REPORTING THE IDENTIFICATION OF A SELECT AGENT OR TOXIN FROM A CLINICAL/DIAGNOSTIC SPECIMEN
(APHS/CDC FORM 4A)

Detailed instructions are available at [http://www.selectagents.gov/form4.html](http://www.selectagents.gov/form4.html). This report must be submitted to either DASAT or DSAT.

### Part 1 – Report of Identification

**Section A – Reference Laboratory Information**

- **1. Name of individual completing Sections A and B (First, MI, Last):**
- **2. E-mail address:**
- **3. Telephone #:**

- **4. Entity name or Name of Clinical/Diagnostic Laboratory:**

- **5. Responsible Official or Laboratory Supervisor name (First, MI, Last):**
- **6. E-mail address:**
- **7. Telephone #:**

- **8. Address (NOT a post office address):**
- **9. City:**
- **10. State:**
- **11. Zip Code:**

**Section B – Select Agent or Toxin Identified from Clinical/Diagnostic Specimen(s)**

- **1. Select Agent or Toxin Identified:**
- **2. Date identified:**
- **3. Date of Immediate Notification for Tier 1:**
- **4. Type of notification to APHIS or CDC:**
- **5. # of samples received:**
- **6. Sample type received:**
- **7. Zip code for case/patient/sample origin:**

- **8. Type of test performed:**
  - [ ] Biochemical
  - [ ] Culture
  - [ ] DFA/IFA
  - [ ] ELISA/EIA/RIA

- **9. Dispositions of select agent or toxin listed by entity (complete all that apply):**
  - [ ] Transferred (Provide entity name and date of transfer. Entity: __________________ Date: __________________)
  - [ ] Destroyed (Provide destruction method and date. Method: __________________ Date: __________________)
  - [ ] Retained (Provide name of Principal Investigator retaining sample. Name: __________________)

- **10. Were any of the samples containing a select agent or toxin handled outside of primary containment which may have led to an unintentional release and/or exposure to the select agent or toxin?**
  - [ ] No
  - [ ] Yes

- **11. Has the sender(s) (i.e., sample provider(s)) of the specimen(s) been notified of the identification of the select agent or toxin?**
  - [ ] No
  - [ ] Yes

- **12. Was your entity the source of the sample(s)?**
  - [ ] No
  - [ ] Yes

- **13. Is the sample provider located outside the United States?**
  - [ ] No
  - [ ] Yes

- **14. Sample Provider Entity Name:**
- **15. Address (NOT a post office address):**
- **16. City:**
- **17. State:**
- **18. Zip Code:**

- **19. Sample Provider Point of Contact (First, MI, Last):**
- **20. Sample Provider E-mail Address:**
- **21. Sample Provider Contact Number:**

- **22. Comments / Notes:**

I hereby certify that the information contained in Part 1 of this form is true and correct to the best of my knowledge. I understand that if I knowingly provide a false statement on any part of this form, or its attachments, I may be subject to criminal fines and/or imprisonment. I further understand that violations of 7 CFR Part 331, 9 CFR Part 121, or 42 CFR Part 73 may result in Civil or criminal penalties, including imprisonment.

**Signature of Responsible Official/Laboratory Supervisor:** ___________________________  **Date Signed:** ___________________________

Public reporting burden: Public reporting burden of providing this information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D74, Atlanta, Georgia 30329; ATTN: PRA (0920-0576).