# DELAWARE HEALTH STATISTICS CENTER
# APPLICATION FOR PROTECTED DATA FILES
**(FOR USE BY DIVISION OF PUBLIC HEALTH SECTIONS/PROGRAMS)**

CHECKLIST FOR ACCESS TO PROTECTED VITAL STATISTICS INFORMATION

In order to avoid delays in processing your application, please indicate on the checklist below the items included in your application.

| REQUIRED FOR ALL APPLICATIONS |
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| ☐ All relevant sections of the enclosed application have been completed. |
| ☐ A brief abstract of the project has been enclosed on a separate page that provides the information requested in the Abstract section of the application. |
| ☐ A signed copy of the attached Delaware assurance page. |

| ADDITIONAL REQUIREMENTS FOR APPLICATIONS INVOLVING FOLLOWBACK |
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| ☐ A copy of an approval letter from your governing Institutional Review Board for this project. |
| ☐ A copy of any survey to be used for followback. |
| ☐ A copy of the consent form to be used for followback. |

Submit this completed application to:
**Marianne Letavish**
**Delaware Health Statistics Center**
**Division of Public Health**
**417 Federal St**
**Dover, Delaware 19901**

IMPORTANT

If you are requesting data for a previously approved study and the methodologies/procedures have not changed, it is not necessary to complete another application. Simply send a letter of request to the address above and identify the original approval number and title of the study.

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The information and assurances obtained from the requester will be used by the Vital Statistics Review Subcommittee to determine whether the proposed use of data is consistent with regulations established by the Delaware State Board of Health. A copy of these regulations is available upon request.

| Requester Information | | |
|---|---|---|
| **Name**: | | **Date:** |
| **Title:** | **Section or Office:** | |
| **Street Address:** | **City:** | |
| **State:** | **Zip Code:** | **Phone:** |
| **Email Address:** | | |
| **Other person who may be contacted if more information is needed** | | |
| **Name:** | | |
| **Telephone:** | | |
| **Address (if different than project director):** | | |

| Project or Study Summary |
|---|
| Title of project or study: |
| Name and address of sponsor(s), if any: |

| Abstract |
|---|
| On a separate page include the following:<br>1. A description of the health, medical or other problem addressed by the proposed project or study.<br>2. A list of the primary project or study objectives and a description of the hypotheses to be tested, if any.<br>3. A summary of the project's methodology, including specific followback procedures, if applicable.<br>4. A summary of the project's analysis procedures, indicating how the data will be used.<br>5. A description of any data files that will be linked with the data provided by the State of Delaware specifying the source of these data files.<br>6. A description of how the results of your project or study will be released. |

**Has this research project or study been reviewed and approved by an Institutional Review Board for the Protection of Human Subjects? This is a requirement for all projects or studies involving followback.**

☐ Yes (attach copy of approval)
☐ No
Reason:

**Records and/or Identifiable Data Requested**

Check the appropriate space for the type and format of records and/or identifiable data requested

| | Comma delimited (*.csv) | Tab delimited (*.dat) | SPSS (*.sav) | Excel | SAS |
|---|---|---|---|---|---|
| Birth Records | ☐ | ☐ | ☐ | ☐ | ☐ |
| Death Records | ☐ | ☐ | ☐ | ☐ | ☐ |
| Linked Medicaid-VS | ☐ | ☐ | ☐ | ☐ | ☐ |
| Others | ☐ | ☐ | ☐ | ☐ | ☐ |

Specify:

**Describe the cohort of records requested (for example, specify years, ages , geographic locations, etc.)**

**Do you wish records to be selected based upon matching criteria which you will provide? If yes, specify. (The next page contains the list of variables.)**

1. The specific data items to be matched:

2. The source of these data items:

3. The manner in which you will provide the data to be matched (e.g., how will it be sent and in what format)

**If you are requesting an electronic file containing items, please indicate "X" at the items you expect to obtain. It is not necessary to fill out this section if a copy of the entire record has been requested above.**

