Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Alias, Married)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( )	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type Social Security	*Number		

U.S. Department of Health and Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 years of age at time of diagnosis) *Information NOT transmitted to CDC

Centers for Disease Control and Prevention (CDC)

Report Status: New Update

Health Department Use Only (record all dates as mm/dd/yyyy)

Form approved OMB no. 0920-0573 Exp. 11/30/2022

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID	State Number
Reporting Health Dept—City/County	City/County Number	
Document Source	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic transfer ☐ 6-CD/disk	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( )
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	*Inpatient*: ☐ Hospital ☐ Other, specify _____	*Outpatient*: ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency*: ☐ CTS ☐ STD clinic ☐ Other, specify _____	*Other Facility*: ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form		*Phone ( )	

Patient Demographics (record all dates as mm/dd/yyyy)

Sex Assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US dependency (please specify) _____
Date of Birth __ __/__ __/__ __ __ __	Alias Date of Birth __ __/__ __/__ __ __ __
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __/__ __/__ __ __ __	State of Death
Current Gender Identity ☐ Male ☐ Female ☐ Transgender male-to-female (MTF) ☐ Transgender female-to-male (FTM) ☐ Unknown ☐ Additional gender identity (specify) _____		
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		Expanded Ethnicity
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown		Expanded Race

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address			
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary			
*Street Address			
City	County	State/Country	*ZIP Code

STATE/LOCAL USE ONLY	
*Provider Name (Last, First, M.I.)	*Phone ( )
Hospital/Facility	

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (check all that apply to facility below) ☐ HIV ☐ Stage 3 (AIDS) ☐ Check if SAME as facility providing information			
Facility Name			***Phone ( )**
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**
Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Private physician's office ☐ Adult HIV clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency:* ☐ CTS ☐ STD clinic ☐ Other, specify _____	*Other Facility:* ☐ Emergency room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
***Provider Name**	***Provider Phone ( )**		**Specialty**

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ **Pediatric Risk (please enter in Comments)**

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments)	☐ Yes ☐ No ☐ Unknown
First date received __ __/__ __/__ __ __ __ Last date received __ __/__ __/__ __ __ __	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, please describe:* Date of evidence __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

Please include copies of HIV related labs with this report

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Nondifferentiating)

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay** (differentiates between HIV-1 Ab and HIV-2 Ab) **Role of test in diagnostic algorithm** ☐ Screening/initial test ☐ Confirmatory/supplemental test

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative

Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate [1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid

Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____

Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____

HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____

HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____

Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test** [2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) **Note: Include earliest test at or after diagnosis.**

TEST 1 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

TEST 2 ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) **Test brand name/Manufacturer** _____

Lab name _____ **Facility name** _____

Provider name _____ **Collection Date** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

First CD4 result <200 cells/μL or <14%: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __

Test brand name/Manufacturer _____ **Lab name** _____

Facility name _____ **Provider name** _____

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown

If YES, provide specimen collection date of earliest positive test for this algorithm __ __ /__ __ /__ __ __ __

*Complete the above only if none of the following were positive for **HIV-1**: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown

If YES, provide date of diagnosis __ __ /__ __ /__ __ __ __

Date of last documented negative HIV test (before HIV diagnosis date) __ __ /__ __ /__ __ __ __

Specify type of test:

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown	**This patient's partners will be notified about their HIV exposure and counseled by** ☐ 1-Health dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown

Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments)
☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __ __/__ __/__ __ __ __

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services ☐ Yes ☐ No ☐ Unknown	**Is this patient currently pregnant?** ☐ Yes ☐ No ☐ Unknown	**Has this patient delivered live-born infants?** ☐ Yes ☐ No ☐ Unknown

For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)

***Child's Name**	**Child's Date of Birth** __ __/__ __/__ __ __ __
Child's Last Name Soundex	**Child's State Number**
Facility Name of Birth (if child was born at home, enter "home birth")	***Phone** ( )

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Other, specify _____ *Other Facility:* ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address**		***ZIP Code**
City	**County**	**State/Country**

Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other — **Date patient reported information** __ __/__ __/__ __ __ __

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply)

☐ HIV Tx	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PrEP	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PEP	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ PMTCT	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ HBV Tx	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __
☐ Other (specify reason)_____			
	ARV medications_____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __

HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one) ☐ Patient interview ☐ Medical record review ☐ Provider report ☐ NHM&E ☐ Other — **Date patient reported information** __ __/__ __/__ __ __ __

Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown **Date of first positive HIV test** __ __/__ __/__ __ __ __

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown **Date of last negative HIV test** *(if date is from a lab test with test type, enter in Lab Data section)* __ __/__ __/__ __ __ __

Number of negative HIV tests within the 24 months before the first positive test __ __ ☐ Unknown

Comments

☐ CHECK OOS STATE: If pregnant, list EDD(due date):

Link With e-HARS stateno(s):

*Local/Optional Fields

NIR STATUS:

STARS# _____ DOC# _____ NIR OP__ Date__/__/____

Other Risks: A__ B/C__ D__ F__ M__ V__ J__ O__ NIR CL__ Date__/__/____

Hepatitis: A__ B__ C__ Other__ Unknown__ NIR RE__ Date__/__/____

Test and Treat (Yes/No): Initials(3) _____ Source code: _____

This report to 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. Information in CDC's National HIV 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).

