



Utah Department of
Health & Human Services
Medical Examiner

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

DNA SAMPLE REQUEST FORM

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

DECEDENT INFORMATION

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: _____ FACILITY PHONE #: _____
FACILITY CONTACT: _____
NAME OF FACILITY: _____
ADDRESS: _____
CITY, STATE, ZIP: _____

NEXT OF KIN AUTHORIZING REQUEST

CURRENT SPOUSE SIBLING CHILD (18+) PARENT GRANDPARENT GRANDCHILD (18+)
 LEGAL GUARDIAN (ATTACH DOCUMENTATION) LEGAL REPRESENTATIVE (ATTACH DOCUMENTATION)

NAME: _____

PHONE #: _____

EMAIL: _____

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

My Commission Expires: _____

(SEAL)