Cottage Health Data Use Committee

Data Request Form

For DUC Use:	
IRB #	
Date reviewed	

The information contained in this form will be reviewed and evaluated by the Data Use Committee (DUC) 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:
Sponsor, if any:		

Project Design

The intended scope of this project / data collection request is (please check only one):

☐ **Research** (generate new knowledge to add to professional literature)

☐ **Quality Improvement** (improve patient care within unit or organization)

- Complete Data Request Form Appendix A: QI Project Questions

☐ **Evidence Based Practice** (change practice in an identified population; attach published research)

- Complete Data Request Form Appendix B: EBP Project Questions

☐ **Evaluation** (improve a specific program, policy, system and/or inform decision making)

- Complete Data Request Form Appendix C: Evaluation Project Questions

☐ **Other** (explain): _____

What is the purpose of your project?

My project is:

☐ **Descriptive/Exploratory** (no set hypothesis; aims to summarize trends in the data)

☐ **Confirmatory** (confirms or denies a specific hypothesis)

Does your request involve a device? ☐ Yes ☐ No

Does your request include the creation of a database/registry? ☐ Yes ☐ No

Data

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

List or attach all data points required for the project. (Some good examples include "date of birth" and "asthma" instead of "medical history" and "chronic diseases".) ☐ Attached

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* ☐ *Not required

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.

_____ _____ _____

Manager/Director's Name Signature Date