

**HERITAGE ID CONSENT AND CHAIN OF CUSTODY
 (ANTE-MORTEM)**

Name of Collection Site: _____ Location of Site: _____

Specimen Collector's Statement: I _____ certify that I did take buccal swab specimens from the individual named below. I have identified the individual and have included identification information. The specimen is clearly labeled with the individual's name, date of birth, date collected, and my initials. A photo of that individual is attached.

Signature: _____ Date: _____


C L I E N T	First Name	Last Name	Right Thumbprint 
	Date of Birth		
	ID TYPE	ID #	
	Has had a blood transfusion within the last 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Has ever had a bone marrow or stem cell transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Race (please circle one): Caucasian / Black / Asian / Hispanic / Aboriginal		
	Other (specify):		
	Gender (please circle one): Male / Female		
	Date of Collection		

PHOTO AND IDENTIFICATION INFORMATION

Please securely attach (with stapler) a photo or a copy of official photo identification (i.e. driver's licence, passport, government issued photo ID).
The attached documents must be signed and dated by the client and initialed by the specimen collector.

STATEMENT OF CONSENT AND RELEASE

The person as named above, agrees to the following: I give my consent to the Collection Site, as listed above, to have my sample extracted for delivery to Orchid Cellmark. I consent to have a DNA profile generated and a DNA sample placed onto a long term storage card for self-storage. I agree that Orchid Cellmark, the Collection Site, the Specimen Collector and their respective mandataries and employees are not liable in any way for any damages, costs or expenses incurred for any reason in connection with the specimen collection, testing, or the use and disclosure of the test results or other personal information. I certify that I have fully disclosed all information that could have a material bearing on the results such as blood transfusions, bone marrow transplants or possible involvement of close relatives.

Client's Signature: _____
 (Signature of Authorizing Party)

Date: _____