|  |  |
| --- | --- |
| **Lori A. Weaver****Interim Commissioner****Patricia M. Tilley****Director** | **STATE OF NEW HAMPSHIRE****DEPARTMENT OF HEALTH AND HUMAN SERVICES*****DIVISION OF PUBLIC HEALTH SERVICES******BUREAU OF PUBLIC HEALTH STATISTICS AND INFORMATICS*****29 HAZEN DRIVE, CONCORD, NH 03301****603-271-4988 1-800-852-3345 Ext. 4988****Fax: 603-271-7623 TDD Access: 1-800-735-2964****www.dhhs.nh.gov** |

**APPLICATION FOR ACCESS TO CONFIDENTIAL VITAL RECORDS DATA FOR HEALTH RELATED RESEARCH**

New Hampshire Vital Records birth and death certificate data are available for health related research purposes only by application to, and approval of the Vital Records Privacy Board for Health Related Research (Privacy Board) under a process governed by state statute RSA 126:24-d, Disclosure of Information from Vital Records and the federal Health Insurance Portability and Accountability Act.

This *Application* for *Access to Vital Records Data for Health Related Research* form provides the information the Privacy Board requires to make a decision about whether or not to grant the request for data. The Privacy Board will consider your request only upon receipt of a completed application. *Any areas of this application left blank without explanation will delay the review of this request, so please take the time to review your completed application carefully. Please provide responses to the questions in the application in this document only.* In addition, you will be required to read and sign a Data Sharing Agreement (DSA) upon approval of your data request. Please reference accompanying document.

The approval process generally takes approximately four to eight weeks from the time a completed application is received by the Privacy Board. The Privacy Board meets monthly to review requests. Applicants will be notified of the status of a request after the Privacy Board's monthly meeting.

Prior to receipt of data, applicants will be notified of any fees that may be required to be paid in order to receive the requested data.

If the Privacy Board ascertains that part or all of a request can be accomplished through receipt of aggregate data, public use data sets, or creation of proxy variables, it reserves the right to deny the request and redirect the applicant to the appropriate agency to obtain the information required.

The Privacy Board reserves the right to independently validate anything contained in this application and may at its discretion contact any Institutional Review Board that has purview over the research project for which data is requested.

*Vital Records Privacy Board for Health Related Research NH Department of Health and Human Services*

Please send completed application materials to the following address:

*Vital Records Privacy Board for Health Related Research Bureau of Public Health Statistics and Informatics Division of Public Health Services*

*Department of Health and Human Services 29 Hazen Drive*

*Concord, NH 03301-6504*

For questions, please do not hesitate to contact us vital.rec.data@dhhs.nh.gov.

This form, as well as the Renewal and Termination Request forms are available online at: <https://www.dhhs.nh.gov/about-dhhs/advisory-organizations/vital-records-privacy-board-health-related-research>.

*Vital Records Privacy Board for Health Related Research NH Department of Health and Human Services*

**Part I: Request for Data With Personal Identification Information**

All information provided in these sections and in the separate data element forms is required. This information will serve as criteria for the Privacy Board’s decision regarding release of confidential data.

**Section A: Individual and Organization Requestor Information**

|  |
| --- |
| Contact Person’s Name and Title (name of person who will receive the data): |
| Organization: |
| Address: |
| Telephone Number: |
| Fax Number: |
| E-mail Address: |
| Principal Investigator or Overall Responsible Party’s Name and Title: |
| Principal Investigator or Overall Responsible Party’s Telephone Number: |
| Application Date: |

