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KY Medical Professionals For Life Foundation – QUESTIONNAIRE

Please provide all of the following information so we can include on our website and annual program. Answer the following questions, sign your name and enter your address.

- (Please circle one.) (I am opposed to) (I support)**
abortion on demand as defined by the 1973 Supreme Court decision, Roe vs. Wade.
- (Please Circle one: YES NO)**. You may use my name in the Kentucky Doctors For Life Website.
SIGNATURE: _____ **(Required)**
(Signature required to add your name to the list of Pro-Life Medical Professionals.)
- OCCUPATION: _____ SPECIALTY: _____ (Please print)
- COUNTY: _____ (Please Print)
- OFFICE PHONE: _____
- I'M RETIRED: **(Please circle one: YES NO)**
- Please send my correspondence to the address below: _____ OFFICE _____ HOME

NAME (please print): _____
ADDRESS (please print): _____ Suite: _____
CITY (please print): _____ STATE: _____ ZIP: _____
PHONE: (_____) _____ EXTENSION: _____ FAX: (_____) _____
EMAIL (please print): _____
- I am enclosing my TAX DEDUCTIBLE donation of:
\$1000_____, \$500_____, \$200_____, \$100_____, \$50_____, Other \$_____.
Physicians who contribute \$200 or more will become members of the Kentucky Doctors for Life Foundation Advisory Board; and your name will also be included on the home page of our website: kydoctorsforlife.org.
Please make your check payable to the **Kentucky Doctors for Life Foundation, Inc.** Your donation is tax deductible. (Donations are not required but will help defray the cost of the ads and future mailings.)
- Please send me _____ more copies of this questionnaire.

(Please feel free to make copies of this form before you fill it out, to hand out to other Medical Professionals.)

Please return this form via: FAX (502)897-2426 or Scan it and email a pdf to: info@kydoctorsforlife.org
Or Mail to: KENTUCKY DOCTORS FOR LIFE FOUNDATION PO Box 6418 Louisville, KY 40206