I. STATE/LOCAL USE ONLY

Patient's Name: _____ (Last, First, M.I.) Phone No.: ( ) _____

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT — *– Patient identifier information is not transmitted to CDC! –*

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): 1 HIV infection (not AIDS); 2 AIDS

AGE AT DIAGNOSIS: Years / Years

DATE OF BIRTH: Mo. Day Yr.

CURRENT STATUS: Alive 1, Dead 2, Unk. 9

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

SEX: 1 Male; 2 Female

ETHNICITY: (select one) 1 Hispanic; 9 Unk; 2 Not Hispanic or Latino

RACE: (select one or more) American Indian/Alaska Native; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; White; Unk

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____ 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code:

IV. FACILITY OF DIAGNOSIS

Facility Name

City

State/Country

FACILITY SETTING (check one): 1 Public; 2 Private; 3 Federal; 9 Unk.

FACILITY TYPE (check one): 01 Physician, HMO; 31 Hospital, Inpatient; 88 Other (specify): _____

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify disorder: 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____			
• *HETEROSEXUAL* relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. Yr. Last Mo. Yr.			
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo.	Yr.
• HIV-1 EIA	1	0	–	9		
• HIV-1/HIV-2 combination EIA	1	0	–	9		
• HIV-1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. POSITIVE HIV DETECTION TEST: (Record earliest test) Mo. Yr.

culture; antigen; PCR, DNA or RNA probe

• Other (specify): _____

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* COPIES/ML Mo. Yr.

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

• Date of last documented negative HIV test (specify type): _____ Mo. Yr.

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1, No 0, Unk. 9

If yes, provide date of documentation by physician Mo. Yr.

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

• CD4 Count ___,___ cells/µL Mo. Yr.

• CD4 Percent ___ % Mo. Yr.

First <200 µL or <14%

• CD4 Count ___,___ cells/µL Mo. Yr.

• CD4 Percent ___ % Mo. Yr.

VII. STATE/LOCAL USE ONLY

Physician's Name: (Last, First, M.I.) _____ Phone No.: ( ) _____ Medical Record No. _____

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. Symptomatic (not AIDS): Mo. Yr.

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Candidiasis, bronchi, trachea, or lungs	1	NA			Lymphoma, Burkitt's (or equivalent term)	1	NA		
Candidiasis, esophageal	1	2			Lymphoma, immunoblastic (or equivalent term)	1	NA		
Carcinoma, invasive cervical	1	NA			Lymphoma, primary in brain	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA			*Mycobacterium avium* complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
Cryptococcosis, extrapulmonary	1	NA			*M. tuberculosis*, pulmonary*	1	2		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA			*M. tuberculosis*, disseminated or extrapulmonary*	1	2		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			*Mycobacterium*, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Cytomegalovirus retinitis (with loss of vision)	1	2			*Pneumocystis carinii* pneumonia	1	2		
HIV encephalopathy	1	NA			Pneumonia, recurrent, in 12 mo. period	1	2		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			Progressive multifocal leukoencephalopathy	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA			Salmonella septicemia, recurrent	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			Toxoplasmosis of brain	1	2		
Kaposi's sarcoma	1	2			Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.: _____

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

-- OPTIONAL --

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by: [1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

	Yes	No	NA	Unk.
• HIV related medical services	1	0	–	9
• Substance abuse treatment services	1	0	8	9

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	1	0	9
• PCP prophylaxis	1	0	9

This patient has been enrolled at:

Clinical Trial	Clinic
1 NIH-sponsored	1 HRSA-sponsored
2 Other	2 Other
3 None	3 None
9 Unknown	9 Unknown

This patient's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

FOR WOMEN:
- This patient is receiving or has been referred for gynecological or obstetrical services: [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

CHILD'S DATE OF BIRTH: Mo Day Yr.

Hospital of Birth: _____

City: _____ State: _____

Child's Soundex: _____

Child's State Patient No. _____

X. COMMENTS: _____

Public reporting burden of this collection of information is estimated to average 10 minutes 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, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). Do not send the completed form to this address.

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT — *– Patient identifier information is not transmitted to CDC! –*

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients <13 years of age at time of diagnosis)

CDC — CENTERS FOR DISEASE CONTROL AND PREVENTION

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

SOUNDEX CODE:	REPORT STATUS:	REPORTING HEALTH DEPARTMENT:	
	1 New Report 2 Update	State: _____ City/County: _____	State Patient No.: City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) 3 Perinatally HIV Exposed; 4 Confirmed HIV Infection (not AIDS); 5 AIDS; 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months — HIV Infection (not AIDS) ... ; AIDS .....

CURRENT STATUS: 1 Alive; 2 Dead; 9 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes 1 No 0 Unk. 9

SEX: 1 Male; 2 Female

ETHNICITY: (select one) 1 Hispanic; 2 Not Hispanic or Latino; 9 Unk.

