



Dr. Anne Johnson
dranne@ourladyofhopeclinic.com

Dr. Michael Kloess
drmike@ourladyofhopeclinic.com

Letter of Interest

I / We are interested in becoming benefactors and receiving our care at Our Lady of Hope Clinic.

Each benefactor may choose their physician to be Dr. Anne Volk Johnson, Dr. Michael Kloess, or list no preference.

Name	Birth Date	Physician
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____

Contact Information

Primary Contact Person: _____

Email address: _____ Phone Number: _____

Mailing Address: _____
(Street) (City) (Zip)

Benefactor Levels

Individual	\$1,200 (if <35 subtract \$300 or >60 add \$300)
Couple	\$2,300 (if <35 subtract \$300 or >60 add \$300 for each)
Kids <19 and Students <23	\$500 (no additional fee for the 4th or more kids)

Please return this completed form with a fully refundable deposit of \$100 per person to:

Our Lady of Hope Clinic, 6425 Odana Road, Madison, WI 53719

For questions, please contact Steve Karlen (608-445-2063).

I have reviewed the practice website at www.ourladyofhopeclinic.org. I understand and agree that Our Lady of Hope Clinic Inc is tax-exempt under section 501(c)(3) of the Internal Revenue Code and that the primary purpose of Our Lady of Hope Clinic Inc is to serve the medical needs of individuals and families that cannot afford, or do not otherwise have access to, private health care coverage.

Signed _____ Date _____