



Biological Relationship Case Submission Form

LSD&FC Case #: _____ Agency Case #: _____

A. Type of Case: Court/Police Order YES NO **B. How did you find us?** _Ref_ _Web_ _Fbook_ _Insta_ _Tweeter_ _LinkedIn_ _Other

C. Authorized Person(s)/Organization to Receive Report:

1. Name/Address:		Contact Person:
		Phone:
2. Surname:	First name:	Middle Name:
Address:		
Email:	Phone:	Relationship: <input type="checkbox"/> A Tested Party <input type="checkbox"/> Agency
3. Surname:	First Name:	Middle Name:
Address:		
Email:	Phone:	Relationship: <input type="checkbox"/> A Tested Party <input type="checkbox"/> Agency


D. Terms & Conditions for Service: This is our contract. It specifies the terms/conditions for performing your DNA test. By signing below, you are acknowledging that you understand and accept the terms/conditions. Specifically, as a party to be tested or person handing over sample;

1. Give consent for DNA collection, authorize LSD&FC to perform the desired DNA test and accept to pay the fee in advance for the DNA test.
2. Agree that LSD&FC will choose the appropriate course of analysis. Sample collection maybe by Concurrent Technologies & Services (CTS) or a center certified for DNA collection by LSD&FC.
3. Understand that the appropriate course may include sending the sample to a partner laboratory (ISO certified) in USA for testing.
4. Understand that information you provide will be kept confidential. It will not be released by LSD&FC to unauthorized persons, unless required by law.
5. You must pick up submitted samples if you decide not to proceed, or **LSD&FC will destroy them after 60 days**, without further notice.
6. Understand that leftover DNA after analysis will be destroyed. There is a fee if you want DNA sample(s) returned to you or stored at LSD&FC.
7. Understand that the profile generated from samples may be deleted from our database 12 months after report is issued, thus not recoverable.
8. _Consent/_ Do-not-consent, to the use of your anonymized data (no name and personal identifiers) for research or publication by LSD&FC.
9. Accept that if this test is a Court or Police Order, the result will be issued ONLY to the Court/Police, and you will pay if LSD&FC must deliver the report to the Court or Police. There is no fee if the Court or Police will pick up the report from LSD&FC.
10. Agree that, if an Expert is required to appear in person, in Court to testify, for each court visit, you will; a) pay expert witness fees, b) provide an acceptable form of transport and security and c) provide an acceptable hotel if overnight stay is required. You understand that the fee payable for expert witness appearance in court is not known at this time and is in addition to the fee paid for the test.
11. Affirm that the test is for: Peace-of-Mind Use Only Legal Use (Additional fees may apply).

I accept: **Name:** _____ **Sign:** _____ **Date:** _____

E. Preferred Method for Report Delivery: E-Mail Pick-up Delivery (Additional fee applies)

Individual #1	Surname (Last):	First Name:	Middle Name:	
	Address:	Date of Birth:	Day	
			Month	
			YEAR	
	Collection Date:			
	Email:	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
	Nationality/Race:	Ethnicity:		
	Role of Individual to the DNA testing in this case:			
	<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____ <input type="checkbox"/> Alleged			
	Any Previous Stem Cell Transplant, Blood Transfusion or Paternity Test? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes Specify _____			
Photo taken and attached to submission form with individual's name? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Form of Id: <input type="checkbox"/> Driver License; <input type="checkbox"/> Int. Passport; <input type="checkbox"/> Voters ID; <input type="checkbox"/> National ID; <input type="checkbox"/> Birth Cert.; <input type="checkbox"/> Affidavit. ID No. _____				
I authorize the genetic analysis of this sample for the purpose of biological relationship determination. I have verified the above information and determined the information to be correct.				
Signature: _____ <input type="checkbox"/> Self <input type="checkbox"/> Guardian				

Individual #2	Surname (Last): _____		First Name: _____		Middle Name: _____	
	Address: _____			Date of Birth:	Day _____	
					Month _____	
					YEAR _____	
	Email: _____			Collection Date: _____		
	Nationality/Race: _____			Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
	Nationality/Race: _____			Ethnicity: _____		
	Role of Individual to the DNA testing in this case: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____ <input type="checkbox"/> Alleged					
	Any Previous Stem Cell Transplant, Blood Transfusion or Paternity Test? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes Specify _____					
	Photo taken and attached to submission form with individual's name? <input type="checkbox"/> Yes <input type="checkbox"/> No Form of Id: <input type="checkbox"/> Driver License, <input type="checkbox"/> Int. Passport, <input type="checkbox"/> Voters ID, <input type="checkbox"/> National ID, <input type="checkbox"/> Birth Cert. <input type="checkbox"/> Affidavit. ID No. _____					
I authorize the genetic analysis of this sample for the purpose of biological relationship determination. I have verified the above information and determined the information to be correct. Signature: _____ <input type="checkbox"/> Self <input type="checkbox"/> Guardian						
Individual #3	Surname (Last): _____		First Name: _____		Middle Name: _____	
	Address: _____			Date of Birth:	Day _____	
					Month _____	
					YEAR _____	
	Email: _____			Collection Date: _____		
	Nationality/Race: _____			Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
	Nationality/Race: _____			Ethnicity: _____		
	Role of Individual to the DNA testing in this case: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Child <input type="checkbox"/> Sister <input type="checkbox"/> Brother <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other _____ <input type="checkbox"/> Alleged					
	Any Previous Stem Cell Transplant, Blood Transfusion or Paternity Test? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes Specify _____					
	Photo taken and attached to submission form with individual's name? <input type="checkbox"/> Yes <input type="checkbox"/> No Form of Id: <input type="checkbox"/> Driver License, <input type="checkbox"/> Int. Passport, <input type="checkbox"/> Voters ID, <input type="checkbox"/> National ID, <input type="checkbox"/> Birth Cert. <input type="checkbox"/> Affidavit. ID No. _____					
I authorize the genetic analysis of this sample for the purpose of biological relationship determination. I have verified the above information and determined the information to be correct. Signature: _____ <input type="checkbox"/> Self <input type="checkbox"/> Guardian						
F. Collector Certification: If applicable, I affirm that I have verified the identity of ALL parties, explained the Terms & Conditions of Service, obtained authorization through signature and properly collected, packaged, labeled and sealed the sample(s) for DNA analysis.					Address for Collection	
Name: _____			Signature: _____			 48 Broad Street Lagos, Nigeria POC: Casework Coordinator Email: info@LSDFC.org
Date:	Day	_____	Time:	<input type="checkbox"/> AM <input type="checkbox"/> PM		
	Month	_____				
YEAR	_____					
G. Name/Signature of Staff reviewing Form		Name: _____		Sign: _____		Date: _____