

**CWD PROGRAM SPECIES ANNUAL INVENTORY**

(COMPLETE BOTH SIDES OF THIS FORM)

**ATTACH COPIES OF ALL CWD LAB TEST RESULTS**

**OFFICIAL ID IS REQUIRED FOR ALL DEATHS 12 MONTHS OF AGE OR OLDER**

**ALL DEATHS IN THE HERD**

(DEATHS LESS THAN 12 MOS OLD DO NOT REQUIRE TESTING)

PA PREMISES ID:

**PA**

DATE INVENTORY COMPLETED:

PROGRAM STATUS: (CHECK BOX)

- FULLY CERTIFIED     3<sup>RD</sup> YEAR HCP
- 5<sup>TH</sup> YEAR HCP     2<sup>ND</sup> YEAR HCP
- 4<sup>TH</sup> YEAR HCP     1<sup>ST</sup> YEAR HCP
- HERD MONITORED – 50% TESTING

OWNER NAME:			BUSINESS NAME:		
MAILING ADDRESS:			PHYSICAL LOCATION (911 ADDRESS AND/OR DESCRIPTION):		
CITY	STATE	ZIP	AGENT PREPARING INVENTORY:		
AGENT PHONE:		AGENT CELL PHONE:		EMAIL ADDRESS:	

#	OFFICIAL ID – USE FULL ID <small>(REQUIRED FOR ALL DEATHS 12 MONTHS OR OLDER)</small>	DATE OF BIRTH	SEX M/F	SAMPLE SENT TO: (LIST LAB)		DATE OF DEATH (MM/DD/YEAR)	CAUSE OF DEATH
	UNOFFICIAL AND/OR SECONDARY ID			ACCESSION NUMBER	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER <small>(CHECK APPROPRIATE BOX)</small>		
1				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
2				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
3				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
4				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
5				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
6				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
7				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		

CWD PROGRAM SPECIES ANNUAL INVENTORY  
PLEASE PRINT CLEARLY

**ALL DEATHS IN THE HERD**

(DEATHS LESS THAN 12 MOS OLD DO NOT REQUIRE TESTING)

PA PREMISES ID:  
**PA**

OWNER LAST NAME:

INVENTORY DATE:

#	OFFICIAL ID – USE FULL ID <small>(REQUIRED FOR ALL DEATHS 12 MONTHS OR OLDER)</small>	DATE OF BIRTH	SEX M/F	SAMPLE SENT TO: (LIST LAB)		DATE OF DEATH (MM/DD/YEAR)	CAUSE OF DEATH
	UNOFFICIAL AND/OR SECONDARY ID			ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER <small>(CHECK APPROPRIATE BOX)</small>		
				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
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				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		
				LAB NAME:			
				ACCESSION NO:	RESULTS: <input type="checkbox"/> ND <input type="checkbox"/> OTHER		

I hereby affirm and verify the foregoing information to be a true and correct record of all CWD Program Species that have died on my premises since my last annual inventory as of this day and make such statements subject to the penalties established at 18 Pa.C.S.A. §§ 4903- 4904, related to false swearing and unsworn falsification to authorities.

\_\_\_\_\_  
PRINT NAME (AGENT PREPARING INVENTORY)

\_\_\_\_\_  
SIGNATURE (AGENT PREPARING INVENTORY)

\_\_\_\_\_  
DATE