



**INCIDENT NOTIFICATION AND REPORTING  
APHIS/CDC FORM 3  
(THEFT/LOSS/RELEASE)**

FORM APPROVED OMB  
NO.0579-0213 OMB NO.  
0920-0576 EXP DATE  
10/31/2020

**INSTRUCTIONS**

Answer all items completely and type or print in ink. Detailed instructions are available at <http://www.selectagents.gov/form3.html>. This report must be signed and submitted to either APHIS or CDC:

Animal and Plant Health Inspection Service  
Agriculture Select Agent Services  
4700 River Road Unit 2, Mailstop 22, Cubicle 1A07  
Riverdale, MD 20737  
FAX: (301) 734-3652  
Email: [AgSAS@aphis.usda.gov](mailto:AgSAS@aphis.usda.gov)

Centers for Disease Control and Prevention  
Division of Select Agents and Toxins  
1600 Clifton Road NE, Mailstop A-46  
Atlanta, GA 30329  
FAX: (404) 471-8375  
Email: [form3@cdc.gov](mailto:form3@cdc.gov)

Accession Number:

(For Program Use ONLY)

**Submit completed form only once by either email, fax, or mail**

**SECTION A – ENTITY INFORMATION**

1. Name of Entity:		2. Entity Registration/ NRE Number (if applicable):		
3. Physical Address (NOT a post office box):		4. City:	5. State:	6. Zip Code:
7. Name of Responsible Official or Laboratory Supervisor:		8. Name of Principal Investigator:		
9. Telephone Number:	10. Fax Number:	11. Email address:		

**SECTION B – INCIDENT INFORMATION**

1. Date and Time of Incident:	2. Date of Immediate Notification:	3. Type of Immediate Notification : <input type="checkbox"/> Email <input type="checkbox"/> Fax <input type="checkbox"/> Telephone	4. Location of Incident (bldg., room, equipment, etc.):
5. Name of Select Agent or Toxin:		6. Strain designation of Select Agent or Toxin:	7. Quantity (Unit (vial, plates, etc.))

8. Type of Incident:  <input type="checkbox"/> Theft (After completing Section B. Go to Section C) <sup>♦</sup>  <input type="checkbox"/> Loss (After completing Section B. Go to Section D) <sup>♦</sup>  <input type="checkbox"/> Release/ Potential Exposure (After completing Section B. Go to Section E) <sup>♦</sup>  Note: Please complete Appendix A, event timeline, to provide details on the theft/loss/release incident.	9. Severity of the incident:  <input type="checkbox"/> None <input type="checkbox"/> Negligible <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	10. What Biosafety Level did the incident occur?  <input type="checkbox"/> BSL2 <input type="checkbox"/> ABSL2 <input type="checkbox"/> BSL3 <input type="checkbox"/> ABSL3 <input type="checkbox"/> BSL4 <input type="checkbox"/> ABSL4 <input type="checkbox"/> ACL 2 <input type="checkbox"/> BSL3 Ag <input type="checkbox"/> ACL 3 <input type="checkbox"/> NIHBL2 <input type="checkbox"/> ACL 4 <input type="checkbox"/> NIHBL3 <input type="checkbox"/> NIHBL2N <input type="checkbox"/> NIHBL4 <input type="checkbox"/> NIHBL3N <input type="checkbox"/> NIHBL4N <input type="checkbox"/> NIHBL2-LS <input type="checkbox"/> NIHBL4-LS <input type="checkbox"/> NIHBL3-LS <input type="checkbox"/> PPQ Agent
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<p>11. Is this incident associated with an APHIS/CDC Form 2 (Transfer):</p> <p><input type="checkbox"/> Yes (Fill out Appendix B, if incident occurred during transfer.)</p> <p><input type="checkbox"/> No</p> <p>APHIS/CDC Form 2 transfer #: _____</p>		<p>12. Is this incident associated with an APHIS/CDC Form 4 (Identification):</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>APHIS/CDC Form 4 clinical ID#: _____</p>	
<b>SECTION C – REPORT OF THEFT</b>			
<p>1. Type of Theft:</p> <p><input type="checkbox"/> Forced Entry</p> <p><input type="checkbox"/> Insider/Insider-assisted access</p> <p><input type="checkbox"/> Unauthorized access</p>	<p>2. Has Local Law Enforcement been Notified:</p> <p>(If yes, complete sections C3-C5)</p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>	<p>3. Local Law Enforcement Agency:</p> <p>_____</p>	
<p>4. Local Law Enforcement Agent Name:</p> <p>First: _____ MI: _____ Last: _____</p>		<p>5. Local Law Enforcement Contact Information (phone/email):</p> <p>_____</p>	
<p>6. Has the FBI been Notified:</p> <p>(If yes, fill out #s C7-8):</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>7. FBI Agent Name: (First M. Last)</p> <p>_____</p>	<p>8. FBI Agent Contact Information (phone/email):</p> <p>_____</p>	
<p>9. Was the stolen BSAT material recovered:</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>10. Was there a potential exposure: (If yes, go to section E- Q: 5-11)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unsure</p>		

Certification: 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 the select agent regulations may result in civil or criminal penalties, including imprisonment. 7 CFR 331, 9 CFR 121, 42 CFR 73.

