APPLICATION FOR ACCESS TO PROTECTED DATA

FOR STATE, FEDERAL & LOCAL GOVERMENTAL AGENCIES

BUREAU OF HEALTH STATISTICS & REGISTRIES
PA DEPARTMENT OF HEALTH
555 WALNUT ST - 6TH FLOOR
HARRISBURG, PA 17101-1914
(717) 783-2548

November 2017
(revised)

Please read *USER'S GUIDE FOR ACCESS TO PROTECTED DATA* before completing this application.

I. ORGANIZATION OR INDIVIDUAL REQUESTING ACCESS

A. Project Director: ____

B. Title: ____

C. Organization: ____

D. Street Address or P.O. Box: ____

E. City, State, Zip Code: ____

F. Telephone: ________________________ Email Address : ________________________
(area code)

G. Other persons who should be contacted if more information is needed:

1. Name: ____

Telephone: ________________________ Email Address: ______________________
(area code)

Address (if different than above):

____

____

2. Name: ____

Telephone: ________________________ Email Address: ______________________
(area code)

Address (if different than above):

____

____

II. TITLE OF PROJECT

____

III. OTHER ORGANIZATIONS PARTICIPATING IN THIS STUDY OR PROJECT

List the name(s) of any organizations which will obtain identifiable information or individual case record data from Pennsylvania files. Include consultants, contractors, and data processing vendors. A "Supplemental Assurances Form" (see pages 7-10) must be completed by EACH organization listed below and must be signed by responsible officials of that organization. The completed forms must be submitted as an attachment(s) to this application form.

IV. SUMMARY OF STUDY PROTOCOL OR PROJECT ACTIVITIES

In responding, please be as clear and as succinct as possible using the space available. If you require additional space for answers, insert a separate page(s) and number each answer. **Please note that if your project is to identify deceased individuals who are possibly receiving monetary or other benefits, the Department of Health requires that those benefits can not be discontinued without an independent secondary source.**

A. Please state the purpose of your request for Access to Protected Data.

B. Briefly explain how the Department of Health's protected data will be used.

C. Please describe any follow back procedures including who will be contacted (i.e. family, next of kin, etc.) and type of information to be obtained from the respondents.

V. RECORDS AND IDENTIFIABLE DATA REQUIRED

1. Identify the records you will require to address the needs of this project. Place an X(s) in the appropriate box(es):

	Data (Text) Files	Noncertified copies	Verifications	Certifications
Death Files				
Birth Files		Not Available		

Other data set; specify: ____

Please list the data variables that you need:

B. List the data years you require for this project: e.g.; 2007 or 2002-2005, etc.;

C. If data file linkage is required, identify and briefly describe your data files that will be linked with the Department of Health's vital records and the source of this data.

D. If the project requires data linkage, the PA Department of Health requires that the linkage

be conducted by the Department of Health. If linkage is required, tell us how many records there are, and how often will the linkages take place (annually, quarterly).

E. In what form and to whom will the results of your study or activities be released?

F. How many future requests do you expect to make?

VI. MAINTAINING THE CONFIDENTIALITY AND SECURITY OF IDENTIFIABLE INFORMATION

A. How will you maintain the confidentiality and security of identifiable data obtained from Department of Health records? (Identifiable data refers to any information which could permit the identification of any individual. This is not only name and address, but also individual case record data where other demographic items such as age, sex, race, and place of residence could possibly be used to identify subjects.)

B. Disposition of Identifiable data (NOTE: the Pennsylvania Department of Health requires that paper records or electronic data files be destroyed at the end of the projects or as soon after the end of the project as possible. This includes case-level data files with or without personal identifiers.)

1. How long will you store copies or other identifiable data?

2. How will you dispose of copies of records or other identifiable data?

3. Will any of the identifiable data obtained from records and/or follow back investigation be used as a basis for legal, administrative, or other actions which may directly affect particular individuals as a result of their specific identification in this project? _________Yes _________No

   If YES, please explain:

4. Will the identifiable data obtained from the records or follow back investigations be used either directly or indirectly for any project or purpose other than the one described in Part IV? _____________Yes ____________No

   If yes, briefly describe other projects or purposes for which the data will be used. A separate application form must be submitted for each project which will be using protected data obtained from the PA Department of Health Records.

5. Approximate date of study completion: _________________________________

VII. APPLICANT ASSURANCES

The undersigned hereby agrees to the following terms and conditions related to this application and to the use of information obtained from the Pennsylvania Department of Health.

A. The identifiable data obtained following written approval from the Department of Health shall be used only for the study or activities proposed and the purposes described in the "Summary of Study Protocol or Project Activities" (Part IV). Use of the information for a project or purpose other than that described in Parts IV shall not be undertaken unless a separate application form for the subsequent project has been submitted to, and approved by, the Pennsylvania Department of Health.

B. No individually identifiable data shall be released without prior written approval by the Pennsylvania Department of Health. Paper records and electronic data files containing Pennsylvania case-level data from vital statistics or cancer files will be destroyed upon completion of the study, or as soon as possible thereafter.

C. If data extracted from Pennsylvania records are used in any publication, the following statement must be included in such publication or any other release of the data:

> These data were supplied by the Bureau of Health Statistics & Registries, Pennsylvania Department of Health, Harrisburg, Pennsylvania. The Pennsylvania Department of Health specifically disclaims responsibility for any analyses, interpretations or conclusions.

A copy of any published materials or study results should be made available to the Pennsylvania Department of Health upon request.

D. I have thoroughly reviewed the contents of the *User's Guide for Access to Protected Data* dated November 2017, which are incorporated herein by reference, and I shall adhere to the guidelines set forth therein.

E. I agree to pay in full the invoice provided to me for services rendered by the Bureau of Health Statistics & Registries as detailed in the *User's Guide* dated November 2017.

F. All statements entered in this application are true, complete, and correct to the best of my knowledge and belief.

____

Project Director's Name

____

Project Director's Title

____

Organization

____ __________

Signature Date

VIII. ADDITIONAL EMPLOYEES AUTHORIZED TO ACCESS PROTECTED DATA

List the names and titles of all employees representing your organization or agency for the **purpose of obtaining birth or death verifications or certifications**. Each listed employee must sign and date this page to provide acknowledgement of an agreement to the assurances as listed on the previous page. If additional space is needed, attach a separate page containing the names, titles, signatures and date signed for each additional employee.

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

ATTACHMENT A

PENNSYLVANIA DEPARTMENT OF HEALTH
APPLICATION FOR ACCESS TO PROTECTED DATA
SUPPLEMENTAL ASSURANCES FORM

A separate Supplemental Assurances Form (pages 7-10) must be completed and signed by EACH organization listed on page 3 of the application form as participating in this study. The Supplemental Assurances Form(s) must then be submitted as an attachment to the application form. Additional copies of pages 7-10 may be made as required.

Name: ____

Title: ____

Organization: ____

Street Address or P.O. Box: ____

City, State, Zip Code:
____

Telephone: ____
(area code) E-Mail Address

A. How will you maintain the confidentiality and security of identifiable data obtained from Department of Health records? (Identifiable data refers to any information which could permit the identification of any individual. This is not only name and address, but also individual case record data where other demographic items such as age, sex, race, and place of residence could possibly be used to identify subjects.)

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If YES, please explain:

4. Will the identifiable data obtained from the records or follow back investigations be used either directly or indirectly for any project or purpose other than the one described in Part IV?
______________Yes ____________No

If yes, briefly describe other projects or purposes for which the data will be used. A separate application form must be submitted for each project which will be using protected data obtained from the PA Department of Health Records.

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Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date

Name	Title
Signature	Date