

DNA TWIN ZYGOSITY DNA TESTING APPLICATION (Curiosity)

To initiate a DNA test to determine if twins are fraternal or identical, please complete this form and fax or mail to Orchid Cellmark.
All results will be sent by US Mail to the parties indicated on this form.

PARTIES TO BE TESTED	Orchid Cellmark Case #
Child #1	Date of Birth
Child #2	Date of Birth

PERSON REQUESTING TEST	
Name	To Receive Test Results? <input type="checkbox"/> Yes <input type="checkbox"/> No
Relationship to above individuals	
Address	
City/State/Zip	
Daytime Phone #	Evening Phone #

CHEEK SWAB KIT DISTRIBUTION

All cheek swab kits are sent to clients by Priority Mail. Shipment to a single address is covered by the regular testing fee. Each additional shipment is \$25/address. If you prefer kits to be shipped to you by courier, a surcharge will apply. In the table below, please indicate where kits are to be sent and the preferred method of shipment. Please note that we provide you with a pre-paid courier waybill and packaging for the shipment of samples to our laboratory.

Cheek Swab Kit Distribution	Via Priority Mail	Via Courier (must provide street address)
<input type="checkbox"/> Both kits to one address. Please specify which address:	<input type="checkbox"/> Free	<input type="checkbox"/> \$25 surcharge
<input type="checkbox"/> Each kit to a separate address	<input type="checkbox"/> \$25/add'l address	<input type="checkbox"/> \$25/shipment

PAYMENT INFORMATION

* The price for a curiosity twin zygosity test is \$375 for two children. Each additional test party is \$125.
 * Deposit of \$100 required prior to sending out specimen collection kits
 * Non-standard, non-cheek swab samples may be tested for a surcharge of \$225/sample
 * If this case is cancelled at any time prior to testing, there will be a \$100 non-refundable administration fee. Cases are non-refundable after 6 mos.
 * We can accept Western Union wire transfers - please call for specific directions

\$ _____ is included (Money order, Cashier's or Attorney's check accepted. Please make payable to Orchid Cellmark)

\$ _____ may be charged to the following credit card: Visa / MasterCard /Discover /American Express

Card #: _____ Expiration: _____ 3 Digit Authorization Code: _____

Name of Card Holder: _____ Cardholder Signature: _____

Address of Cardholder if different than person receiving results (we will mail credit card receipt to cardholder):