BIRTH RECORDS

- ☐ Name
- ☐ Date of Birth
- ☐ Sex
- ☐ Plurality
- ☐ City of Birth
- ☐ Hospital of Birth
- ☐ County of Birth
- ☐ Mother's Age
- ☐ County of Mother's Residence
- ☐ Race of Mother
- ☐ Education of Mother
- ☐ Month Prenatal Care Began
- ☐ Number of Prenatal Visits
- ☐ Marital Status
- ☐ Birth Weight
- ☐ Previous Deliveries
- ☐ Date of Last Live Birth

DEATH RECORDS

- ☐ Name
- ☐ Sex
- ☐ County of Death
- ☐ Hospital or Institution of Death
- ☐ State of Residence
- ☐ County of Residence
- ☐ City of residence
- ☐ Race
- ☐ Marital Status
- ☐ Occupation
- ☐ Age
- ☐ Place of Birth (State or Country)
- ☐ Military Service
- ☐ Cause of Death
- ☐ Autopsy
- ☐ Disposition (Burial, Cremation, Other)

## Confidentiality and Use of Data

A. How will you maintain confidentiality, access to, and security of identifiable data or other confidential materials obtained from the State of Delaware? Include an explanation of how copies of vital records or data extracted from them will be stored. Delaware State Board of Health regulations require you to destroy or return copies of records/ computer listings upon project completion. Explain how and when you plan to destroy or return copies of vital records/computer listings after your project is completed and the approximate project completion date.

B. Will you require follow-back investigations to obtain additional information directly from patients, decedent's next-of-kin, physicians, hospitals, and/or other individuals or facilities mentioned on, or derived from information on the records?
☐ Yes ☐ No If **YES**,

If **YES**, briefly describe the following: (use additional Sheets of paper, if necessary)

1. Types of follow-back respondents to be contacted.

2. Information to be obtained from respondents (attach a copy of the survey form, if available).

3. Methods to be used in conducting such investigations, including a copy of consent form to be signed by individuals or facilities.

4. How will you maintain the confidentiality of identifiable data obtained from the followback investigations? Explain how such data will be stored as well as how and when you will dispose of the data.

C. For the purposes of this project, as described above, will any of the identifiable data obtained from the records or followback investigation be used by other organization, e.g., other divisions, agencies, consultants, contractors and/or subcontractors? ☐ Yes ☐ No

If YES, indicate the name of any other organization and its role in this project. If the name is unknown at this time, indicate the type of organization. Also describe the safeguards that exist or will be implemented to insure that the data will be used solely for the purposes of this project.

D. Will any of the identifiable data obtained from records and/or followback investigations be used as a basis for legal, administrative or other actions which may directly affect particular individuals or facilities as a result of their specific identification in this project? ☐ Yes ☐ No

If YES, explain:

| Assurances |
|---|
| The undersigned hereby agrees to the following terms and conditions related to this application and the use of the information obtained from the Delaware Health Statistics Center (DHSC).<br><br>A. The identifiable data obtained from DHSC will be used only for the project proposed and the purposes described in this application. Use of the information for purposes other than those described will not be undertaken until a separate application form for the project has been submitted to, and approved by, the Vital Statistics Review Subcommittee.<br><br>B. Confidentiality and handling of the information obtained will be maintained as described in this application.<br><br>C. Copies of vital records, computer listings or electronic files abstracted from vital records obtained through this application will be returned to the DHSC or destroyed following their described use.<br><br>D. No information will be released to or used by any organization/agency other than the undersigned, except as shown in this application. Release of identifier information for commercial purposes is prohibited.<br><br>E. Information obtained from follow-back investigations, if conducted, will be subject to the same procedures and measures of confidentiality and security after the research is completed.<br><br>F. All the statements made in this application are true, complete and correct to the best of my knowledge and belief.<br><br>G. I understand that failure to comply with the above terms and conditions will result in the following:<br><br>1. The immediate termination of access to protected vital statistics data for this project and all other previously approved projects conducted by me or my organization.<br><br>2. Prohibition from access to protected vital statistics data for all future projects conducted by me or my organization.<br><br>3. Other penalties pursuant to Delaware law. |

| | |
|---|---|
| **Project Director's Signature:** | **Date:** |
| **Section Chief's Signature:** | **Date:** |
| **Delaware Health Statistics Center (DHSC) Use Only** | |
| **Application complete:** | **Date:** |
| **DHSC Authorization:** | |