RACE: (select one or more) American Indian/ Alaska Native; Asian; Black or African American; Native Hawaiian or Other Pacific Islander; White; Unk

COUNTRY OF BIRTH: 1 U.S.; 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____; 8 Other (specify): _____; 9 Unk.

RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/ Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/ Country: _____

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 88 Other (specify): _____

V. PATIENT/MATERNAL HISTORY *(Respond to ALL categories)*

• **Child's biologic mother's HIV Infection Status:** (check one)

1 Refused HIV testing; 2 Known to be uninfected after this child's birth; 9 HIV status unknown

Diagnosed with HIV Infection/AIDS:

3 Before this child's pregnancy; 4 During this child's pregnancy; 5 At time of delivery; 6 Before child's birth, exact period unknown; 7 After the child's birth; 8 HIV-infected, unknown when diagnosed

• Date of mother's first positive HIV confirmatory test: ..... Mo. Yr.

• Mother was counseled about HIV testing during this pregnancy, labor or delivery? ..... Yes 1 No 0 Unk. 9

After 1977, this child's biologic mother had:

	Yes	No	Unk.
• Injected nonprescription drugs	1	0	9
• *HETEROSEXUAL* relations with:			
- Intravenous/injection drug user	1	0	9
- Bisexual male	1	0	9
- Male with hemophilia/coagulation disorder	1	0	9
- Transfusion recipient with documented HIV infection	1	0	9
- Transplant recipient with documented HIV infection	1	0	9
- Male with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9

Before the diagnosis of HIV Infection/AIDS, this child had:

	Yes	No	Unk.
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
(specify disorder): 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____			
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First: Mo. Yr. Last: Mo. Yr.			
• Received transplant of tissue/organs	1	0	9
• Sexual contact with a male	1	0	9
• Sexual contact with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• Other (Alert State/City NIR Coordinator)	1	0	9

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. HIV DETECTION TESTS:
(Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify _____	1	0	9		

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

			Mo.	Yr.
• CD4 Count	,	cells/µL		
• CD4 Count	,	cells/µL		
• CD4 Percent		%		
• CD4 Percent		%		

5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? ..... Yes 1 No 0 Unk. 9

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 8 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. _____ Yr. _____ *PYOT CASE NO. _____

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] Unk. *If No or Unknown, proceed to Section X.*

HOSPITAL AT BIRTH:

Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:

City: _____ County: _____ State/Country: _____ Zip Code: _____

BIRTHWEIGHT: (enter lbs/oz OR grams)

____ lbs. ____ oz

____ grams

BIRTH: Type: .... [1] Single [2] Twin [3] >2 [9] Unk.

Delivery: ..... [1] Vaginal [2] Elective Caesarean [3] Non-elective Caesarean [4] Caesarean, unk. type [9] Unk.

Birth Defects: .... [1] Yes [0] No [9] Unk.

Specify type(s): _____ Code: _____

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks ____ 99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: ____ mos. (99 = Unk. 00 = None)

Total number of prenatal care visits: ____ (99 = Unk. 00 = None)

- Did mother receive zidovudine (ZDV, AZT) during pregnancy? Refused [8] Yes [1] No [0] Unk. [9]
- If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: ____ 99 = Unk.
- Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Refused [8] Yes [1] No [0] Unk. [9]
- Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes [1] No [0] Unk. [9]
- Did mother receive any other Anti-retroviral medication during pregnancy? Yes [1] No [0] Unk. [9] If yes, specify: _____
- Did mother receive any other Anti-retroviral medication during labor/delivery? Yes [1] No [0] Unk. [9] If yes, specify: _____

Maternal Date of Birth: Mo. ____ Day ____ Yr. ____

Maternal Soundex: _____

Maternal State Patient No. _____

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____

[8] Other (specify): _____ [9] Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo.	Day	Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	1	0	9			
• Other neonatal anti-retroviral medication for HIV *prevention*	1	0	9			
• Anti-retroviral therapy for HIV *treatment*	1	0	9			
• PCP prophylaxis	1	0	9			

If yes, specify: _____

Was child breastfed? Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial: [1] NIH-sponsored [2] Other [3] None [9] Unk.

Clinic: [1] HRSA-sponsored [2] Other [3] None [9] Unk.

This child's medical treatment is primarily reimbursed by:

[1] Medicaid [4] Other Public Funding

[2] Private insurance/HMO [7] Clinical trial/government program

[3] No coverage [9] Unk.

This child's primary caretaker is:

[1] Biologic parent(s) [2] Other relative [3] Foster/Adoptive parent, relative [4] Foster/Adoptive parent, unrelated [7] Social service agency [8] Other (specify in Section XI.) [9] Unk.

XI. COMMENTS:

_____

_____

_____

_____

_____

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes 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, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0008). Do not send the completed form to this address.