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: 10 (Month) 27 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd Cleveland, Ohio 44120

4. Date post RU-486 complication began:
11/29/17

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: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486: Mitchell Reider, MD

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

Date 12/1/17

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

MEDICAL BOARD
DEC 05 2017

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

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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: 10 (Month) 28 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland, OH 44120

4. Date post RU-486 complication began:
11/11/17

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: 3 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Justin Lapper, MD

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

Date 12/2/17

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

MEDICAL BOARD
DEC 07 2017

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: 10 (Month) 28 (Day) 2017 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
12000 Shaker Blvd. Cleveland, OH 44120

4. Date post RU-486 complication began:
11/17/2017

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: 2 Hours _____ Days

7. Remarks:

8. a. Name of physician who provided RU-486 Justin Lapper, MD

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

Date 12/2/17

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

MEDICAL BOARD
DEC 07 2017

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: 7 (Month) / 12 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 7/19/17

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: Med abortion process was initiated per FDA regimen on 7/12/17. Follow up ultrasound on 7/19/17 showed an ongoing pregnancy. Surgical aspiration was done on 7/20/17, pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress (M.D./D.O.)

Date 8/15/17

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: 7 (Month) / 13 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 7/17/17

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: Med abortion process initiated per FDA regimen on 7/13/17 second dose of misoprostol was given on 7/17/17 due to lack of results from first dose. Follow-up ultrasound on 7/19/17 showed ongoing pregnancy. Surgical aspiration was performed and pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress M.D./D.O.

Date 8/15/17

Send completed forms to: State Medical Board of Ohio
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MEDICAL BOARD
AUG 23 2017

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: 7 (Month) 19 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/2/17

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: Medication abortion procedure was initiated per FDA regimen on 7/19/17. At follow-up visit on 8/2/17 ultrasound revealed continued pregnancy. Surgical abortion was performed the same day and pt. did well post-op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy Kress MD/DO

Date 9/1/17

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

MEDICAL BOARD
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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) / 1 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/15/17

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: Medication abortion procedure was initiated per FDA regimen on 8/1/17. At follow-up visit on 8/15/17, Ultrasound revealed a continuing pregnancy. Surgical abortion was done the same day and pt. did well post-op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy Kress MD/DO

Date 9/1/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD
SEP 15 2017

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: 8 (Month) / 1 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/18/17

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: Med abortion procedure was initiated per FDA regimen on 8/1/17. Bloodwork on 8/18/17 and ultrasound on 8/22/17 revealed an incomplete abortion. Pt chose to repeat the medication regimen on 8/22/17; ultrasound on 8/29/17 showed abortion was complete.

8. a. Name of physician who provided RU-486 Timothy Kress MD

8. b. Physician's signature Timothy Kress (M.D./D.O)

Date 9/1/17

Send completed forms to: State Medical Board of Ohio
Legal Department
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Columbus, OH 43215-6127

MEDICAL BOARD
SEP 15 2017

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: 8 (Month) / 2 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 10/3/17

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: Med ab procedure started 8/2/17 per FDA protocol. Pt. returned for follow-up on 10/3/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did well post-op.

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress (M.D./D.O)

Date 11/10/2017

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MEDICAL BOARD
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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) / 9 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/15/17

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: Medicatum abortim procedure was initiated per FDA regimen on 8/9/17. At follow-up visit on 8/15/17, ultrasound revealed a continuing pregnancy. Surgical abortion was done on 8/17/17 and the pt. did well post-op.

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____ M.D. / D.O Audrey Gelfand, MD

Date 7/5/2017

STATE MEDICAL BOARD OF OHIO OCT 04 2017

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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: 8 (Month) / 15 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 8/24/17

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: Medication abortion procedure was initiated per FDA regimen on 8/15/17. At follow-up visit on 8/24/17, ultrasound showed absence of gestational sac, but incomplete abortion. Surgical aspiration was done on 8/24/17 and pt. did well post op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy Kress MD/DO

Date 9/1/17

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MEDICAL BOARD
SEP 15 2017

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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: 9 (Month) 8 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 10/14/17

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: pmed ab procedure started 9/8/17 per FDA protocol. Pt. returned for follow-up on 10/14/17 at which time ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/14/17; pt did well post-op

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, M.D.

8. b. Physician's signature Timothy Kress M.D./D.O

Date 11/10/2017.

