

GRANDPARENT TESTING APPLICATION (Court Ready)

To initiate a DNA test, please complete this form and fax or mail to Orchid Cellmark.
A customer service associate will contact the clients directly to arrange for sample collection at a convenient collection site.

Referred by: _____

Have client(s) been tested before? Yes No

PARTIES TO BE TESTED		Orchid Case #
M O T H E R	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	
	City/State/Zip	
	Phone #	Date of Birth:
C H I L D	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	
	City/State/Zip	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
	Phone #	Date of Birth:
G R A N D M O T H E R	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	
	City/State/Zip	
	Phone #	Date of Birth:
G R A N D F A T H E R	Name	To Receive Test Results <input type="checkbox"/> Yes <input type="checkbox"/> No
	Address	
	City/State/Zip	
	Phone #	Date of Birth:

SCHEDULING INFORMATION

Please indicate scheduling preferences in the space below:

All parties together
 Each party separately
 Other arrangement. (Please specify) _____

PAYMENT INFORMATION - Please note that applicable taxes will be added to the price

* The price for testing mother, child and one paternal grandparent is \$825. Each additional grandparent tested at the same time is an additional \$175.
 * The price to test a new person at a later date is \$175 plus \$100 for each sample that is re-used. Samples are stored for one year only.
 * Minimum non-refundable deposit of \$100 is required in order to schedule specimen collection appointments.
 * Cases are fully non-refundable after 6 months.
 * Non-cheek swab samples submitted for testing are subject to a \$225 non-refundable surcharge.
 * We can accept Western Union wire transfers too - please call for specific instructions

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED BELOW:

\$ _____ is included (Please send a money order, cashier's or certified check, made 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):

INTERNET