



DNA Diagnostics Center

One DDC Way • Fairfield, OH 45014
1-800-929-0815 • 1-800-363-1707 (fax)

Client Identification Form

Chain of Custody

Corporate Partner: _____

Address: _____

C/S/Zip: _____

Phone: _____ Fax: _____

Email: _____

LAB USE ONLY

Partner Logo Here

To Collector: Please print clearly. **Entire** box must be completed for each party collected.

Mother	First Name (Please print clearly)	Last Name	Middle Initial
	Date of Birth	SSN Last 4 Digits	Client History: (Please check applicable) Have you had a blood transfusion within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a bone marrow or stem cell transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you previously participated in a parentage test? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Race: (Please check one) <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify): _____	Form of Photo ID Used: (Please check one) <input type="checkbox"/> Driver's License <input type="checkbox"/> Military ID <input type="checkbox"/> Other (specify): _____	

I certify I have read and agree to the Terms and Conditions provided on this form.

Sign Here Mother's Signature: _____ Date: _____

Child	First Name (Please print clearly)	Last Name	Middle Initial	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Date of Birth	SSN Last 4 Digits	Client History: (Please check applicable) Have you had a blood transfusion within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a bone marrow or stem cell transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you previously participated in a parentage test? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Race: (Please check one) <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify): _____	Form of Photo ID Used: (Please check one) <input type="checkbox"/> Driver's License <input type="checkbox"/> Military ID <input type="checkbox"/> Other (specify): _____		

I certify I have read and agree to the Terms and Conditions provided on this form.

Sign Here Custodian's Signature: _____ Date: _____

Alleged Father	First Name (Please print clearly)	Last Name	Middle Initial
	Date of Birth	SSN Last 4 Digits	Client History: (Please check applicable) Have you had a blood transfusion within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a bone marrow or stem cell transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you previously participated in a parentage test? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Race: (Please check one) <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify): _____	Form of Photo ID Used: (Please check one) <input type="checkbox"/> Driver's License <input type="checkbox"/> Military ID <input type="checkbox"/> Other (specify): _____	

I certify I have read and agree to the Terms and Conditions provided on this form.

Sign Here Alleged Father's Signature: _____ Date: _____

Additional Party	First Name (Please print clearly)	Last Name	Middle Initial	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	Additional <input type="checkbox"/> Child <input type="checkbox"/> Father	Date of Birth	SSN Last 4 Digits	Client History: (Please check applicable) Have you had a blood transfusion within the past 3 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a bone marrow or stem cell transplant? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you previously participated in a parentage test? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Race: (Please check one) <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other (specify): _____		Form of Photo ID Used: (Please check one) <input type="checkbox"/> Driver's License <input type="checkbox"/> Military ID <input type="checkbox"/> Other (specify): _____	

I certify I have read and agree to the Terms and Conditions provided on this form.

Sign Here Additional Party's Signature: _____ Date: _____

Collector Statement

I certify that I have properly identified the parties and have collected, packaged and sealed the specimen(s) and have witnessed the signatures. I affirm, under penalties for perjury, that no tampering with the specimen(s) occurred while under my control.

Collector's Signature: _____

Collector (Printed Name): _____

Collection Date: _____ Time: _____ AM PM

Collection Facility Information

(If different from address above)

Facility: _____

Address: _____

C/S/Zip: _____

Phone: _____

Mother's Contact Information

Address: _____

C/S/Zip: _____

Phone: _____

Alleged Father's Contact Information

Address: _____

C/S/Zip: _____

Phone: _____

Additional Party's Contact Information

Address: _____

C/S/Zip: _____

Phone: _____

Terms and Conditions

I acknowledge, consent and agree to the following:

- I verify that the information contained on this form is correct and true to the best of my knowledge.
- I authorize DDC, or its agents, to collect biological specimens and perform DNA testing with my specimen or that of the minor or incapacitated individual(s) named on this form.
- I understand that the biological specimens will be used for genetic testing and may be stored for future testing.
- If this test involves a person who is a minor or who is otherwise legally incapable of consenting, I attest that I have the legal authority to consent to testing and assume all legal responsibility.
- I witnessed the labeling of my name and/or individual's name I am consenting for on the envelope/tube or package containing the specimen.
- I acknowledge and agree that the laboratory's liability to me arising out of or in any way related to the provision of testing services contemplated herein shall not exceed the cost of the test, and I agree to indemnify, defend, and hold DDC, its officers, agents, employees, representatives and any persons or entities collecting specimens harmless from all further claims or damages.
- I acknowledge and understand that if for any reason the biological specimen is inadequate for evaluation, DDC or the entities collecting specimens shall not be held liable if it is unable to produce test results due to insufficient specimen or due to the nature or condition of the specimen. DDC may request additional samples.
- I understand that to ensure testing of the highest quality, DDC reserves the right to perform more testing to satisfy strict laboratory standards and guidelines. If this process delays the reporting of results, I will not hold DDC or the entities collecting specimens liable for any refund or damages.

DNA Diagnostics Center Laboratory Use Only

Package Received Sealed and Secure: Yes No

I hereby affirm that I received the specimens for the individuals named on this form and found no evidence that the specimens had been tampered with or that the package had been opened prior to our receipt.

Received By *(Printed Name)*: _____

Recipient's Signature: _____

Date: _____ **Time:** _____

AM PM

Laboratory Notes: _____
