CWD Certified Collector Receipt

CWD Certified Collector: _____* Keep a copy for your records*

Cervid Owner Information

Name: _____ Phone Number: (____)_____

Address: _____

Premise ID: ____ ____ ____ ____ ____ ____ ____

I, the undersigned, do hereby certify that I am the owner listed above, and I authorize sampling and submission for chronic wasting disease (CWD) by the above certified collector.

Owner's Signature: _____ Date: ____/____/____

Sample Collection

Date cervid head was received: _____/_____/_____

Date cervid died: _____/_____/_____

Condition of head *(check all that apply)*:

☐ Frozen ☐ Good ☐ Decomposed

☐ Maggots ☐ Other: _____

Date of CWD sample collection: _____/_____/_____

Date CWD sample shipped to ADDL: _____/_____/_____

Method Shipped/Tracking Number: _____

Cervid Official ID: _____

Cervid Secondary ID: _____

Remarks: _____

_____