



**REPORTING THE IDENTIFICATION OF A SELECT AGENT OR TOXIN: PROFICIENCY TESTING REPORT (APHIS/CDC FORM 4B)**

FORM APPROVED  
OMB NO. 0579-0213  
OMB NO. 0920-0576  
EXP DATE XX/XX/XXXX

**INSTRUCTIONS**

Read guidance instructions at [www.selectagents.gov](http://www.selectagents.gov) before completing this form. Answer all items completely and type or print in ink. The form must be signed and submitted to either APHIS or CDC by email attachment, fax, or mail:

Animal and Plant Health Inspection Service  
Agricultural Select Agent Program  
4700 River Road Unit 2, Mailstop 22, Cubicle 1A07  
Riverdale, MD 20737  
FAX: (301) 734-3652  
E-mail: [Agricultural.Select.Agent.Program@aphis.usda.gov](mailto:Agricultural.Select.Agent.Program@aphis.usda.gov)

Centers for Disease Control and Prevention  
Division of Select Agents and Toxins  
1600 Clifton Road NE, Mailstop A46  
Atlanta, GA 30333  
FAX: (404) 718-2096  
Email: [CDCForm4@cdc.gov](mailto:CDCForm4@cdc.gov)

<p>Accession Number(s):</p>  <p>(For Program use ONLY)</p>
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**Submit completed form only once by either email, fax, or mail**

SECTION A - INFORMATION FOR LABORATORY THAT RECEIVED PROFICIENCY TESTING SAMPLE(S)					
1. Name of individual completing the form: First: _____ MI: _____ Last: _____			2. Email address: _____		3. Telephone #: _____
4. <input type="checkbox"/> Registered Entity (APHIS or CDC Registration #: (_____) ) <input type="checkbox"/> Clinical or Diagnostic Laboratory [non-registered entity (NRE)] (NRE # (provided by APHIS or CDC): _____)			5. Entity name: _____		
6. Responsible Official or Laboratory Supervisor name: First: _____ MI: _____ Last: _____			7. Address (NOT a post office address): _____		
8. Telephone #: _____	9. Fax #: _____	10. Email address: _____	11. City: _____	12. State: _____	13. Zip Code: _____
14. Sponsor/entity that you received select agent or toxin from:  Entity name: _____ Registration #: _____ Entity address: _____ Telephone #: _____ Email: _____					

SECTION B - SELECT AGENTS AND TOXINS IDENTIFIED FROM PROFICIENCY TESTING		
1. Select Agent or Toxin Identified	2. Date obtained from sponsor	3. Date identified
4. Dispositions of select agents or toxins (complete all that apply): <input type="checkbox"/> Transferred (Provide entity name and date of transfer. Entity: _____ Date: _____) <input type="checkbox"/> Destroyed (Provide destruction method and date. Method: _____ Date: _____) <input type="checkbox"/> Retained (Provide name of person retaining sample. Name: _____)		
5. Were any of the samples containing a select agent or toxin, listed in the table above, handled outside of primary containment which may have led to an unintentional release and/or exposure to the select agent or toxin? <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, you are required under 7 CFR Part 331.19, 9 CFR Part 121.19, and 42 CFR Part 73.19 to complete and submit an APHIS/CDC Form 3)		

I hereby certify that the information contained on 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 331, 9 CFR 121, or 42 CFR 73 may result in civil or criminal penalties, including imprisonment.

Signature of Responsible Official/Laboratory Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

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 0579-0213. The time required to complete this information collection 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.