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OMB APPROVED
0579-0189
EXP.: XX/XXXX

**UNITED STATES DEPARTMENT OF AGRICULTURE
ANIMAL AND PLANT HEALTH INSPECTION SERVICE
VETERINARY SERVICES**

**APPLICATION FOR CHRONIC WASTING DISEASE HERD
CERTIFICATION PROGRAM (CWD HCP) APPROVAL, RENEWAL, OR
REINSTATEMENT OF A STATE**

1. STATE

2. APPLICATION FOR ("X" one)

☐ APPROVED STATUS

☐ RENEWAL OF APPROVED STATUS

☐ REINSTATEMENT OF APPROVED STATUS

3. REPORTING PERIOD:

4. STATUS OF ACTION ITEMS IDENTIFIED ON THE LAST RENEWAL OR AS PART OF AN APPROVED STATE REVIEW
(Use an attachment sheet, if necessary)

5. QUALIFICATION ("X" all that apply)

A. ☐ The requirements of 9 CFR 55.23 (a) have been met. State CWD HCP regulations, program policies and standards, legal authorities, and other supporting documentation are attached. (The supporting documentation must describe which requirement(s) of 9 CFR 55.23 are being met.)

B. ☐ The CWD National Database OR an equivalent State database to maintain CWD HCP data is updated as needed and data are current, accurate and complete for the reporting period.

C. ☐ The annual Approved State CWD HCP Report has been completed and submitted to the VS Regional Office.

6. INVENTORY OF ENROLLED HERDS

A. TOTAL NO. OF ENROLLED DEER HERDS	B. TOTAL NO. OF ENROLLED ELK HERDS	C. TOTAL NO. OF DEER ENROLLED IN HCP	D. TOTAL NO. OF ELK ENROLLED IN HCP

Comments (Note any mixed herds, etc):

7. SURVEILLANCE ACTIVITIES

A. Number of animals tested through on-farm surveillance	B. Number of animals tested at slaughter	C. Number of animals tested at hunt facilities (shooter operations)

CERTIFICATION

The provisions of 9 CFR Parts 55 and 81 have been met. APHIS requests that this State be designated an Approved State CWD HCP.

8. Signature of State Official	9. Please Type or Print Name	10. Date
11. Signature of Area Veterinarian in Charge	12. Please Type or Print Name	13. Date

14. Approval by VS Region

☐ Application for Approved Status is complete and approved ☐ Renewal of Approved Status is approved ☐ Reinstatement of Approved Status is approved.

☐ Form is being returned for completion or correction

☐ Renewal or Reinstatement of Approved Status is provisionally approved contingent on the conditions listed in the attachment being met by the following date: _____

15. Signature of Regional Epidemiologist	16. Please Type or Print Name	17. Date
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18. Veterinary Services hereby declares the above State Approved for the period beginning _____ and ending _____

19. Signature of CWD Program Certifying Official	20. Please Type or Print Name	21. Date
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