Signature of Respondent: \_\_\_\_\_

Title: \_\_\_\_\_

Typed or printed name of Respondent: \_\_\_\_\_

Date: \_\_\_\_\_

## SECTION D- REPORT OF LOSS

1. Type of Loss: <input type="checkbox"/> Inventory/Recordkeeping error <input type="checkbox"/> Sample lost/discard at entity <input type="checkbox"/> Sample lost in transit (Go to Appendix B to enter add'l info) <input type="checkbox"/> Other: _____	2. Has Local Law Enforcement been Notified: (If yes, fill out #s D3-D5) <input type="checkbox"/> Yes <input type="checkbox"/> No	3. Local Law Enforcement Agency: _____	
4. Local Law Enforcement Agent Name:  First: M: Last: _____	5. Local Law Enforcement Contact Information (phone/email): _____		
6. Was the FBI Notified: (If yes, fill out #s D7-D8) <input type="checkbox"/> Yes <input type="checkbox"/> No	7. FBI Agent Name:  First: M: Last: _____	8. FBI Agent Contact Information (phone/email): _____	
9. Was the lost BSAT material found? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. How long was the BSAT material missing?  Date recovered: _____ Duration of loss (hrs/days): _____	11. Give the date of the last inventory/audit performed, which meets the FSAP regulatory requirement: _____	12. Was there a potential exposure: (If yes, complete Section E- Q: 5-11) <input type="checkbox"/> Yes <input type="checkbox"/> No

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Signature of Respondent: \_\_\_\_\_ Title: \_\_\_\_\_

Typed or printed name of Respondent: \_\_\_\_\_ Date: \_\_\_\_\_

## SECTION E- REPORT OF RELEASE

<p>1. Type of Potential Exposure/Release (choose all that apply):</p> <p><input type="checkbox"/> Animal bite/scratch      <input type="checkbox"/> Equipment/mechanical failure</p> <p><input type="checkbox"/> PPE failure      <input type="checkbox"/> Package damaged in transit (fill out Appendix B)</p> <p><input type="checkbox"/> Spill      <input type="checkbox"/> Unintended Animal Infection</p> <p><input type="checkbox"/> Needle stick/Sharps      <input type="checkbox"/> Unintended Plant Pathogen Release</p> <p><input type="checkbox"/> Decontamination failure      <input type="checkbox"/> Work performed on an open bench</p> <p><input type="checkbox"/> Inactivation failure      <input type="checkbox"/> Other _____</p>	<p>2. Was there a release outside containment barriers? (choose all that apply)</p> <p><input type="checkbox"/> Release outside primary containment (e.g., biosafety cabinet, leaking storage vial within storage unit)</p> <p><input type="checkbox"/> Release beyond secondary containment (e.g., laboratory)</p> <p><input type="checkbox"/> Release outside all containment barriers of the facility (e.g., resulting in possible agricultural/environmental/public health threat)</p>	
<p>3. What PPE was worn at the time of the incident (choose all that apply)?</p> <p><input type="checkbox"/> Hand Protection (gloves)      <input type="checkbox"/> Foot Protection (e.g., booties, shoe covers)</p> <p><input type="checkbox"/> Head Protectors/Covers      <input type="checkbox"/> Eye/Face Protection (e.g., goggles, face shield)</p> <p><input type="checkbox"/> Body Protection      <input type="checkbox"/> Respiratory Protection: Type _____</p> <p><input type="checkbox"/> Other: _____</p>	<p>4. Did the release result in potential exposure(s)?</p> <p><input type="checkbox"/> Yes</p> <p>If yes, how many individuals/animals/plants were exposed? _____</p> <p><input type="checkbox"/> No</p>	
<p>5. Did the release result in a laboratory acquired infection or an infection/outbreak in agriculture or in the environment?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not currently known</p>	<p>6. Has medical surveillance been initiated?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>7. Has prophylaxis or treatment been provided?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
<p>8. Has an internal investigation been initiated to lessen the likelihood of recurrences of incident involving the select agents and toxins at this entity?</p> <p><input type="checkbox"/> Yes (If yes, please provide additional details.)      <input type="checkbox"/> No</p>		
<p>9. Other than a potential for occupational illness, what other hazards have been identified as a result of this incident?</p>		
<p>10. Provide a brief summary of how the laboratory and work surfaces were decontaminated after the incident.</p>		
<p>11. Provide a brief summary of the medical surveillance conducted (do not provide names or confidential information).</p>		

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Signature of Respondent: \_\_\_\_\_

Title: \_\_\_\_\_

Typed or printed name of Respondent: \_\_\_\_\_

Date: \_\_\_\_\_

**APPENDIX A**  
**EVENTS TIMELINE**

Provide a detailed summary of events, including a timeline of what occurred.

Save and continue on next page

## **APPENDIX B**

**IF THE INCIDENT OCCURRED DURING TRANSFER, COMPLETE SECTIONS A AND B OF FORM 3 AND PROVIDE THE FOLLOWING INFORMATION (INCLUDE A COPY OF THE RELEVANT APHIS/CDC FORM 2)**

1. Transfer authorization number from APHIS/CDC Form 2:		2. Date Shipped:
3. Name of Carrier:	4. Airway bill number, bill of lading number, tracking number:	
5. Package Description (size, shape, description of packaging including number and type of inner packages; attach additional sheets as necessary):		
<p>6. Package with select agents and toxins received by requestor:</p> <p><input type="checkbox"/> No   <input type="checkbox"/> Yes   If yes, date of receipt: _____</p> <p>7. Package with select agents and toxins appears to have been opened or damaged during shipment:</p> <p><input type="checkbox"/> No   <input type="checkbox"/> Yes   If yes, include explanation in box 5 above.</p>		
8. Sender was contacted regarding incident:		9. Carrier/courier was contacted regarding incident:
<p><input type="checkbox"/> No   <input type="checkbox"/> Yes</p>		<p><input type="checkbox"/> No   <input type="checkbox"/> Yes</p>

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Signature of Respondent: \_\_\_\_\_

Title: \_\_\_\_\_

Typed or printed name of Respondent:

Date:

**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).