According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0579-0182. The time required to complete this information collection is estimated to average .5 hours per response, including the time for reviewing instructions, search existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

FORM APPROVED -OMB NO. 0579-0182

U.S. DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service Plant Protection and Quarantine

KARNAL BUNT COMPENSATION CLAIM FORM

(No compensation can be made without completion of this form)

1. APPLICANT'S NAME, ID NUMBER, AND ADDRESS (INCLUDE STREET, CITY, STATE AND ZIP CODE)	2. CROP YEAR 3. WHEAT CLASS				
	4. APPLICANT'S REQUEST (Check the appropriate request)				
	Producer				
	National Karnal Bunt Survey Participant				
	Handler Other (Please specify)				
5. TYPE OF COMPENSATION (Check the applicable type)					
Wheat Grain Wheat Seed Other (Please Specify)					
PART A - APPLICANT'S REPORT OF DATA					
6. DOCUMENTATION (Attach applicable documents) (Check all that apply)	7. KARNAL BUNT CERTIFICATE AVAILABLE				
Contract (If checked, date of contract)	YES NO				
Final Sales Receipt	Date of certificate(s)(Positive)				
Emergency Action Notification	(Negative)				
Weight Verification	8. TO WHOM SOLD				
Certified Seed Documentation					
Other (Please Specify)	Contract Price:				
	Price Received:				
9. QUANTITY REQUESTED FOR COMPENSATION					
Bushels Other(Please Specify)					
10. REGULATED CROP SEASON					
First Regulated Crop Season (FSA must complete PPQ FORM 927) Second Regulated Crop Season N/A					
PART B - APPLICANT'S CERTIFICATION I certify that the above statements are true and correct to the best of my knowledge and belief. I request all amounts due me in accordance with all applicable laws and					
regulations governing the payment of such compensation. I further agree to accept the compensation payment for said losses incurred.					
11. APPLICANT'S SIGNATURE	12. DATE				
PART C - COMPENSATION PAYMENT CALCULATION OR SEE WORKSHEET (PPQ FORM 927 or PPQ FORM 928 completed by FSA) 13. COMPENSATION RATE					
Producer/Handler:	Other (Please Specify)				
14. COMPENSATION CALCULATION		15. CHECK NUM	MBER	16. DATE	
X = \$ Quantity Compensation Rate Compensation Payn					
PART D - COUNTY FSA COMMITTEE (COC) DETERMINATION					
17. REMARKS					
T. REMARKO					
18. COC or REPRESENTATIVE ACTION					
APPROVED	DISAPPROVED				
19. COC or REPRESENTATIVE SIGNATURE		20. DAT	E		
		1			