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DNA IDENTITY TEST APPLICATION

Please complete this form and email, fax or mail to the location indicated above. **The test report will be sent to the Applicant (person requesting the test)**.

PARTY TO BE TESTED

Name:

APPLICANT (person requesting test)

❑ Participant ❑ Lawyer ❑ Executor of Will ❑ Public Trustee ❑ Other (please specify):

Name:

Organization/Firm (if applicable):

Address:

City:	Prov:	Postal Code:

Phone:	Fax:

Email:

AGENCY RELEASING SAMPLE (if applicable)

Contact Person:

Organization:

Address:

City:	Prov:	Postal Code:

Phone:	Fax:

Email:

TYPE OF TEST REQUIRED

❑ Legal (includes DNA profile and DNA sample stored on FTA card)

❑ Home (includes DNA profile only)

PAYMENT INFORMATION

* Full payment for services is required prior to sample collection.
* Non-cheek swab samples are subject to a surcharge.
* 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:			Phone:
Credit Card Billing Address:			Signature:
City:	Prov:	Postal Code:	Date: