Contained in this document:

CONSUMER COMPLAINT

Office of the Indiana Attorney General
(R5 / 12-17)

INSTRUCTIONS: 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. ***Please note:*** If you have already obtained a judgment, or there is pending litigation, we may be limited or unable to take further action on your complaint.

Section 1: Your Information

Salutation
☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Miss ☐ Rev.

Street Address [redacted]

Full Name or Organization/Agency: Jodi Smith

City: Pittsboro | State: IN | Zip Code: 46167

If an Organization/Agency provide a Primary Contact Name

County: Hendricks | Daytime Phone [redacted]

Age Group
☐ 18-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-59 ☒ 60+

Email Address [redacted]

May we contact you by email? If yes, we will not contact you by regular mail ☒ Yes ☐ No
Are you or your spouse active military? ☐ Yes ☐ No

Section 2: Who is the Complaint Against?

Individual/Business: Women's Medical Center

Name of Individual/Representative you dealt with: Dr. Jeffry Glazer

Street Address: 1201 N. Arlington

City: Indpls. | State: IN | Zip Code: 46219

County: Marion | Daytime Phone: 317-353-957(

Email Address

Section 3: Transaction/Incident Details

3-A: Date of Transaction/Incident: 5/11/2018

3-B: If a Transaction, what was the Transaction for?
☐ My business ☐ My family/household ☐ My farm ☐ Non-Profit/Church

3-C: Where did the Transaction/Incident occur? (*check box where applicable*)
☐ My home
☒ At the location of the business
☐ Away from the location of the business (*work, convention, etc.*)
☐ By Mail
☐ By Internet/Email
☐ By Telephone
☐ By Social Media
☐ Other _____

3-D: What was the very first contact between you and the Individual/Business?
☐ I telephoned the individual/business
☐ I responded to a TV/radio ad
☐ A person came to my home
☐ I received information by email
☐ I received information in the mail
☐ I went to the location of the business
☐ I received a phone call from the business
☐ I responded to an offer on the internet
☐ I responded to a printed advertisement
☒ Other, describe below: _____

3-E: How did you Pay?
☐ Cash ☐ Credit Card/Pre-Pay ☐ Medicaid ☐ Pay-Pal ☐ Wire Transfer
☐ Check ☐ Installment Loan ☐ Medicare ☐ Private Insurance ☐ Other _____

3-F: What, if any, is the Dollar amount associated with your loss? $

Section 4 Actions Taken by Consumer

☐ Yes ☐ No 4-A: Did you sign a written agreement or contract? If yes, please attach a copy of the documentation.
☐ Yes ☐ No 4-B: Have you hired a private attorney?
☐ Yes ☐ No 4-C: Have you started a court action? If yes, please attach a copy of all court papers.
☐ Yes ☐ No 4-D: Have you sued, or have you been sued, over this incident/transaction? If yes, please attach a copy of all court papers.

Section 4 Actions Taken by Consumer - *continued*

☐ Yes ☐ No 4-E: Have you complained to the Individual/Business?

☐ Yes ☐ No 4-F: Have you filed a complaint with any other agency? If yes, list other agency:

Section 5 Transaction/Incident Details – *attach additional pages if necessary*

Please remember to attach a copy of all documentation involved (order blank, warranty, credit card receipt and statement, invoice, contract or written agreement, advertisement, cancelled check, correspondence etc). Please print clearly or type. **Do Not Include your Social Security Number.**

If you answered "Yes" to 4-E or 4-F above, please include those details also with your description of the Transaction/Incident.

Dr. Glazer performed an abortion on a 12yr. old and did not properly report it to DCS. as evidenced by the incomplete form

Section 6 How would you like your Complaint resolved?

An investigation and appropriate sanctions, fines or license revocation.

Section 7 WHAT HAPPENS NEXT?

The Consumer Protection Division will send a copy of your complaint to the respondent individual/business 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.

Section 8 Mail Completed Forms to:

Office of the Indiana Attorney General
Consumer Protection Division
Government Center South, 5th Floor
302 W. Washington Street
Indianapolis, IN 46204
317-232-6330 (phone) • 317-233-4393 (fax)
www.IndianaConsumer.com

Section 9 Consent and Verification

Do you consent to disclosing the *following information to the public?* →

☒ Yes ☐ No The nature of the complaint and the individual/business name
☒ Yes ☐ No Your name
☐ Yes ☒ No Your phone number

I affirm, under 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(2).