**Section B: Summary of Research Study Protocol or Project Activities:**

|  |
| --- |
| Please submit a copy of your research/study/project protocol. Use as much space as you need below to answer the questions. If you are not using this electronic document, attach a separate document with numbered answers. |
| **1. Title of study or project:** |
| **2. Purpose of the study or project.** What is the hypothesis? How will this study benefit New Hampshire residents and/or contribute to general knowledge? |
| **3. Requestor and Principal Investigator’s qualifications and affiliation** *(briefly describe and attach resumes)* |
| **4. Personnel.** Please describe all research and other staff who will have access to the confidential data. These include personnel, subcontractors, and affiliated agencies. |
| **5. Source of funds.** Please describe the source(s) and duration of all funding for the study (including in-kind contributions). Identification should include the name, address, and a contact number for the agency directly responsible for the funding, as well as identifying links to any umbrella organization. |
| 1. **Study background and design.** Please address the following points. Please note, an attached protocol shall not serve as a replacement for providing answers to the questions below:
	* What are the specific aims of your project? Specifically state the goal(s) of the research. This should be as focused and detailed as possible.
	* Based on the study goal(s) and design of the information to be collected, provide an outline of the study, intended start and completion dates, and sampling or data collection methodology.
	* Describe the study’s case definition (demographics, medical criteria, geographic location, and other appropriate descriptions).
	* Describe the method of data analysis and software programs you anticipate using.
	* If you intend to link data to other databases, resulting in the determination of additional individuals’ identifying data being added, please describe the process and provide IRB approval to conduct this research (indicating procedures for gaining consent) with or without these individuals’ consent. Include any copies of informed consent forms.
 |

1. **IRB approval.** If applicable, please include the current documentation of the Institutional Review Board approval for the study. The IRB of record shall be in compliance with the requirements of the U.S. Department of Health and Human Services Code of Federal Regulations for Protection of Human Subjects (45 CFR 46). If not applicable, please state below.
2. **Datasets requested.** Please check all requested datasets and the time period you require for your project.

|  |  |
| --- | --- |
| ***Dataset Requested*** | ***Years Required for Project*** |
| Vital Records (Death) |  |
| Vital Records (Birth) |  |

*Note: if your study anticipates requesting records into the future, please indicate final year that will be requested.*

1. **Records requested.** Will a specific list of records being requested be sent to the Privacy Board or will the selection of records be based on a set of criteria?

You **shall** also refer to and complete a variable/element list form **(Appendix A**) for each dataset requested; the variable list forms require justification for all confidential data elements requested.

1. **Estimated number of records.** What is the estimated number of records/files you are requesting (if known)?
2. **Data will be provided in a password-protected encrypted file that will be uploaded to a secure site on the DHHS server. Please indicate how you would like to receive the data (check only one box):**

|  |  |  |
| --- | --- | --- |
|  | ***File Format*** |  |
|  | MS Access | Fixed Length Text File |
|  | MS Excel | Delimited Text File |

1. **Contact with human subjects.** Will the study or project activities involve contact with any persons identified *within* the requested data records? Please explain the need for and the nature of the expected contact.
2. **Data management and security.** Please describe, in detail, the methods used to store the confidential data and how confidentiality of the data will be maintained.

Section C: Data Use Agreement

Please review the accompanying Data Use Agreement. You will be asked to sign this document once your data request has been approved. By signing the DUA, you agree to the terms and conditions related to using protected health information for health related research purposes and any other terms the Vital Records Privacy Board for Health Related Research (Privacy Board) imposes as part of release of the data.

***I have reviewed the request form. All statements made in the request form are true, complete, and correct to the best of my knowledge, and I agree to abide by the aforementioned stipulations.***

|  |  |
| --- | --- |
| Name of person requesting data: | Name of overall responsible party / principal investigator: |
| Title: | Title: |
| Organization: | Organization: |
| Signature: | Date: | Signature: | Date: |

**Data Set Element Selection and Justification**

Please see Attachments for:

**Vital Records Data – Appendix A**

**APPENDIX A**

**Vital Records Death Certificate Data Set Element Selection**

Under New Hampshire law RSA 5-C:9, access to and release of most Vital Records information is restricted. For the purposes of health-related research, only the minimum necessary records and data elements will be released. Elements below with ‘Need:’ indicated in the third column must have a justification of why the data element is necessary for the research project or they will not be released. In the same column also supply any filtering of data records (e.g., certain causes of death) or pre-grouping of information (e.g., age groups).

