/13/24 - failed
Successful D&C on 3/22/24

8. a. Name of physician who provided RU-486 ~~Dr. David~~ Burkons

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

Date 4/5/24

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

APR 12 2024
STATE MEDICAL BOARD OF OHIO

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