IRB#:

Case Report / Case Series Data Request

The information contained in this form will be reviewed and evaluated by the Data Use Committee (DUC) and Institutional Review Board (IRB) if three or more patients are included in this request to ensure that all HIPAA and Privacy and Security regulations are in place prior any collection of data.

Please type directly into this form.

Project Title:		
Person submitting request:	Phone:	E-Mail:
Please list all individuals involved:	Phone:	E-Mail:

Project Design

The scope of this project to publish a case report or case series. If possible, the patient/s will sign a Release of Information (ROI) to publish or present the findings.

The population studied includes (check all that apply):

☐ Adults ☐ Children/Fetuses (< 18 years) ☐ Homeless individuals ☐ Substance users

1. What is the illness / type of population you are targeting?
2. How many people will be included in this request?
3. What are the objectives of the case report/series?
4. How do you plan to accomplish the objectives and what events or outcomes were/are going to be measured?

Data

What is the time frame of the data you propose to collect? **Start Date:** _____ **End Date:** _____

Attach a list of all data points required for the project. (Some good examples include "date of birth" and "asthma" instead of "medical history" and "chronic diseases".)

Will you be performing a chart review or requesting a generated report? ☐ **Chart Review** ☐ **Generated Report**

From where will this data be retrieved?

☐ **CottageOne**
☐ **Institutional registry**
☐ **Physician's office medical record**
☐ **Other (specify):** _____

Will any of the individuals involved (refer to the individuals listed above) be non-CH employees or not have privileges at a CH facility? ☐ Yes ☐ No

If yes, specify: _____

Will all individuals involved need access to the **raw data**? ☐ Yes ☐ No

If not, specify: _____

Will the data and/or the findings **leave Cottage Health** for any reason? (e.g., external collaborators, poster presentation, conference talk, journal publications) ☐Yes ☐No

If yes, specify where: _____

If yes, specify if the shared data will contain any identifiers listed above OR will it be anonymous?

☐ **Contain identifiers** ☐ **Anonymous**

Protected Health Information (PHI)

Which of the following identifiers will be associated with the data you propose to collect? Check all that apply.

☐ None of the data listed below will be collected.

☐	Names	☐	Telephone Numbers
☐	Address	☐	E-mail Addresses
☐	Fax Numbers	☐	Medical Record Numbers
☐	Social Security Numbers	☐	Account Numbers
☐	Health Plan Beneficiary Number	☐	Vehicle Identifiers and Serial Numbers
☐	Certificate/License Numbers	☐	Web Universal Resource Locators (URL)
☐	Device Identifiers and Serial Numbers	☐	Biometric Identifiers (finger and voice prints)
☐	Internet Protocol (IP) Address Numbers	☐	Any Elements of Dates (**specify which of the following identifiers you will use:** birth date, admission date, discharge date, date of death, age over 89) _____
☐	Any Geographic Subdivisions Smaller Than a State (**specify which of the following identifiers you will use:** county, city, parish, or zip code)		
☐	Full face photographic images and comparable images	☐	Any other unique identifying number, characteristic, or code (**please specify**): _____

My signature below attests that:

1) ***The information given in this request is correct to the best of my knowledge;***
2) ***I shall willingly comply with any/all required data use policies and parameters surrounding this request;***
3) ***I acknowledge that the DUC review is only one of the approvals and I may need to also contact the IRB in order to conduct the project; and***
4) ***I will not begin the project until all of the necessary approvals have been secured.***

_____ _____ _____

Name Signature Date

Manager/Director Attestation*

I have met with the individual interested in conducting the project and have determined that the project is feasible. I have reviewed the overhead needed to conduct the study and I am able and willing to support it.

My signature below attests that the individual will have the support of the department to conduct the project, and will be provided with sufficient resources to properly conduct and complete the project.

☐ *Not required

_____ _____ _____

Manager/Director's Printed Name Signature Date