



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

FORM APPROVED  
OMB NO. 0920-0576  
EXP DATE: 01/31/2024

**INSTRUCTIONS**

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

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

Centers for Disease Control and Prevention  
Division of Select Agents and Toxins  
1600 Clifton Road NE, Mailstop H21-7  
Atlanta, GA 30329  
FAX: (404) 471-8469  
E-mail: [CDCForm4@cdc.gov](mailto:CDCForm4@cdc.gov)

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

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 agents or N/A for non-Tier 1 agent to APHIS or CDC:	4. Type of notification to APHIS or CDC: <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Telephone <input type="checkbox"/> eFSAP <input type="checkbox"/> N/A
5. # of samples received:	6. Sample type received:	7. Zip code for case/patient/sample:	
8. Type of test performed:			
<input type="checkbox"/> Biochemical	<input type="checkbox"/> Immunochemistry	<input type="checkbox"/> PCR	
<input type="checkbox"/> Culture	<input type="checkbox"/> Mass Spectrometry (e.g., MALDI)	<input type="checkbox"/> Sequencing	
<input type="checkbox"/> DFA/IFA	<input type="checkbox"/> Microscopy	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> ELISA/EIA/RIA	<input type="checkbox"/> Mouse Bioassay		
9. Dispositions of select agent or toxin listed by entity (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 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, you are required under 7 CFR §331.19, 9 CFR §121.19, and 42 CFR §73.19 to complete and submit an APHIS/CDC Form 3)			
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? <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Notification: _____ <b>NOTE:</b> Please request completed and signed Part 2 from each facility that was in possession of the specimen(s).			
12. Was your entity the source of the sample(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, skip to #22 if you have any additional comments.)			
13. Is the sample provider located outside the United States? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, provide country: _____			
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:			

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**PART 2 – REPORT OF IDENTIFICATION**

**SECTION C – SAMPLE PROVIDER INFORMATION**

1. Name of individual completing Sections C and D (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 D – SPECIMEN(S) CONTAINING SELECT AGENT OR TOXIN PROVIDED TO REFERENCE LABORATORY**

1. Select Agent or Toxin Identified:		2. Date notified by reference laboratory of select agent or toxin identification reported to APHIS or CDC:		
3. # of samples shipped:	4. Sample type provided:		5. Zip code for case/patient/sample origin:	
6. Date sample(s) shipped to Reference Laboratory:		7. Name of Reference Laboratory:		
8. Disposition of any remaining select agent or toxin listed by entity: <input type="checkbox"/> Destroyed (Provide destruction method and date. Method: _____ Date: _____) <input type="checkbox"/> Retained (Provide name of Principal Investigator retaining sample. Name: _____) <input type="checkbox"/> Not applicable, the entire specimen was transferred to the Reference Laboratory.				
9. 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? <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, you are required under 7 CFR §331.19, 9 CFR §121.19, and 42 CFR §73.19 to complete and submit an APHIS/CDC Form 3)				
10. Was your entity the source of the sample(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, skip to #21 if you have any additional comments.)				
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? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>NOTE:</b> Please request completed and signed Part 2 from each facility that was in possession of the specimen(s).				
12. Is the sample provider located outside the United States? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, provide country: _____				
13. Sample Provider Entity Name:				
14. Address (NOT a post office address):		15. City:	16. State:	17. Zip Code:
18. Sample Provider Point of Contact (First, MI, Last):		19. Sample Provider E-mail Address:	20. Sample Provider Contact Number:	
21. 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).