Cheque/Postal Order (Payable to: Orchid Cellmark)

Cheque Number: Amount: £ : p

Name:

Address:

Postcode: –

On behalf of (Solicitor/Institution/Court)

Credit/Debit Card: Amount: £ : p

Please debit my account: Mastercard ☐ Visa ☐ Maestro ☐ Delta ☐ Solo ☐

Card Number:

Cardholders Name:

Valid from: / Valid to: / CVV No (3 digits on reverse)

Address:

Postcode: –

A receipt will usually be sent to the address of the cardholder or address given in this section.
Please contact Cellmark if you wish to discuss this.

I request Cellmark to proceed with DNA tests. I understand the Cellmark recommendations concerning the involvement of all those with parental responsibility or care and control for the child(ren) under 16 years of age. Please refer to Cellmark's recommendations on Consent

Signed: **Date:** / /

52245

Tel: 01235 528000 PO Box 265 ABINGDON Oxon OX14 1YX

Cellmark
DNA PATERNITY SERVICES

REGISTRATION FORM

DNA Testing

Fast

Confidential

Conclusive

Court Approved

Reliable

Experienced

All testing in the UK

Cellmark
DNA PATERNITY SERVICES

Mother / or other relationship please specify (e.g. Aunt)

Full Name:

Address:

Postcode: - D.O.B. / /

Tel No:

Is a copy of the report to be sent to this person at this address? (please tick) ☐ Yes ☐ No

Child / or other relationship please specify (e.g. uncle)

Full Name:

Address:

Postcode: - D.O.B. / /

Tel No:

Is a copy of the report to be sent to this person at this address? (please tick) ☐ Yes ☐ No

Alleged Father or other relationship please specify (e.g. uncle)

Full Name:

Address:

Postcode: - D.O.B. / /

Tel No:

Is a copy of the report to be sent to this person at this address? (please tick) ☐ Yes ☐ No

52245

Tel: 01235 528000 PO Box 265 ABINGDON Oxon OX14 1YX

Cellmark DNA PATERNITY SERVICES

Appointment details

Dr's Name: List No:

Address:

Postcode: - Date of Appt: / /

Tel No: or to be arranged: ☐ Yes ☐ No

Appointment details

Dr's Name: List No:

Address:

Postcode: - Date of Appt: / /

Tel No: or to be arranged: ☐ Yes ☐ No

Appointment details

Dr's Name: List No:

Address:

Postcode: - Date of Appt: / /

Tel No: or to be arranged: ☐ Yes ☐ No

Additional reports

Full Name:

Address:

Postcode: - Reference:

Please see overleaf for important payment requirements