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ANONYMOUS DNA TEST APPLICATION & PAYMENT

Please complete this form and return to Orchid PRO-DNA. **The test report will be sent to the applicant (person requesting the test).**

The ANONYMOUS DNA test results are for **information purposes only and not intended for use in legal proceedings.**

DNA TEST REQUIRED: Paternity Maternity Twin Zygosity Grandparent Sibship Half Sibship
 Other (Please specify) _____

APPLICANT (person requesting the test)			
Name:		Date (yyyy/mm/dd):	
Address:		Apt.:	Phone:
City:	Prov:	Postal Code:	Email:

PARTIES TO BE TESTED	
#1	CODE A (please use this same code on the consent form and the envelope containing the sample) Role: <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Other (please specify):
#2	CODE B (please use this same code on the consent form and the envelope containing the sample) Role: <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Other (please specify):
#3	CODE C (please use this same code on the consent form and the envelope containing the sample) Role: <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Other (please specify):
#4	CODE D (please use this same code on the consent form and the envelope containing the sample) Role: <input type="checkbox"/> Mother <input type="checkbox"/> Child <input type="checkbox"/> Father <input type="checkbox"/> Other (please specify):

ADDITIONAL INFORMATION
Is there a first degree relative of the person being tested who may possibly be the father/mother of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No

PAYMENT INFORMATION	
* Full payment for services is required prior to testing. * For kinship testing and non-cheek swab samples, additional fees will apply.	
Does the person paying for the test require a receipt to be mailed to them? <input type="checkbox"/> Yes <input type="checkbox"/> No	
PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:	
<input type="checkbox"/> Certified cheque or money order payable to Orchid PRO-DNA (personal cheques are not accepted) <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> American Express	
Card Number:	Exp: CVC:
Name of Cardholder:	Phone:
Credit Card Billing Address:	Signature:
City: Prov: Postal Code:	Date: