

STATE	ALL INCOMPLETE RECORDS WILL BE RETURNED FOR COMPLETION					OMB Approved 0579-0101 Exp 05/2027
COOPERATIVE STATE - FEDERAL SCRAPIE CONTROL PROGRAM						A
SCRAPIE TEST RECORD						REFERRAL NO. (e.g. COBTP05012023 ¹)

COUNTY OF OWNER	FLOCK OWNER'S NAME - LAST	FIRST	MI	PREVIOUS TEST DATE	VET ACCRED. # / PERSON ID	TOTAL # OF SAMPLES
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FLOCK ID	FLOCK OWNER'S COMPLETE ADDRESS	CERTIFICATION FOR PAYMENT <input type="checkbox"/> Cooperative Agreement <input type="checkbox"/> Federal Expense <input type="checkbox"/> Owner's Expense I certify: That this test was made by me on the animals identified below on the dates as entered in appropriate spaces. That when payment is claimed at program expense in accordance with agreement number below, no payment has been or will be received from any other source.
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REASON FOR TEST	FLOCK OWNER'S TELEPHONE NUMBER	COUNTY OF FLOCK
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1 SURVEILLANCE	7 SUSPECTED	COMPLETE FLOCK TEST OF ALL ELIGIBLE ANIMALS: <input type="checkbox"/> YES <input type="checkbox"/> NO	VETERINARIAN'S SIGNATURE	TELEPHONE NO
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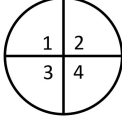
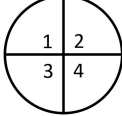
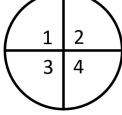
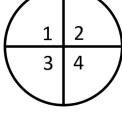
2 POSITIVE	8 EXPOSED	NO. OF ANIMALS IN FLOCK _____	VETERINARIAN'S NAME (Please print)	COLLECTION DATE
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3 SFCP	9 INFECTED OR SOURCE RSSS POS.	KIND OF FLOCK <input type="checkbox"/> SHEEP <input type="checkbox"/> MIXED <input type="checkbox"/> GOAT <input type="checkbox"/> OTHER _____	VETERINARIAN'S ADDRESS	
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4 HIGH RISK TRACE TO FLOCK	10 INFECTED OR SOURCE NOT RSSS	GENOTYPE LAB TURN AROUND TIME <input type="checkbox"/> 5 DAY TURNAROUND <input type="checkbox"/> 10 DAY TURNAROUND	FAX NO. OR E-MAIL ADDRESS	AGREEMENT NO.
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5 OWNER'S REQUEST	11 MISSING EXPOSED EWE (ME)	TEST TYPE SHEEP: <input type="checkbox"/> RECTAL BIOPSY <input type="checkbox"/> 136 CODON <input type="checkbox"/> 171 CODON GOAT: <input type="checkbox"/> RECTAL BIOPSY <input type="checkbox"/> 146 CODON <input type="checkbox"/> 222 CODON <input type="checkbox"/> OTHER _____	FLOCK STATUS <input type="checkbox"/> SFCP <input type="checkbox"/> EXPOSED <input type="checkbox"/> INFECTED <input type="checkbox"/> NONE <input type="checkbox"/> SOURCE <input type="checkbox"/> INVEST <input type="checkbox"/> OTHER _____	
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6 IMPORT/EXPORT	12 RETEST/OTHER	<input type="checkbox"/> OTHER _____			
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Specimen #	Official ID Number(s)	Other ID Numbers	Designation pos, sus, exp, me, n/a	Age	Sex (m,f,cm)	Breed (if unkn, face)	Rectal Biopsy Sample Loc (Type one #) ³
							
							
							
							

NOTE: Sample numbers on specimens must be the same as listed on this form.

¹ Referral Number Format: State abbreviation, collector's initials, collection date.
² For farms where a scrapie risk factor questionnaire was completed, check appropriate box.
³ For animals that may be sampled multiple times, e.g. ,SFCP or Exposed animals, type the quadrant number in the space next to the diagram.

DSE/VMO Name:	Remarks:
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Address:	Remarks:
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Phone Number:	DATE	OWNER'S SIGNATURE:
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Fax Number: _____

E-Mail: _____

I hereby acknowledge receiving a copy of this record which I have examined and find correct.