

**From:** [brcadmin](#)  
**To:** [APHIS-AnimalCare](#)  
**Subject:** Signed Application for Registration  
**Date:** Wednesday, December 16, 2020 2:17:49 PM  
**Attachments:** [USDA Registration Packet\\_Signed 20201216.pdf](#)

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Hello,

Attached, please find the signed and completed Application for Registration for the Biomedical Resource Center at the Medical College of Wisconsin.

Thank you,

(b) (6), (b) (7)(C)

Research Resource Coordinator

**Biomedical Resource Center** | Medical College of Wisconsin

8701 W. Watertown Plank Road | Milwaukee, WI 53226

P: (b) (6), (b) (7)(C) | F: (414) 955-6508 | E: (b) (6), (b) (7)(C)@mcw.edu

Every research facility, exhibitor, carrier, and intermediate handler not required to be licensed under Section 3 of the Animal Welfare Act, shall register with the USDA (7 USC 2136). This application provides information for such registration.		OMB No. 0579-0036 FORM APPROVED	
<b>U.S. DEPARTMENT OF AGRICULTURE</b> <b>ANIMAL AND PLANT HEALTH INSPECTION SERVICE</b> <b>APPLICATION FOR REGISTRATION</b> (TYPE OR PRINT)  <b>REGISTRATION UPDATE</b>		<b>USDA USE ONLY</b>  Applicant should send completed form to this address. <b>USDA APHIS ANIMAL CARE</b> <b>EASTERN</b> <b>2150 Centre Ave.</b> <b>Building B, Mailstop #3W11</b> <b>Fort Collins, CO 80526-8117</b> <b>(970) 494-7478</b>	
		<b>CERTIFICATE NO./CUST NO:</b> 35-R-0029 634	<b>RENEWAL DATE</b> 23-Jul-2020
<b>1. REGISTRANT (Name and permanent mailing address, including Zip Code)</b> Medical College of Wisconsin 8701 Watertown Plank Road Milwaukee, WI 53226  Milwaukee <b>COUNTY:</b> <b>TELEPHONE</b> 414-955-4209		<b>2. LOCATION (S) OF BUSINESS, EXHIBITION SITE(S), OR RESEARCH FACILITIES</b> <i>(Use additional sheets if necessary)</i> Medical College of Wisconsin 8701 Watertown Plank Road Milwaukee, WI 53226	
<b>3. (A) PREVIOUS USDA REGISTRATION NUMBER (IF ANY)</b>		<b>4. (B) ACTIVE USDA CERTIFICATE NUMBER(S) IN WHICH YOU HAVE AN INTEREST:</b>	
<b>5. ARE YOU USING FEDERAL FUNDS TO CARRY OUT RESEARCH, TESTS, OR EXPERIMENTS</b>  <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<b>6. TYPE OF REGISTRATION:</b> <input type="checkbox"/> Class E – Exhibitor <input type="checkbox"/> Class H – Intermediate Handler <input checked="" type="checkbox"/> Class R – Research Facility <input type="checkbox"/> Class T – Carrier	
<b>7. FEDERAL FUND TYPES:</b> <input checked="" type="checkbox"/> Award <input checked="" type="checkbox"/> Contract <input checked="" type="checkbox"/> Grant <input checked="" type="checkbox"/> Loan		<b>8. TYPE OF ORGANIZATION:</b> <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Other (Specify) _____	
<b>9. IF INDIVIDUAL IDENTIFY EACH OWNER, IF PARTNERSHIP IDENTIFY EACH PARTNER OR OFFICER, IF CORPORATION, IDENTIFY PRINCIPAL OFFICERS FOR RESEARCH FACILITIES INCLUDE THE INSTITUTIONAL OFFICIAL (Use separate sheet if needed)</b>			
<b>A. NAME</b>	<b>B. TITLE</b>	<b>C. ADDRESS (full address, including ZIP Code)</b>	
John R. Raymond, Sr., MD	President & CEO	8701 Watertown Plank Road, Milwaukee, WI 53226	
(b) (6), (b) (7)(C)		8701 Watertown Plank Road, Milwaukee, WI 53226	
		8701 Watertown Plank Road, Milwaukee, WI 53226	
		8701 Watertown Plank Road, Milwaukee, WI 53226	
<b>CERTIFICATION</b>			
I hereby register as a Research Facility, Exhibitor, Carrier, or Intermediate Handler under the Animal Welfare Act, 7 U.S.C. 2131 et seq, and I certify that the information provided herein is true and correct to the best of my knowledge. I hereby acknowledge receipt of and agree to comply with all the regulations and standards contained in 9 CFR, Subpart A, parts 1, 2 and 3. I certify that all listed persons are 18 years of age or older.			
<b>10. SIGNATURE</b> (b) (6), (b) (7)(C)		<b>12. DATE SIGNED</b> 12/16/2020	

APHIS FORM 7011  
(FEB 2009)

STATE:

CUSTOMER #:

# IMPORTANT

THE FEDERAL DEBT COLLECTION ACT of 1996 requires us to obtain your Federal Taxpayer Identification Number (FTIN). This would be either your Federal Employer Identification Number (EIN) or your Social Security Number(s) (SSN's).

This number is for the purpose of collecting and reporting any delinquent amounts arising out of a relationship with the federal government.

Our computer system will not allow processing of your application or renewal without this number.

You must submit your SSN or EIN number in the appropriate space below. If the number submitted does not match your previously submitted number, you will be contacted for clarification.

If you change the SSN, Tax Id Number, and /or Type of Organization we have on file, you may have to apply for a new License/Registration.

Thank you for your cooperation.

If Type of Organization is Corporation, Partnership (with an EIN), or Other, please fill out A or B

A. Corporation Name: Medical College of Wisconsin

EIN: 39-0806261

B. Partnership Legal Name: \_\_\_\_\_

EIN: \_\_\_\_\_

If Type of Organization is Individual or Partnership (with SSNs), please fill out either C or D

C. Individual: Name: \_\_\_\_\_ SSN: \_\_\_\_\_

D. Partnership:

Partner Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Partner Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Partner Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Partner Name: \_\_\_\_\_ SSN: \_\_\_\_\_

August 25, 2014

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