

FSA-409 (Proposal 9) U.S. DEPARTMENT OF AGRICULTURE Farm Service Agency <h2 style="text-align: center;">MEASUREMENT SERVICE RECORD</h2>	1. FARM NUMBER 2. PROGRAM YEAR 3. REQUEST NUMBER 4. FARM LOCATION
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5A. PRODUCER'S NAME AND ADDRESS 5B. TELEPHONE NO. (Include Area Code):	6A. NAME AND ADDRESS OF PERSON TO CONTACT 6B. TELEPHONE NO. (Include Area Code):
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PART A - SERVICE REQUEST AND COST

7. KIND OF SERVICE REQUEST	8. COMMODITY/LAND USE	9. NO. ACRES	10. NO. BINS/PLOTS	11. BASIC RATE: \$ _____
<input type="checkbox"/> Stake and Reference <input type="checkbox"/> Measurement after Planting <input type="checkbox"/> Ground <input type="checkbox"/> NAIP <input type="checkbox"/> Remeasurement <input type="checkbox"/> Ground <input type="checkbox"/> NAIP <input type="checkbox"/> Bins <input type="checkbox"/> Other (Specify)				12A. NO. of HOURS: _____ 12B. HOURLY COST: \$ _____
				13A. NO of MILEAGE: _____ 13B. MILEAGE COST: \$ _____
				14. TOTAL COST: \$ _____

15. PERSON MAKING REQUEST

I have reviewed the request and hereby agree to pay the cost of the service as requested.

A. SIGNATURE OF PERSON MAKING REQUEST	B. DATE (MM-DD-YYYY)
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16. CASH RECEIPT	17. FOR REFUNDS ONLY			
A. PAYMENT RECEIVED FOR SERVICES REQUESTED \$ _____	A. REFUND YES <input type="checkbox"/> NO <input type="checkbox"/>	B. REFUND FOR (Crop or Service)		
B. SIGNATURE OF COUNTY OFFICE EMPLOYEE	C. AMOUNT \$ _____	D. CHECK NO.	E. DATE (MM-DD-YYYY)	F. APPROVAL (CED Initials)

18A. SPECIAL INSTRUCTIONS

18B. EMPLOYEE NAME	18C. DATE WORK ISSUED (MM-DD-YYYY)	18D. DATE WORK RETURNED (MM-DD-YYYY)	18E. DATE MAILED
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PART B - RECORD OF MEASUREMENT SERVICE PERFORMED (If applicable, attach a copy of GPS Information to the FSA-409).

19. BIN/TRACT NO.	20. CLU NO.	21. COMMODITY OR LAND USE	ACRES DETERMINED			25.	26.	27.	28.	29.	30. METHOD
			22. GROSS	23. DEDUCTIONS	24. NET						
31. MEASURED ACREAGE/PRODUCTION											
32. OFFICIAL ACREAGE											
33. TOTALS:											

34. ALL required determination for this farm visit have been made in accordance with applicable procedures.	A. EMPLOYEE NAME	B. DATE (MM-DD-YYYY)
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35. REMARKS:

NOTE: *The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 7 CFR 718. The information will be used to fulfill the producer's request for service. Furnishing the requested information is voluntary. Failure to furnish the requested information will result in no service. This information may be provided to other agencies, IRS, Department of Justice, or other State and Federal law enforcement agencies, and in response to a court magistrate or administrative tribunal. The provisions of criminal and civil fraud statutes, including 18 USC 286, 287, 371, 641, 651, 1001; 15 USC 714m; and 31 USC 3729, may be applicable to the information provided.*

*According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0560-XXXX. The time required to complete this information collection is estimated to average 15 minutes 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. **RETURN THIS COMPLETED FORM TO YOUR COUNTY FSA OFFICE.***

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