



**REPORTING THE IDENTIFICATION OF A SELECT AGENT  
OR TOXIN: PROFICIENCY TESTING REPORT  
(APHIS/CDC FORM 4B)**

FORM APPROVED  
OMB NO. 0920-0576  
EXP DATE 2/28/2027

**INSTRUCTIONS**

Detailed instructions are available at <http://www.selectagents.gov/form4.html>. Answer all items completely and type or print in ink. This report must be signed and submitted to either APHIS or CDC:

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 Regulatory Science and Compliance  
1600 Clifton Road NE, Mailstop H21-4,  
Atlanta, GA 30329  
FAX: (404) 471-8469  
E-mail: [CDCForm4@cdc.gov](mailto:CDCForm4@cdc.gov)

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

SECTION A – INFORMATION FOR LABORATORY THAT RECEIVED PROFICIENCY TESTING SAMPLE(S)					
1. Name of individual completing the form: First: _____ MI: _____ Last: _____		2. E-mail address: _____		3. Telephone #: _____	
4. <input type="checkbox"/> Registered Entity <input type="checkbox"/> Clinical or Diagnostic Laboratory [non-registered entity (NRE)]		5. Entity name: _____			
6. Responsible Official or Laboratory Supervisor name: First: _____ MI: _____ Last: _____		7. Address (NOT a post office address): _____			
8. Telephone #: _____	9. E-mail address: _____	10. City: _____	11. State: _____	12. Zip Code: _____	
13. Sponsor/entity that you received select agent or toxin from:  Entity name: _____ Entity address: _____ Telephone #: _____ E-mail: _____					
SECTION B – SELECT AGENTS AND TOXINS IDENTIFIED FROM PROFICIENCY TESTING					
1. Select Agent or Toxin Identified		2. Date obtained from sponsor		3. Date identified	
4. Dispositions of select agents or toxins (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. Must be on-site. Method: _____ Date: _____) <input type="checkbox"/> Retained (Provide name of person retaining sample. Name: _____)					
5. 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)					

I hereby certify that the information contained on 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)