

**Minnesota Board of Animal Health
 Farmed Cervidae Chronic Wasting Disease
 Submission Form**

Submit Samples and this form to:
**Minnesota Veterinary Diagnostic Laboratory
 College of Veterinary Medicine
 1333 Gortner Avenue
 St. Paul, MN 55108**

Phone: 612-625-8787 Toll free: 800-605-8787
 Fax: 612-624-8707 Email: VDL@umn.edu

***This
 Space for
 Lab
 Use
 Only***

NOTE: Submitters without Sample Collector ID must submit payment with samples.
 \$39.00 for CWD testing, plus \$34.00 for whole head submission.

Submitter Information

FILL IN ALL FIELDS AND PRINT CLEARLY:

Date Submitted: _____

Premises ID:	Veterinarian Submissions <i>(veterinarian will automatically receive copy if filled out)</i>
Owner Name:	Veterinarian Name:
<u>Mailing</u> Address:	<u>Mailing</u> Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
CHECK ONE:	CHECK ONE:
<input type="checkbox"/> Mail Results (using address above)	<input type="checkbox"/> Mail Results (using address above)
<input type="checkbox"/> Fax Results – number:	<input type="checkbox"/> Fax Results – number:
<input type="checkbox"/> Email Results – address:	<input type="checkbox"/> Email Results – address:

Death Report Information (*Samples must be submitted to lab within 14 days of collection)

Name of Sample Collector:	Sample Collector ID:
Sample Collection Date:	Date of Animal Death:
<input type="checkbox"/> Slaughtered at slaughter facility Facility Name: _____ <input type="checkbox"/> Harvested on farm <input type="checkbox"/> Died on Farm	

Sample Information

ALL FIELDS REQUIRED:

CHECK ALL THAT APPLY:

Official ID (required)	Add'l Tag(s)	Species	Age	Sex	Brain Stem	Lymph Node	Whole Head	Ear Tissue and Tag
1.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Premises ID:	Owner Name:	Date:
--------------	-------------	-------

ALL FIELDS REQUIRED:

CHECK ALL THAT APPLY:

Official ID (required)	Add'l Tag(s)	Species	Age	Sex	Brain Stem	Lymph Node	Whole Head	Ear Tissue and Tag
5.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26.					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>