

**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](mailto:VDL@umn.edu)

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

***NOTE: BAH no longer pays for CWD testing. Submitter must submit payment with samples.***  
 \$43.00 for CWD IHC testing, plus \$10.00 accession fee, and an additional \$40.00 if whole head is submitted.

***Submitter Information***

***FILL IN ALL FIELDS AND PRINT CLEARLY:***

**Date Submitted:** \_\_\_\_\_

Premises ID:	<b><i>Veterinarian Submissions</i></b> <i>(veterinarian will automatically receive copy if filled out)</i>
Owner Name:	Veterinarian Name:
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
<b>RESULTS ARE AVAILABLE VIA EMAIL ONLY</b>	
Owner Email:	Veterinarian Email:

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

Name of CWD Authorized Sample Collector:	Authorized CWD Sample Collector ID:
Sample Collection Date:	Date of Animal Death:
<input type="checkbox"/> Moved live to slaughter facility for harvest <input type="checkbox"/> Harvested on farm Slaughter Facility Name: _____ <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:
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**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"/>