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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:** |  | | | | |
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| **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):** | | | | | | | | | | |
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| **Frequency of Report:** *(e.g. once quarterly)* | | |  | | | | | | | |
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| **DATA ELEMENTS BEING REQUESTED:** | | | | | | | | | | |
| **Identified Dataset:** | | | | | | | | | | |
| Data Elements | | | | ICD9/10 Code | | | Description | | | |
| 1. | | | |  | | |  | | | |
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| **De-Identified Dataset:** | | | | | | | | | | |
| Data Elements | | | | ICD9/10 Code | | | Description | | | |
| 1. | | | |  | | |  | | | |
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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:** | | | | | | | | | | |  |
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| **Research Administration Review:** | | | | | | | | | | | | |
| Name: | |  | | | Title: |  | | | | | | |
| Signature: | |  | | | | | | Date: | | |  | |
|  | | | | | | | | | | | | |
| **Grant Administration Review:** | | | | | | | | | | | | |
| Name: | |  | | | Title: |  | | | | | | |
| Signature: | |  | | | | | | Date: | | |  | |
|  | | | | | | | | | | | | |
| **Legal Review:** | | | | | | | | | | | | |
| Name: | |  | | | Title: |  | | | | | | |
| Signature: | |  | | | | | | Date: | | |  | |
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