



**REQUEST TO TRANSFER  
SELECT AGENTS AND TOXINS  
(APHIS/CDC FORM 2)**

FORM APPROVED  
OMB NO. 0579-0213  
OMB NO. 0920-0578  
EXP DATE 12/31/2018

Detailed instructions are available at <http://www.selectagents.gov/form2.html>. Answer all items completely and type or print in ink. This request must be signed and submitted to either APHIS or CDC:

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

Centers for Disease Control and Prevention  
Division of Select Agents and Toxins  
1600 Clifton Road NE, Mailstop A-46  
Atlanta, GA 30329  
FAX: (404) 471-8468  
E-mail: [cdcform2@cdc.gov](mailto:cdcform2@cdc.gov)

<b>Accession Number:</b> _____
<b>Transfer ID Number:</b> _____
(For Program Use ONLY)

**Submit completed form only once by either e-mail, fax, or mail**

**APHIS/CDC AUTHORIZATION NUMBER:** \_\_\_\_\_ **EXPIRATION DATE:** \_\_\_\_\_

SECTION 1 – TO BE COMPLETED BY RECIPIENT				
SECTION A – RECIPIENT INFORMATION				
1. Entity name:		2. Entity registration number:		
3. Address (NOT a post office address):		4. City:	5. State:	6. Zip code:
7. Principal Investigator name: First:                      MI:                      Last:		8. APHIS Permit #:		
9. Responsible Official (RO) name: First:                      MI:                      Last:		10. RO telephone #:		
11. RO fax #:		12. RO e-mail address:		
SECTION B – SENDER INFORMATION				
13. Entity name:		14. <input type="checkbox"/> Entity registration number: _____ <input type="checkbox"/> Clinical/diagnostic laboratory <input type="checkbox"/> Other: _____		
15. Address (NOT a post office address):		16. City:	17. State:	18. Zip code:      19. Country:
20. Responsible Official (RO) or facility director: First:                      MI:                      Last:		21. RO/Facility Director telephone #:		
22. RO/Facility Director fax #:		23. RO/Facility Director e-mail address:		
24. This transfer request is for a select agent or toxin that was identified in a clinical or diagnostic sample: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please ensure that an APHIS/CDC Form 4 "Report of the Identification of a Select Agent or Toxin" is submitted to APHIS or CDC within 7 calendar days.				
25. Is the agent a product of a restricted experiment, as defined in section 13 of the select agent regulations? If yes, provide the description used in the Federal Select Agent Program approval letter for the restricted experiment that produced the agent. <input type="checkbox"/> Yes <input type="checkbox"/> No				
SECTION C – LIST OF SELECT AGENTS AND TOXINS REQUESTED (attach additional sheets if necessary)				
26. Select agents and/or toxins to be transferred:				
A				
B				
C				
D				
E				

I hereby certify that the information contained in Section 1 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, and 42 CFR 73 may result in civil or criminal penalties, including imprisonment.

Signature of Responsible Official: \_\_\_\_\_ Title: \_\_\_\_\_  
Typed or printed name of Responsible Official: \_\_\_\_\_ Date: \_\_\_\_\_



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**SECTION 2 – TO BE COMPLETED BY SENDER**

**SECTION D – LIST OF SELECT AGENTS AND TOXINS SHIPPED (attach additional sheets if necessary)**

	27. Select agents and/or toxins:	28. Characterization of agent:	29. Number of items (e.g., vial, slant, plant, etc.):	30. Form (powder/liquid/slant):	31. Total volume or weight of item contents (e.g., mL, mg, ng):
A					
B					
C					
D					
E					

**SECTION E – RECIPIENT NOTIFICATION INFORMATION**

32. Name of individual at recipient entity notified of expected shipment: First: _____ MI: _____ Last: _____	33. Date of notification: _____	34. Type of notification: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Telephone
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**SECTION F – SHIPPING INFORMATION**

35. Name of individual who packaged shipment: First: _____ MI: _____ Last: _____	36. Number of packages shipped: _____	37. Shipment date: _____
38. Package description (size, shape, description of packaging including number and type of inner packages): _____		
39. Name of carrier (If hand-delivered, please provide name of individual): _____	40. Airway bill number/bill of lading number/tracking number: _____	

I hereby certify that the select agents and/or toxins were packaged, labeled, and shipped in accordance with all federal and international regulations and information contained in Section 2 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 331, 9 CFR 121, and 42 CFR 73 may result in civil or criminal penalties, including imprisonment.

Signature of Sender: \_\_\_\_\_ Title: \_\_\_\_\_

Typed or printed name of Sender: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION 3 – TO BE COMPLETED BY RECIPIENT  
(Within 2 days of transfer receipt as defined in Section 16 2(h) of the Select Agent Regulations)**

41. Name of individual who received shipment: First: _____ MI: _____ Last: _____	42. <input type="checkbox"/> Transfer did not occur <input type="checkbox"/> Transfer occurred/date of receipt: _____
43. The agents/toxins listed in Section 2 were received: <input type="checkbox"/> Yes <input type="checkbox"/> If no, explain discrepancy in separate attachment.	44. Shipment was packaged, labeled, and shipped in accordance with regulations: <input type="checkbox"/> Yes <input type="checkbox"/> If no, explain discrepancy in separate attachment.

I hereby certify that the information contained in Section 3 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, and 42 CFR 73 may result in civil or criminal penalties, including imprisonment.

Signature of Responsible Official: \_\_\_\_\_ Title: \_\_\_\_\_

Typed or printed name of Responsible Official: \_\_\_\_\_ Date: \_\_\_\_\_

**Public reporting burden:** Public reporting burden of this collection of information 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. 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 D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0576).