Jodi Smith — Your signature

10/18/18 — Date

SFN:002915

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

** **If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov.
Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed.** Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address	City or town, of pregnancy termination	County of pregnancy termination
THE WOMENS MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	INDIANAPOLIS	MARION

Patient's age**	Married	Date of pregnancy termination	Education
12	☐ Yes ☒ No	05/11/2018	8th Grade or Less

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☒ White ☐ Other ☐ Unknown

Ethnicity
☐ Hispanic or Latino ☒ Not Hispanic or Latino ☐ Unknown

Live Births:	Number now living: 0	Number now deceased: 0
Other Terminations:	Number of spontaneous terminations: 0	Number of induced terminations: 0

Dates of terminations *(Do not include this termination. If more than six (6), those most recent.)*
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive? ☐ Yes ☒ No	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination: ☒ None ☐ Uterine Perforation ☐ Hemorrhage ☐ Cervical Laceration ☐ Infection ☐ Retained Products ☐ Other *(Specify)*
Fetus viable? ☐ Yes ☒ No	If viable, medical reason for termination:	
Pathological examination performed? ☒ Yes ☐ No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	Did this termination of pregnancy result in a maternal death? ☐ Yes ☒ No

Type of Termination Procedures

Procedure that Terminated Pregnancy	Additional Procedure that Terminated Pregnancy
☐ Medical (Nonsurgical) Mifepristone ☐ Medical (Nonsurgical) Misoprostol ☐ Medical (Nonsurgical) Other *(Specify)*	☐ Medical (Nonsurgical) Mifepristone ☐ Medical (Nonsurgical) Misoprostol ☐ Medical (Nonsurgical) Other *(Specify)*
☒ Medical (Surgical) Suction Curettage ☐ Medical (Surgical) Menstrual Aspiration ☐ Medical (Surgical) Other *(Specify)*	☐ Medical (Surgical) Suction Curettage ☐ Medical (Surgical) Menstrual Aspiration ☐ Medical (Surgical) Other *(Specify)*
For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? ☐ Yes ☒ No	For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? ☐ Yes ☐ No
If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? ☐ Yes ☐ No	If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? ☐ Yes ☐ No
What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation *(in weeks)*	Post fertilization age of the fetus *(in weeks)*
03/01/2018	8	6

How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination
DR. JEFFREY D. GLAZER

Address of physician performing termination *(number and street, city, state, and zip code)*
1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

**Date Reported to DCS, if Patient under 16 *(month, day, year)*: _____

DATE RECEIVED BY ISDH *(month, day, year)*: 05/11/2018

Indiana State Department of Health
Division of Acute Care
Division of Long Term Care

Complaint Report Form

This form is intended to assist individuals in reporting concerns about a health care facility, agency, center, or clinic. This form provides many of the questions that are helpful to state surveyors in conducting surveys. Individuals are not required to use this form. To utilize this form, complete the form and then email completed form to complaints@isdh.in.gov or fax to 317-233-7494. Individuals may call our toll-free Complaint Report Line at 1-800-246-8909 or simply send an email or fax.

For additional information about the complaint and survey process, consumers should go to the *Reporting a Complaint* page at www.in.gov/isdh/21533.htm.

Complaint Report

Health care facility or provider where you have a concern:

Facility Name: Women's Medical Center

Facility Address: 1201 N. Arlington

Facility City: INdpls State: IN Zip: 46219

Facility Phone:

Patients / residents that the concern is about:

Patient / Resident Name: Room #: Age:
Diagnosis:

Patient / Resident Name: Room #: Age:
Diagnosis:

What is your relationship with patient / resident?

Individuals who were witnesses, involved, or knowledgeable about the issue:

Name:
Check Applicable:

- ☐ Staff
- ☐ Family Member

☐ Other Patient or Resident
☐ Visitor
☐ Other - Describe:

How was the individual involved?

Name:
Check Applicable:

☐ Staff
☐ Family Member
☐ Other Patient or Resident
☐ Visitor
☐ Other - Describe:

How was the individual involved?

Name:
Check Applicable:

☐ Staff
☐ Family Member
☐ Other Patient or Resident
☐ Visitor
☐ Other - Describe:

How was the individual involved?

Description of Concerns:

Brief description of concern: Abortion done on a 12 yr. old with out being reported to DHS by Dr. Jeffery Glazer

If this has been an ongoing concern, how long has the situation been going on?

If this is related to a specific incident, what is the date 05/18/2018 and the time that it occurred.

Describe any injury/injuries:

Is the patient / resident still at the facility?

After notifying the facility administrator or staff of your concerns, what actions or changes have taken place?

Are law enforcement agencies involved?

Your Contact Information:

Complaints may be submitted anonymously. Even if you provide the ISDH with your contact information, your name is always kept confidential. The name of the person

submitting a complaint is not provided to the facility or included in a survey report. By providing your contact information, you will receive a copy of the survey report. The state surveyor will also call you when ready to begin the survey so that you can clarify or provide additional details.

Name: Jodi Smith

Address: [redacted]

City: Pittsboro State: IN Zip: 46267

Phone: [redacted] (best number to contact you)

Best time of day to contact at that number:

Email Address: [redacted]