Note: some unrestricted information is available to the public at the website <https://nhvrinweb.sos.nh.gov> maintained by the Division of Vital Records Administration.

|  |  |  |
| --- | --- | --- |
| **Check to Request Element** | **Data Element** | **Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.** |
|  | State File Number | Need: |
|  | Decedent Name | Need: |
|  | Decedent Sex |  Need: |
|  | Decedent SSN | Need: |
|  | Decedent Age |  Need: |
|  | Decedent Armed Forces Flag |  Need: |
|  | Decedent Birth Date | Need: |
|  | Decedent Birth City | Need: |
|  | Decedent Birth State  |  Need: |
|  | Decedent Death Date | Need: |
|  | Decedent Death Location Geography | Need: |
|  | Decedent Death Place |  Need: |
|  | Decedent Death Site in Hospital |  Need: |
|  | Decedent Death Site Other |  Need: |
|  | Decedent Marital Status |  Need: |
|  | Spouse Name | Need: |
|  | Decedent Occupation | Need: |
|  | Decedent Industry |  Need: |
|  | Decedent Industry Type |  Need: |
|  | Decedent Employer | Need: |
|  | Decedent Residence by Census Block | Need: |
|  | Decedent Residence by Census Tract\*Census tract information may be limited | Need: |
|  | Decedent Residence by Longitude / Latitude (Information may be limited) | Need: |
|  | Decedent Residence Address Street | Need: |
|  | Decedent Residence Address City | Need: |
|  | Decedent Residence Address County |  Need: |
|  | Decedent Residence Address State |  Need:  |
|  | Decedent Residence Address Zip code | Need: |
|  | Decedent Race | Need: |
|  | Decedent Ancestry | Need: |
|  | Decedent Hispanic Ethnicity | Need: |
|  | Decedent Education |  Need: |
|  | Father’s Name | Need: |
|  | Mother’s Name | Need: |

|  |  |  |
| --- | --- | --- |
| **Check to Request Element** | **Data Element** | **Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.** |
|  | Informants Name | Need: |
|  | Informants Address | Need: |
|  | Method of Disposition |  Need: |
|  | Place of Disposition | Need: |
|  | Disposition City & State | Need: |
|  | Disposition Date | Need: |
|  | Funeral Director Name | Need: |
|  | Funeral Director License Number | Need: |
|  | Funeral Home Name | Need: |
|  | Pronouncer’s Official Capacity |  Need: |
|  | Pronouncer’s Name | Need: |
|  | Pronouncer’s License Number | Need: |
|  | Pronouncer’s Signature Date | Need: |
|  | Pronounced Time of Death |  Need: |
|  | Pronouncer’s Date of Death | Need: |
|  | Referral to Medical Examiner Flag |  Need: |
|  | Cause of Death Text Literals | Need: |
|  | Autopsy Performed Flag |  Need: |
|  | Autopsy Findings Available Flag |  Need: |
|  | Manner of Death |  Need: |
|  | Date of Injury |  Need: |
|  | Time of Injury |  Need: |
|  | Injury at Work Flag |  Need: |
|  | Description of Injury | Need: |
|  | Place of Injury Code |  Need: |
|  | Geographic Location of Injury | Need: |
|  | Certifier’s Official Capacity |  Need: |
|  | Certifier’s Name | Need: |
|  | Certifier’s License Number | Need: |
|  | Certifier’s Signature Date | Need: |
|  | Certifier’s Address | Need: |
|  | Underlying Cause of Death Code | *Note: If applicable, please specify ICD codes required using ICD9 for 1998 and earlier and**ICD10 for 1999 and later* |
|  | Birth Certificate File Number (Infants Only) | Need: |
|  | Multiple Cause of Death Codes 1 – 15 | *Note, if applicable, please specify ICD codes required using ICD9 for 1998 and earlier and**ICD10 for 1999 and later* |
|  | Certifiers Opinion on Tobacco Use as Contributor to Death |  Need: |
|  | Transportation Injury Code |  Need: |
|  | Decedent Pregnancy Flag |  Need: |