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Columbus, OH 43215-6127

MEDICAL BOARD
NOV 17 2017

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: 9 (Month) / 8 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 9/19/17

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: Medication ab procedure started on 9/8/17. Follow-up bloodwork + Ultrasound showed continuing pregnancy. Surgical aspiration completed on 9/23/17; pt did well post-op.

8. a. Name of physician who provided RU-486 Timothy Kress, MD

8. b. Physician's signature Timothy S. Kress (M.D./D.O.)

Date 10/6/17

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

OCT 20 2017

MEDICAL BOARD

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

OCT 20 2017

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: 9 (Month) 13 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, OH 44146

4. Date post RU-486 complication began:
10/3/17

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: Med abortion procedure started 9/13/17 per FDA protocol. Follow-up bloodwork on 10/3/17 indicated an incomplete abortion and ultrasound showed a continuing pregnancy. Surgical abortion was performed on 10/31/17, pt did well post op

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD.

8. b. Physician's signature Timothy Kress (M.D./D.O.)

Date 11/10/2017.

Send completed forms to: State Medical Board of Ohio
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Columbus, OH 43215-6127

MEDICAL BOARD
NOV 17 2017

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: 9 (Month) 27 (Day) 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began:
10/11/17

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: Med ab procedure started on 9/27/17 per FDA protocol. Follow-up ultrasound on 10/11/17 showed intrauterine debris. Surgical aspiration was done on 10/11/17; pt did well post-op

8. a. Name of physician who provided RU-486 TIMOTHY KRESS, MD

8. b. Physician's signature Timothy Kress M.D./D.O.

Date 11/10/2017

Send completed forms to: State Medical Board of Ohio
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MEDICAL BOARD
NOV 17 2017

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: 10 (Month) / 21 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 11/10/17

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: Med ab process was initiated on 10/21/17, following FDA criteria. Follow-up ultrasound on 11/10 showed continuing pregnancy. Surgical ab was done on 11/16/17 and pt. did well post-op.

8. a. Name of physician who provided RU-486 Andrey Bezrukov M.D./D.O.

8. b. Physician's signature _____

Date 12/5/17

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

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: 12 (Month) / 9 (Day) / 17 (Year)

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

3. Address of medical practice or facility at which RU-486 was provided:
25350 Rockside Rd. Bedford Heights, Ohio 44146

4. Date post RU-486 complication began: 12/29/17

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: Med ab procedure was initiated on 12/9/17 per FDA regimen. Pt returned for f/u ultrasound on 12/29/17 and uterine debris was noted. Surgical aspiration was performed at that time; pt did well post op.

8. a. Name of physician who provided RU-486 Dr. T. Kress MD

8. b. Physician's signature Tullia S Kress MD/DO

Date 1/5/18

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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
JAN 17 2018

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: 7 (Month) 10 (Day) 2017 (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:
2127 State Rd Cuyahoga Falls Ohio 44223

4. Date post RU-486 complication began:
7/27/17

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: _____ Hours _____ Days

7. Remarks: post med AB patient had a remaining gestational Sac w/ no fetal pole developed or remaining. patient had D&C on 7/27/17 to Complete her process.

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

8. b. Physician's signature X _____ MD/DO

Date 9/7/17

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Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD
SEP 15 2017

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: 7 (Month) 13 (Day) 2017 (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:
2127 State Rd Cuyahoga Falls 44223

4. Date post RU-486 complication began:
8/12/17

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: _____ Hours _____ Days

7. Remarks: pt had (+) pfu post Medication Abortion. She had heavy bleeding and on ultrasound there was remaining tissue but pregnancy was resolved. pt had a DEC on 8/22/17

8. a. Name of physician who provided RU-486 Dr. L.A. Nunnally

8. b. Physician's signature X L.A. Nunnally MD MD/DO

Date 9/7/17

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30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

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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: October (Month) 21 (Day) 2017 (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:
2127 State Rt
Cuyahoga Falls, Ohio 44223

4. Date post RU-486 complication began:
11/16/17

5. Event(s) (Please check all that apply):

X ~~Incomplete~~ Failed abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks:
a suction D+C was performed on 11/16/17
without difficulty

8. a. Name of physician who provided RU-486 Jennifer Watson

8. b. Physician's signature Watson MD/DO

Date 11/18/17

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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