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Research Project Title:____

Primary Investigator:____

Address:____

Phone:____

Email:____

IRB Approval#: ____

Date of Submission___________ Time Frame of Data Requested: From______ To______

Purpose of the Study

Project Description

Hypothesis

Revised 07/14/2011

Question(s)

For Publication: Yes____ No____

Define Patient Population

☐ Adult (ages 16 and older)

☐ Pediatric (ages 15 and younger)

List Data Points Needed (ICD9 Codes):

I understand that confidentiality policies require that information which would reveal a patient's identity not be released. Any information which I have requested will be destroyed when I have completed the goals stated above in a manner that protects confidentiality of the information. I will abide by all Shands Healthcare System policies. I will acknowledge the Trauma Program Database as the source of the above requested data both in written text, and oral presentations. I will in no form reproduce this information for others, into electronic databases, or sub-reports of any type. I understand that I must have IRB approval before release of patient data elements.

Signature by Primary Investigator/Requestor: ______________________________________

Date: ____________________________

Special Note: *Allow 15 business days for return of data information.

Submit to: **Shands at the University of Florida**
Trauma Registry
P O Box 100108
Gainesville, Fl 32610

Office Use Only

______________________________ Trauma Medical Director

______________________________ Trauma Program Manager

FOR REGISTRY USE

Date received: __________________

Report prepared by: ______________

Date completed: _________________

Total time used: __________________

Delivery date: ___________________

Revised 8/31/06; 07/01/07, 7/14/11