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LEGAL DNA TEST APPLICATION

Please complete this form an d email, fax or mail to the locati on indicated above. A customer serv ice associate w ill contact the clients directly to a rrange appointments for cheek swab sample collection. **The test report will be sent to each adult party tested**.

DNA TEST REQUIRED:

❑ Paternity ❑ Maternity ❑ Grandparent ❑ Sibship ❑ Half Sibship ❑ Other ____________________

PARTIES TO BE TESTED

If client(s) have previously been tested with our lab, please provide case number:__________

CLIENT #1	Name:			Date of Birth (yyyy/mm/dd):
	Address:		Apt.:	Phone:
	City:	Prov:	Postal Code:	Email:
	Role: ❑ Mother ❑ Child ❑ Father ❑ Other (please specify):			
CLIENT #2	Name:			Date of Birth (yyyy/mm/dd):
	Address:		Apt.:	Phone:
	City:	Prov:	Postal Code:	Email:
	Role: ❑ Mother ❑ Child ❑ Father ❑ Other (please specify):			
CLIENT #3	Name:			Date of Birth (yyyy/mm/dd):
	Address:		Apt.:	Phone:
	City:	Prov:	Postal Code:	Email:
	Role: ❑ Mother ❑ Child ❑ Father ❑ Other (please specify):			
CLIENT #4	Name:			Date of Birth (yyyy/mm/dd):
	Address:		Apt.:	Phone:
	City:	Prov:	Postal Code:	Email:
	Role: ❑ Mother ❑ Child ❑ Father ❑ Other (please specify):			

ADDITIONAL INFORMATION

For paternity cases, is there a first degree relative (brother, father) of the man being tested who may possibly be the father of this child? ❑ Yes ❑ No

For maternity cases, is there a first degree relative (sister, mother) of the woman being tested who may possibly be the mother of this child? ❑ Yes ❑ No

APPLICANT (person requesting test)

Name:			Date (yyyy/mm/dd):
Address (if not specified above):			Phone:
City:	Prov:	Postal Code:	Email:

PAYMENT INFORMATION

* Full payment for services is required prior to sample collection.
* For kinship testing and non-cheek swab samples, additional fees will apply. Please call for pricing.
* An administrative fee will apply if this case is cancelled at any time prior to testing.

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

❑ Payment is included (Certified cheque or money order payable to Orchid PRO-DNA)

❑ Please charge my ❑ Visa ❑ MasterCard or ❑ American Express #:____________________Exp:__________

Name of Cardholder:			To Receive Test Results? ❑ Yes ❑ No
Credit Card Billing Address:			Phone:
City:	Prov:	Postal Code:	Signature: