

CONSUMER COMPLAINT FORM

Office of the Indiana Attorney General

To prevent delay, please be sure to complete **both sides** of this form in full. Please print clearly or type. **DO NOT** include your **Social Security Number** on this form or in any accompanying documents.

Security Number on this form or in any accompanying documents.					
1. YOUR INFORMATION	2. WHO IS YO	UR COMP	LAINT AGA	INST?	
☐Mr. ☑Mrs. ☐Miss ☐Ms. ☐Dr. Name Evelyn Witte	Name/Firm Dr. Fo	. Ulrich G. Klop ort Wayne Worr	ofer nen's Health Org	yanization	
Address	Address 2210 II	nwood Drive			
City Fort Wayne State IN	City Fort Way	no		Ctata IN	
ZIP 46815 County Allen Age	City Fort Ways			State IN County Allen	
Phone Day	Phone (260)			7.11011	
Are you or your spouse active military? Yes No	E-mail_				
E-mail_	Person you dea	alt with _	J/A		
O WHITH DID TRANSACTION (NOIDENT COOLIDS	-1-				
3. WHEN DID TRANSACTION/INCIDENT OCCUR?	ate 2/7/2013				
4. WHERE DID THE TRANSACTION/INCIDENT YOU ARE COMPLAINING	ABOUT TAKE I	PLACE? (0	Check box	when applicable)	
★ At the firm's place of business My home Away from the firm's place of business (work, convention, etc.) Other	□ By Mail □ By Internet □ By telepho				
5. WHAT WAS THE VERY FIRST CONTACT BETWEEN YOU AND THE FIF	RM?				
□ I telephoned the firm □ I went to the firm's place of business □ I responded to a TV/radio ad □ I received a telephone call from the firm □ A person came to my home □ I responded to an offer on the Internet □ I received information by e-mail □ I responded to a printed advertisement □ I received information in the mail ☒ Other none					
6. DO YOU CONSENT TO DISCLOSING THE FOLLOWING TO THE PUBLIC	C?	7. WI	IAT WAS TI	HE TRANSACTION FOR?	
The nature and status of your complaint and the name of the firm? Your name? Your phone number? Yes □ No □ Yes □ No			☐ My business ☐ My family/household ☐ My farm		
8. HOW DID YOU PAY?					
□ Cash □ Credit Card □ Medicaid □ Check □ Installment Loan □ Medicare	□Priva ⊠ Othe	ate Insuran er	ice		
9. DID YOU SIGN ANY WRITTEN AGREEMENT? IF YES, PLEASE ATTAC	H A COPY OF T	THE AGRE	EMENT.	☐ Yes ⊠No	
For Office Use Only: Ind Prac PL MO NL NJ	OA:	Inv.	Sec	File #	

-CP-

10. HAVE YOU COMPLAINED TO THE BUSINESS? (Check box when applical	ble)	s 🗵 No				
When? Action taken?						
11. WITH WHAT OTHER AGENCY HAVE YOU FILED THIS COMPLAINT? None						
When? Action taken?						
12. HAVE YOU CONTACTED A PRIVATE ATTORNEY?	□Ye	s 🗷 No				
13. HAVE YOU STARTED A COURT ACTION? IF YES, PLEASE ATTACH A COPY OF	ALL COURT PAPERS.	s 🗷 No				
14. HAVE YOU BEEN SUED OVER THIS ISSUE? IF YES, PLEASE ATTACH A COPY	OF ALL COURT PAPERS.	s 🗷 No				
15. DOLLAR AMOUNT ASSOCIATED WITH YOUR LOSS, IF ANY. \$ N/A						
16. PLEASE DESCRIBE YOUR COMPLAINT IN DETAIL (ATTACH ADDITIONAL PAGES IF NECESSARY)						
Please attach a copy of all papers involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence and all other related documents). Please print clearly or type. DO NOT INCLUDE YOUR SOCIAL SECURITY NUMBER.						
On 2/7/2013 Dr. Ulrich Klopfer performed an abortion on a 13 year old girl at his abortion facility, Fort Wayne Women's Health Organization, 2210 Inwood Drive, Fort Wayne, IN, 46815. This abortion was not reported to the Indiana Department of Health as required by Indiana State law (IC16-34-2-5). A copy of the termination report is attached.						
17. HOW WOULD YOU LIKE YOUR COMPLAINT RESOLVED?						
I request the immediate suspension of the medical license of Dr. Ulrich Klopfer (#02000628A) pending a full investigation.						
Trequest the miniodiate suspension of the medical hostice of Dr. Chief Noplet (#02000020/1) perioding a full investigation.						
18. CONSENT AND VERIFICATION						
I affirm, under the penalties for perjury, that the foregoing representations are true. I consent to the Consumer Protection Division obtaining or releasing any information in furtherance of the disposition of this complaint. I consent to the release of information included in this complaint to						
other public agencies attempting to discover ongoing fraudulent patterns or practices and for the purpose of law enforcement.						
I understand that I should not include my Social Security Number in any information submitted to the Consumer Protection Division. If I do						
provide my Social Security Number, I expressly consent to the disclosure of my Social Security Number in accordance with Indiana Code § 4-1-10-5						
Your Signature Date						

WHAT WILL HAPPEN NOW? WHAT ELSE SHOULD YOU DO?

The Consumer Protection Division will send a copy of your complaint to the respondent firm or licensed professional. This office cannot disclose your complaint against a licensed professional to the public unless this office files a disciplinary action against the licensed professional. This office represents the State of Indiana and is limited in the remedies it can pursue. You may be entitled to compensation or other rights that we cannot pursue for you. In addition to filing this complaint, you may want to consider contacting a private attorney or your local small claims court.

MAIL COMPLETED FORMS TO:

Attorney General Greg Zoeller
Consumer Protection Division
Government Center South, 5th floor
302 West Washington Street
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