General Guidance on Completing Testing and Antiretroviral Use History Section

Yes	evidence that the event occurred
No	evidence that the event did ***NOT*** occur
Don't Know/Unknown	1) evidence that patient said, "Don't know" 2) provider documented "Unknown" or 3) insufficient evidence
Refused	Patient refused, provider documented "Refused," or the facility did not allow for medical record review
Blank	Patient or provider was not asked or source was not investigated

For all dates, only enter information for which you have evidence. For example, if only month and year are known enter 05/__/2000, or if only the year is known enter __/__/2000.

Main Source of Testing and Treatment History Information
Please select the source of Testing and Treatment History (TTH) information by checking the appropriate source box. If you use a source not listed, please specify that source on the "Other" line provided. **Only one source may be reported per form. If other TTH information is gathered from other sources, please report it on a separate form.** Please refrain from reporting TTH data found on CTRS lab reports as this is collected separately at the SHO. Record the date patient reported information as follows:

- For Medical Record Review: Date when most recent TTH data was obtained. Do ***not*** use date of review unless no other date is available.
- For Provider Report: Date when TTH information was obtained from patient. If date is unknown, enter date when report was received at health department.
- For Other: Use the date the TTH information was originally collected.

Ever had previous HIV test?
All of the questions in this section reference the patient's first positive HIV test ever. **Only complete this section when there is evidence regarding a positive test before the one which initiated the case report.** List the month (mm), day (dd), and year (yyyy) of the patient's first positive test. If a previous HIV test exists but the date is unknown, indicate **UNKNOWN (UNK)**. Remember, partial dates are also acceptable.

Ever had a negative HIV test?
All of the questions in this section reference the patient's last negative HIV test. Indicate whether the patient has ever had a negative HIV test prior to receiving their ***first*** positive result. List the month (mm), day (dd), and year (yyyy) of the patient's last negative test. If a previous negative test exists but the date is unknown, indicate **UNKNOWN (UNK)**. Remember, partial dates are also acceptable.

Number of negative HIV tests within 24 months before first positive test
Indicate the total number of negative tests the patient had during the ***twenty-four months prior*** to receiving their ***first*** HIV-positive result.

Ever taken any ARVs?
Indicate whether the patient has ever taken any HIV or antiretroviral medications (ARVs). If yes, indicate date the patient first began taking HIV or ARV medications and the date of their last use of ARV medications; if the date is unknown, indicate **UNKNOWN (UNK).** List the names of the medications taken using the attached list.

Medication Codes

22= Agenerase (amprenavir)	**23=** Hydroxyurea	**21=** Sustiva (efavirenz)
30= Aptivus (tipranavir, TPV)	**18=** Invirase (saquinavir mesylate)	**13=** Trizivir (abacavir sulfate/ lamivudine/ zidovudine
32= Atripla (efavirenz/ emtricitabine/tenofovir DF)	**34=** Intelence (etravirine)	**27=** Truvada (FTC/TDF)
24= Combivir (lamivudine/ zidovudine)	**36=** Isentress (raltegravir)	**01=** Videx (didanosine, ddI)
37= Complera (rilpivirine/ tenofovir/emtricitabine)	**16=** Kaletra (lopinavir/ ritonavir)	**14=** Videx EC (didanosine, ddI)
06= Crixivan (indinavir sulfate)	**31=** Lexiva (fosamprenavir, 908)	**17=** Viracept (nelfinavir mesylate)
38= Edurant (rilpivirine)	**07=** Norvir (ritonavir)	**05=** Viramune (nevirapine)
11= Emtriva (emtricitabine, FTC)	**33=** Prezista (darunavir, DRV)	**12=** Viread (tenofovir)
03= Epivir (lamivudine, 3TC)	**09=** Rescriptor (delavirdine mesylate)	**04=** Zerit (stavudine, d4T)
28= Epzicom (3TC/ABC)	**26=** Retrovir (zidovudine, ZDV, AZT)	**20=** Ziagen (abacavir sulfate)
25= Fortovase (saquinavir)	**15=** Reyataz (atazanavir sulfate)	**88= Other**
10= Fuzeon (enfuvirtide, T-20)	**08=** Saquinavir (Fortavase, Invirase)	**99= Unspecified**
19= Hepsera (adefovir)	**35=** Selzentry (maraviroc)	
02= Hivid (zalcitabine, ddC)	**39=** Stribild (elvitegravir/cobicistat/ tenofovir/emtricitabine)	

Please mail completed case reports and HIV related labs To:

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at Alachua County Health Department
P O Box 5849
Gainesville, FL 32627

Phone: (352) 334-7968
Fax: (352) 334-8867

Updated ~~11/7/2013~~ 12/20/2013 06/29/2021