CAES
The Connecticut Agricultural Experiment Station
Putting Science to Work for Society since 1875

Tick Submission Form

Date: ____________________

Instructions: Complete this form and include it with your tick specimen. (It is important to print information legibly).

Information on person/health department submitting tick (to whom report will be sent):

Name: South Central Health District	

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Address: 196 North Main Street

City: Southington State: CT Zip Code: 06489

E-mail address: ______________________ Telephone number: ____________

Filled out by Resident

Please note that the Tick Testing Program is intended for the identification and/or testing of ticks which have fed on humans. Ticks removed from pets will be identified, but not tested.

Was this tick removed from a pet? Y____N____

Pet species/name/age: ______________________

Information on person bitten by tick:

Name: ______________________

Address: ______________________

Telephone number: ______________________

Email: ______________________

Age: __________ Gender: M_____F_____ Guardian name: ______________________

Date tick was removed: __________ Part of body where tick was found: ______________________

Town in which tick was acquired: ______________________

Please bring samples to:

South Central Health District
196 North Main Street
Southington CT 06489