



FORM APPROVED
OMB NO.0579-0213
OMB NO. 0920-0576
EXP Date XXXXXXXX

1. Date of Incident:		2. Date of Immediate Notification:		3. Type of Immediate Notification: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Telephone	
4. Name of Entity (entities registered with CDC or APHIS) or Name of Hospital or Laboratory (non-registered entities):				5. Entity registration number (For select agent registered entities only):	
6. Physical Address:		7. City:		8. State:	9. Zip Code:
10. Responsible Official (registered) or Name of Laboratory Supervisor (non-registered):					
11. Telephone #:		12. Fax #:		13. E-mail address:	
14a: Type of Incident (Human Health): <input type="checkbox"/> Theft <input type="checkbox"/> Loss <input type="checkbox"/> Release <input type="checkbox"/> Lab Acquired Infection			15. Did the release result in a potential exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A (If N/A , explain in Blocks 28 or 31) If yes, has medical surveillance been initiated? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A (If N/A , explain in Blocks 28 or 31)		
14b: Type of Incident (Animal and Plant Health): <input type="checkbox"/> Unintended Animal Infection <input type="checkbox"/> Unintended Plant Agent Release					
14c: Transfer: <input type="checkbox"/> Transfer incident (complete Sections 1 and 2 and Appendix B)					
16. Time incident occurred:		17. Location of incident (building and room #)		18. Location of incident within room (e.g., freezer, incubator, centrifuge):	
19. Biosafety level: <input type="checkbox"/> BSL2 <input type="checkbox"/> BSL3 <input type="checkbox"/> BSL4 <input type="checkbox"/> ABSL2 <input type="checkbox"/> ABSL3 <input type="checkbox"/> ABSL4 <input type="checkbox"/> PPQ Agent <input type="checkbox"/> Ag		20. Date of last inventory (for reporting loss only):		21. Name of Principal Investigator:	

23. Name of Select Agent or Toxin		24. Characterization of Agent (e. g. strain, ATCC #)	25. Quantity / Amount
A			
B			
C			

26. Provide a detailed summary of events including a timeline of what occurred. Whenever possible, conduct a risk assessment of the event and determine if the root cause can be identified. State specifically what personal protective equipment was worn and what, if any, medical surveillance was provided or planned. If incident involves a non-human primate, please state species.

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 1.5 hours 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.

Block 26. Continued: (Use Appendix A for continuation, if necessary)

**SECTION 3 - TO BE COMPLETED BY ALL ENTITIES ONLY FOR RELEASE
OF SELECT AGENTS AND TOXINS OR OCCUPATIONAL EXPOSURE**

27. An internal review of laboratory procedures and policies has been initiated to lessen the likelihood of recurrences of theft, loss or release of select agents and toxins at this entity.

☐ No ☐ Yes If yes, please provide additional details.

28. What were the hazards posed to humans by the extent of the release or occupational exposure?

29. What is the estimated extent of the release or exposure in relation to the proximity of susceptible humans, animals and plants?

30. Provide a brief summary of how the laboratory and work surfaces were decontaminated after the release.

31. In select agents and toxins posing a risk to humans, please state how many laboratorians were potentially exposed and provide a brief summary of the medical surveillance provided (do not provide names or confidential information).

Certification: 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 the select agent regulations may result in civil or criminal penalties, including imprisonment. 7 CFR 331, 9 CFR 121, 42 CFR 73.

Signature of Respondent: _____

Title: _____

Typed or Printed Name of Respondent: _____

Date: _____



**REPORT OF THEFT, LOSS, OR RELEASE OF SELECT
AGENTS AND TOXIN
(APHIS/CDC FORM 3)
APPENDIX A**

APPENDIX A

ADDITIONAL SHEET FOR CONTINUATION OF INFORMATION

Continue Form 3 comments here. State which block from the Form 3 the continuation is from.
(Example: The following statement is a continuation of block 26 :)

☐

 Save and continue on next page (Form automatically defaults to a blank page for continuation)

**REPORT OF THEFT, LOSS, OR RELEASE OF SELECT
AGENTS AND TOXINS
(APHIS/CDC FORM 3)
APPENDIX B
TRANSFER INCIDENT ADDENDUM**

APPENDIX B- IF THE INCIDENT OCCURRED DURING TRANSFER, COMPLETE SECTIONS 1 AND 2 OF FORM 3 AND PROVIDE THE FOLLOWING INFORMATION (INCLUDE A COPY OF THE RELEVANT APHIS/CDC FORM 2)	
1. Transfer authorization number from APHIS/CDC Form 2:	2. Date Shipped:
3. Name of Carrier:	4. Airway bill number, bill of lading number, tracking number:
5. Package Description (size, shape, description of packaging including number and type of inner packages; attach additional sheets as necessary:	

6. Package with select agents and toxins received by requestor: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date of receipt:	7. Package with select agents and toxins appears to have been opened: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, include explanation in box 5 above.
8. Sender was contacted regarding incident: <input type="checkbox"/> No <input type="checkbox"/> Yes	9. Carrier/courier was contacted regarding incident: <input type="checkbox"/> No <input type="checkbox"/> Yes

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Signature of Respondent : <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	Title: <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>
Typed or Printed Name of Respondent: <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>	Date: <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>