



Resident Access to Data Program

Research and QI Project Data Request

NAME _____ PHONE _____

DEPT _____ SLUHN EMAIL _____

- **This form is required for all data requests related to research. Please note that IRB approval or waiver must be obtained prior to completing this form.**
- Please submit form to analyst partner or Analytics & BI department with ALL required signatures and dates. Due to patient confidentiality concerns, **forms received with missing signatures will not be processed.**
- Note that **patient data must be transmitted securely and remain behind the SLUHN firewall.** We recommend using **Redcap**. Data may not be moved outside SLUHN without permission. Moving data to personal email accounts, thumb drives, other non-secure storage media or transmission mechanisms is prohibited.

PURPOSE _____

IRB STUDY NUMBER (If Applicable, or Attach Waiver) _____

REQUEST DETAILS Data fields, selection criteria, other comments. *Please attach another page for more details or comments as required.*

REQUIRED SIGNATURES:

REQUESTOR _____ DATE _____

PROGRAM DIRECTOR OR QI FACULTY COACH _____ DATE _____