Orchid PRO DNA

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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 may apply if this case is cancelled at any time prior to testing.

Does the person paying for the test require a receipt to be mailed to them? ❑ Yes ❑ No

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

❑ Certified cheque or money order payable to Orchid PRO-DNA (personal cheques are not accepted)

❑ Visa ❑ MasterCard or ❑ American Express

Card Number:	Exp: CVC:
Name of Cardholder:	Phone:
Credit Card Billing Address:	Signature:
City: Prov: Postal Code:	Date: