DNA SAMPLE REQUEST FORM

Department *of* Health & Human Services
Medical Examiner

Mail to: Utah Office of the Medical Examiner
4451 South 2700 West, Taylorsville UT 84129

Phone: 801-816-3850
Fax: 801-964-1240

DECEDENT INFORMATION

Full Name: _____

OME Case # (if known): _____

Date of Death: _____ Birth Date: _____

TYPE OF SAMPLE REQUESTED

$25.00 Processing fee must accompany request. Make check/money order payable to: Utah Medical Examiner's Office

☐ DNA Samples for establishing paternity ☐ Other (specify): _____

Next of Kin must contact the testing facility, obtain a reference number for your request, and submit payment to the testing facility prior to submitting this form to the Office of the Medical Examiner.

TESTING FACILITY INFORMATION

Reference Number: _____ Name of Facility: _____

Facility Contact: _____ Facility Phone #: _____

Address: _____

City, State, Zip: _____

NEXT OF KIN AUTHORIZING REQUEST

☐ Current Spouse ☐ Sibling (18+) ☐ Grandparent ☐ Legal Guardian (attach court order)

☐ Child (18+) ☐ Parent ☐ Grandchild (18+) ☐ Legal Representative (attach court order)

Name: _____

Phone #: _____ Email Address: _____

Signature: _____ Date: _____

FORM MUST BE NOTARIZED AND RECEIVED IN-OFFICE WITHIN 90 DAYS

State of: _____ County of: _____

Subscribed and sworn before me this _____ day of _____, 20___

_____
Notary Public

(SEAL) My Commission Expires: _____

The records maintained by the Office of the Medical Examiner are classified confidential and any release shall be consistent with the provisions of Utah Code Part 26B-8-2 (3); 26-4-17 (2) and (3)