

## Paternity Order Form

*Please designate one person/firm to complete this form for tested persons. Adults tested and those receiving results will be authorized to contact SSI for testing status unless documented otherwise in writing.*

Primary Contact Person's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: (\_\_\_\_\_) \_\_\_\_\_

Additional Contact Person: \_\_\_\_\_ Telephone #: (\_\_\_\_\_) \_\_\_\_\_

Mail Original Report to (Name): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mail Copy to (Name): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**ONLY PROVIDE THE NAMES OF THE PARTIES BEING TESTED BELOW:**

**Will the Mother Be Tested?**  No  Yes,

If yes Full Name: \_\_\_\_\_ Race: \_\_\_\_\_

Are you the Legal Guardian of the Child(ren)?  No  Yes, If No, WHO? \_\_\_\_\_

**The Legal Guardian of the Children Must Sign the Consent/Indemnity Form if the Mother is NOT being tested.**

Alleged Father's Full Name: \_\_\_\_\_ Race: \_\_\_\_\_

Are you the Legal Guardian of the Child(ren)?  No  Yes, If No, WHO? \_\_\_\_\_

Child #1 Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female

Child #2 Full Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  Male  Female

Please provide the preferred city, day of the week and time for collection for each party to be tested.

**Mother** City: \_\_\_\_\_ State: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

**Alleged Father** City: \_\_\_\_\_ State: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

**Child 1** City: \_\_\_\_\_ State: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

**Child 2** City: \_\_\_\_\_ State: \_\_\_\_\_ Day: \_\_\_\_\_ Time: \_\_\_\_\_

**Parties Scheduled:**  Together  Separate, If separate who should Child(ren) be scheduled with: \_\_\_\_\_

Would you like a Home Collection for an additional fee?  No  Yes

Basic: Mother, Child, Alleged Father	<b>\$350 total</b>
Motherless Testing: Child, Alleged Father	<b>\$230 total</b>
Additional Parties: Multiple Children or Alleged Fathers	<b>\$115 per person</b>
Home Collection Fee: Only incurred if not done at an SSI site	<b>\$40 per person</b>

**Full Payment Must be Enclosed. NO PERSONAL CHECKS PLEASE**

Visa  Mastercard  Cashiers Check or Money Order (Made out to Specimen Specialists)

Card Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Cardholder's Street, City, State, Zip : \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

I hereby give Specimen Specialists permission to bill the credit card listed above for the following amount \$ \_\_\_\_\_

**Send completed form with payment to: Specimen Specialists of America Online, Inc.      Or fax to:**  
2003-A Opportunity Drive Suite 5      916-677-0287
Roseville, CA 95678

