

DNA TESTING APPLICATION (Immigration - Kinship)

Please complete this form and return to Orchid Cellmark by mail or fax along with payment. Please print all information.
You will be contacted by a customer service associate to make all of the necessary appointments.

Testing Required: Maternal Relatedness Paternal Relatedness Sib-ship Other

PARTIES TO BE TESTED - Please Print Last Name in Capital Letters	Date of Birth: (d/m/y)	Local or Overseas
Client #1:		
Client #2:		
Client #3:		
Client #4:		

ADDITIONAL INFORMATION:

Have client(s) been tested with Orchid Cellmark / Helix Biotech before? Yes No If yes, previous case number: _____

DNA TESTING NEEDS – Please provide information on the objective of the DNA test

On a separate piece of paper, please provide information on the relationship that needs to be proven. Please also provide information on the relationship of the other parties who are being tested, as compared to the person or persons in question.

OVERSEAS ADDRESS

LOCAL ADDRESS

Name:	Name:
Address:	Address:
	City/Prov/PC:
Country: Phone #:	Phone #:

LEGAL REPRESENTATIVE (if applicable)

LOCAL CONTACT (Sponsor, Translator, Friend)

Name:	Name:
Firm:	Address:
City/Prov/PC:	City/Prov/PC:
Phone #:	Phone #:

EMBASSY, CONSULATE or CIC OFFICE

Location:	Agency File #:
-----------	----------------

**** Please attach a copy of the letter issued by the Embassy, Consulate or CIC Office requesting the DNA test ****

PAYMENT INFORMATION

- * The price to test two parties is \$950 (this includes testing one mother).
- * Each additional person tested at the same time is an additional \$245.
- * Overseas sample collection and shipping charges are in addition to the above price.
- * The price to test a new person at a later date is \$245 plus \$50 for each sample that is re-used.
- * Please note that samples are stored for one year only.
- * If this case is cancelled at any time prior to testing, there will be a \$100 non-refundable administration fee.

PLEASE SELECT ONE OF THE PAYMENT OPTIONS LISTED:

- Payment is included (Please send a certified cheque or money order payable to Orchid Cellmark)
- Please charge my Visa, MasterCard or American Express:

Card Number: _____ Expiry Date: _____

Name of Card Holder: _____ Signature: _____

Address of Cardholder if different from client:

Office Use Only

Base price: \$950

Extra Person(s): _____

O/S Collection: _____

O/S Shipping: _____

Local Collection: Included

Local Shipping: Included

1st Half Payment: \$ _____

2nd Half Payment: \$ _____

Total Payment: \$ _____