

CENTER FOR GENETIC ANALYSIS AND TECHNOLOGIES

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SAMPLE SUBMISSION FORM		TO BE FILLED OUT BY REQUESTING PARTY			
IDENTIFICATION OF ALLEGED FATHER		TEST REQUIRED			
Last Name:		PATERNITY TEST			
First Name:		MATERNITY TEST			
		TWIN TEST			
Date of birth:	Day Month Year	RELATIONSHIP TEST			
Ethnic origin:		REQUESTING PARTY			
Country:		Last Name:			
IDENTIFICATION OF MOTHER		First Name:			
Last Name:		Address:			
First Name:		Phone:			
Date of birth:	Day Month Year	Fax:			
Ethnic origin:		E-mail:			
Country:		METHOD OF PAYMENT			
IDENTIFICATION OF CHILD		I agree with the CGAT's general Terms and Conditions and confirm to pay promptly the CGAT invoice, which will be issued after the samples are collected.			
Last Name:		Signature:			
First Name:		Date:			
Date of birth:	Day Month Year		Day	Month	Year
Gender:	Male Female	Settlement:	Bank Transfer or by cash		
Ethnic origin:		CGAT Bank Account:			
Country:		VIETCOMBANK HANOI THANG LONG BRANCH	A/C NUMBER: 0491 0017 65340		
		SAMPLE INFORMATION			
		Type	DNA	Blood	Swabs
		Date of Collection	Day	Month	Year
		Date Sent	Day	Month	Year
CONSENT					
I hereby order CGAT to perform the test indicated on this form.					
Person	FATHER	MOTHER	CHILD		
Name					
Signature					
Date					
* If the child is < 18 years, a legal guardian has to sign.					