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: 01 (Month) 11 (Day) 2024 (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:
3255 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began: 2/22/24

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: 1 Hours ________ Days

7. Remarks:
Failed MAB procedure, surgical AB provided.

8. a. Name of physician who provided RU-486 Dr. Anne Marie Sinay

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

Date 2/22/24

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

OCT 2 2 2024
STATE MEDICAL BOARD OF OHIO

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