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| **INSTRUCTIONS:** Please type all requested information. Handwritten responses will not be accepted. Upon completion, please forward this document to research@gmh.edu |
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| **PRINCIPAL INVESTIGATOR INFORMATION:** |
| **Name:** |       |
| **Phone:** |       |
| **Department:** |       | **Email:** |       |
|  |
| **DATA REPORT DETAILS:** |
| **This report request will be used to complete Resident’s research requirements:**  | **[ ]  Yes** | **[ ]  No** |
| **The research related to this request is Human Subject based per the IRB:** | **[ ]  Yes** | **[ ]  No** |
| **This is a funded research study:** | **[ ]  Yes** | **[ ]  No** |
| **Purpose for which access to data is being requested (describe in detail):** |
|       |
|  |
| **Frequency of Report:** *(e.g. once quarterly)* |       |
|  |
| **DATA ELEMENTS BEING REQUESTED:** |
| **Identified Dataset:**  |
| Data Elements | ICD9/10 Code | Description |
| 1.       |       |       |
| 2.       |       |       |
| 3.       |       |       |
| 4.       |       |       |
| 5.       |       |       |
| 6.       |       |       |
| 7.       |       |       |
| 8.       |       |       |
| 9.       |       |       |
| 10.       |       |       |
|  |  |  |
| **De-Identified Dataset:** |
| Data Elements | ICD9/10 Code | Description |
| 1.       |       |       |
| 2.       |       |       |
| 3.       |       |       |
| 4.       |       |       |
| 5.       |       |       |
| 6.       |       |       |
| 7.       |       |       |
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| 10.       |       |       |

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| **IRB INFORMATION & ATTESTATION** |
| **IRB Number:** |       | **Expiration Date:** |       |
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| **Data Requestors must certify the following:*** The data for which use or access is sought is the minimum necessary for the stated research purposes.
* Access and use of the data will be limited to the research purposes described above.
* I will comply with all Grady Health System policies concerning individuals’ privacy, information security and HIPAA.
* If the data is disclosed outside of the Grady Health System, I have a process/procedure in place for tracking and documenting any such disclosures.
* I have a duty to immediately report to the appropriate Grady Health System personnel any breach or suspected breach of the data for which use or access is sought.
* When preparing publications or presentations of work substantially aided by the Grady Health System, I will acknowledge the participation of Grady Health System.
 |
| **Signature:**  |  | **Date:** |       |
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|  | **FOR GRADY HEALTH SYSTEM INTERNAL USE ONLY:** |  |
|  |
| **Research Administration Review:** |
| Name: |       | Title: |       |
| Signature: |  | Date: |       |
|  |
| **Grant Administration Review:**  |
| Name: |       | Title: |       |
| Signature: |  | Date: |       |
|  |
| **Legal Review:** |
| Name: |       | Title: |       |
| Signature: |  | Date: |       |
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