PROFESSIONAL REFERRAL INFORMATION

Name of Practice _____

Primary Contact _____

Address _____

City _____ State _____ Zip Code _____

Phone ( )_____ Fax ( ) _____

Email _____ Website _____

Type of Professional Organization:
_____ Attorney
_____ Hospital
_____ Medical Professional

Area of Specialty _____
Years in Practice _____

Other members of the association/firm:

_____ _____
_____ _____
_____ _____

Please list 3 business references:

1. _____ Phone ( ) _____

2. _____ Phone ( ) _____

3. _____ Phone ( )_____

Would you like to receive information about DNA Identification Testing? Yes___ No___

I authorize The Center for Medical Genetics and Dad Test™ to add the professionals listed above to the referral list. I understand that the information will be used for this referral program only and that participation in this program can be discontinued at any time.

Signature: _____ Date: _____

(please fax back Attention: Dad Test to 713-790-1903 or mail to 7400 Fannin, Ste 1150, Houston, TX 77054)