

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-485

| | | | | PTOC | 201402 |
|---|-------------------------------|-----------------|------------------|--|---------|
| 1. Date RU-486 was provided: | (| <u> </u> | 12. | 202 | 4 |
| | | onth | Day | Year | |
| Name of medical practice or facility a Women's Med Dayton | t which KO-486 | s was provided: | | | |
| Wolliella Med Dayton | | | | | |
| 3. Address of medical practice or facility 1401 E Stroop Rd | at which RU-4 | 86 was provided | d: | | |
| Dayton, Ohio 45429 | | | · | | |
| 4. Date post RU-486 complication began | n: | | | | |
| 5. Event(s) (Please check all that apply): | | | | | |
| Incomplete abortion | _ Adverse reaction | n to RU-486 | Patient hospital | ized | |
| Patient received a transfusion Severe | | | | | |
| Oth er serious_ event (specify) | arlet | Medi | catio | ma | burtion |
| 6. Duration of event: Hours | Da ₁ | ys | | and the second s | |
| 7. Remarks: Wude | rwenz Del C | t un | comp | licat | eal |
| 8. a. Name of physician who provided | RU-488 | Jeanne | GNUN | | |
| 8. b. Physician's signature | Data | | 11/06/ | 2024 | |
| Send completed forms to: Sta | Date — ate Medical Bo | | | | |
| Legal Dep | | aid or offic | | | |
| | ad St., 3 rd Floor | | | • | |
| 30 E. Broa | ad St., 3'" Floor | | | | |

Columbus, OH 43215-6127

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To be completed by the physician who provided RU-485

| 1. Date RU-486 was provide | ed: | _9 | 3 | 24 |
|--------------------------------|----------------------------------|--|--|-----------------------|
| | | Month | Day | Year |
| 2. Name of medical practice | | n RU-486 was provid | led: | |
| Women's Med Dayto | on | | | |
| 3. Address of medical practic | ce or facility at whi | ch RU-486 was prov | | |
| Dayton, Ohio 45429 | | | PTOOC | 123467 |
| 4. Date post RU-486 complic | ation began: 9 | 25 24 | The second secon | |
| 5. Event(s) (Please check all | that apply): | The state of the s | | |
| Incomplete abortion | Advers | e reaction to RU-486 | Patient hospitalize | ed |
| Patient received a transfusion | Severe bleeding | | | |
| Other serious event (specify) | fail- | ed abo | ntion | |
| 5. Duration of event: | 2 Hours | Days | | - |
| 7. Remarks: H | ed in | Compli (| cated | DelC |
| . a. Name of physician who | provided R01486 | | arwi | n |
| . b. Physician's signature | Da | te 09/ | 75 (JO) | Y |
| end completed forms to: | State Medi | cal Board of Ohio | L | |
| | Legal Department | | | |
| | 30 E. Broad St., 3 rd | Floor | , | OCT 04 2024 |
| N. | Columbus, OH 43: | 215-6127 | | MAIN . |
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Prescribed: 5/--/2011, Rev. 12/13/12