# ADVANCED HEALTH CARE INC

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Tamilnadu – 629001, India.
Tele No: 04652 295749 Fax No: 04652 278248
Mobile No: 09360036111 OR 09367536777 OR 09367536888
EMAIL: enquiry@advanceddna.in OR marketing@advanceddna.in
URL: www.advanceddna.in

**TESTING DETAILS** ☐Maternity ☐ Paternity ☐ Sibling ☐DNA Profile ☐ Grand parentage ☐ Ancestry

**KITNO :** ☐

**For accurate results, it is extremely important to fill out each section of the form properly. PREPAID: YES** ☐ **NO** ☐

**Relationship #1:** ☐ Mother ☐ Father ☐ Child ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle ☐Grandmother ☐Grandfather
**Name:** ______________________ ______________________ ______________________ ______________________
First Name Middle Initial Last Name Maiden Name
**Date of Birth: Day_____ / Month _____Year /______** **Date Sample was collected: _______________**
**Race:** ☐Caucasian ☐ Black ☐ Hispanic ☐ Asian Other: ___________ **Sex:** F ☐ M ☐
**Notes:**______________________________________________________________
**I have read and accept the terms of contract, and give consent for Advanced Health Care INC to carryout DNA analysis on the sample**
SIGNATURE: ________________________ **REF NO:** ☐

**Relationship #2:** ☐ Mother ☐ Father ☐ Child ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle ☐Grandmother ☐Grandfather
**Name:** ______________________ ______________________ ______________________ ______________________
First Name Middle Initial Last Name Maiden Name
**Date of Birth: Day_____ / Month _____Year /______** **Date Sample was collected: _______________**
**Race:** ☐Caucasian ☐ Black ☐ Hispanic ☐ Asian Other: ____________ **Sex:** F ☐ M ☐
**Notes:**______________________________________________________________
**I have read and accept the terms of contract, and give consent for Advanced Health Care INC to carryout DNA analysis on the sample**
SIGNATURE: ________________________ **REF NO:** ☐

**Relationship #3:** ☐ Mother ☐ Father ☐ Child ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle ☐Grandmother ☐Grandfather
**Name:** ______________________ ______________________ ______________________ ______________________
First Name Middle Initial Last Name Maiden Name
**Date of Birth: Day_____ / Month _____Year /______** **Date Sample was collected: _______________**
**Race:** ☐Caucasian ☐ Black ☐ Hispanic ☐ Asian Other: ___________ **Sex:** F ☐ M ☐
**Notes:**______________________________________________________________
**I have read and accept the terms of contract, and give consent for Advanced Health Care INC to carryout DNA analysis on the sample**
SIGNATURE: ________________________ **REF NO:** ☐

**Relationship #4:** ☐ Mother ☐ Father ☐ Child ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle ☐Grandmother ☐Grandfather
**Name:** ______________________ ______________________ ______________________ ______________________
First Name Middle Initial Last Name Maiden Name
**Date of Birth: Day_____ / Month _____Year /______** **Date Sample was collected: _______________**
**Race:** ☐Caucasian ☐ Black ☐ Hispanic ☐ Asian Other: ___________ **Sex:** F ☐ M ☐
**Notes:**______________________________________________________________
**I have read and accept the terms of contract, and give consent for Advanced Health Care INC to carryout DNA analysis on the sample**
SIGNATURE: ________________________ **REF NO:** ☐

**PLEASE SEE INSTRUCTIONS ON BACK OF THIS FORM**

## DISCLAIMER

Please read the following statement. This document must be returned with test samples. If you have any questions, please call 9360036111.

1. Errors can, and sometimes do, occur in DNA testing;

2. ADVANCED HEALTH CARE INC makes no warranty, either express or implied, with respect to the goods or services provided in connection with this kit or the DNA test, or with respect to the results, whether as to merchantability or fitness for a particular purpose;

3. ADVANCED HEALTH CARE INC shall not be responsible for any direct, indirect, consequential, punitive or incidental damages of any kind whatsoever, with respect to the DNA service provided, whether arising out of or related to the DNA testing, the DNA kit or the accessories to the kit, or any part thereof;

4. If you believe an error has occurred in testing, you will contact ADVANCED HEALTH CARE INC immediately, giving ADVANCED HEALTH CARE INC, a reasonable opportunity to remedy any deficiencies;

5. In the event of any errors in handling or testing the samples submitted by you for DNA testing,
YOUR SOLE AND EXCLUSIVE REMEDY AGAINST ADVANCED HEALTH CARE INC SHALL BE EITHER A REFUND OF THE MONIES PAID BY YOU TO ADVANCED HEALTH CARE INC OR COMPLETION OF A SECOND TEST AT THE EXPENSE OF ADVANCED HEALTH CARE INC, SUCH REMEDY TO BE SELECTED BY ADVANCED HEALTH CARE INC, AT ITS DISCRETION.

By signing below you indicate your agreement to the terms and conditions, and limitations of liability, contained above, and request that ADVANCED HEALTH CARE INC perform DNA testing on the enclosed samples.

Agreed:

___________________________________ ___________________________________
**Print Name/Date** **Signature**

___________________________________ ___________________________________
**Print Name/Date** **Signature**

___________________________________ ___________________________________
**Print Name/Date** **Signature**

Up to two (2) original reports per test, mailed via standard U.S. Mail.

**I authorize ADVANCED HEALTH CARE, Inc. to release the test results to: **Please print clearly****

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

For Postal Mail: ADVANCED HEALTH CARE INC
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KANYAKUMARI, SOUTH INDIA
TELE : 914652 295749/ 09360036111 FAX : 0091 4652 278248
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