**Vital Records Birth Certificate Data Set Element Selection**

Under New Hampshire law RSA 5-C:9, access to and release of most Vital Records information is restricted. For the purposes of health-related research, only the minimum necessary records and data elements will be released. Elements below with ‘Need:’ indicated in the third column must have a justification of why the data element is necessary for the research project or they will not be released. In the same column also supply any filtering of data records (e.g., presence of a risk factor) or pre-grouping of information (e.g., age groups).

Note: some unrestricted information is available to the public at the website <https://nhvrinweb.sos.nh.gov> maintained by the Division of Vital Records Administration.

|  |  |  |
| --- | --- | --- |
| **Check to Request Element** | **Data Element** | **Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.** |
|  | State File Number |  Need: |
|  | Child Name |  Need: |
|  | Child Sex |  Need: |
|  | City of Birth |  Need: |
|  | State of Birth |  Need: |
|  | Type of Place of Birth |  Need: |
|  | Date of Birth |  Need: |
|  | Time of Birth |  Need: |
|  | Specific Facility/Address of Birth |  Need: |
|  | Child’s Medical Record Number |  Need: |
|  | Birth Attendant Title |  Need: |
|  | Birth Attendant Address |  Need: |
|  | Birth Attendant Name |  Need: |
|  | Certifier Name |  Need: |
|  | Certifier Title |  Need: |
|  | Date Certifier Signed |  Need: |
|  | Mother’s Medical Record Number |  Need: |
|  | Mother’s Name |  Need: |
|  | Mother’s Maiden Name |  Need: |
|  | Mother’s Date of Birth |  Need: |
|  | Mother’s Age |  Need: |
|  | Mother’s State of Birth |  Need: |
|  | Mother’s Residence by Census Block |  Need: |
|  | Mother’s Residence by Census Tract\*Census tract information may be limited |  Need: |
|  | Mother’s Residence by Longitude / Latitude (Information may be limited) |  Need: |
|  | Mother’s Residence Street Address |  Need: |
|  | Mother’s Residence City |  Need: |
|  | Mother’s Residence County |  Need: |
|  | Mother’s Residence State |  Need: |
|  | Mother’s Residence Zip code |  Need: |
|  | Mother’s Marital Status |  Need: |

|  |  |  |
| --- | --- | --- |
| **Check to Request Element** | **Data Element** | **Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.** |
|  | Mother’s Race |  Need: |
|  | Mother’s Ancestry |  Need: |
|  | Mother’s Hispanic Ethnicity |  Need: |
|  | Mother’s Occupation |  Need: |
|  | Mother’s Industry |  Need: |
|  | Mother’s SSN |  Need: |
|  | Mother’s Education |  Need: |
|  | Father’s Name |  Need: |
|  | Father’s Date of Birth |  Need: |
|  | Father’s Age |  Need: |
|  | Father’s State of Birth |  Need: |
|  | Father’s Race |  Need: |
|  | Father’s Ancestry |  Need: |
|  | Father’s Hispanic Ethnicity |  Need: |
|  | Father’s Occupation |  Need: |
|  | Father’s Industry |  Need: |
|  | Father’s SSN |  Need: |
|  | Father’s Education |  Need: |
|  | Method of Payment for Delivery |  Need: |
|  | Number of Live Births Now Living |  Need: |
|  | Number of Live Births Now Dead |  Need: |
|  | Number of Previous Terminations |  Need: |
|  | Date Last Live Birth |  Need: |
|  | Date Last Termination |  Need: |
|  | Date Last Normal Menses |  Need: |
|  | Clinical Estimate of Gestation in Weeks |  Need: |
|  | Number of Prenatal Visits |  Need: |
|  | Child Birth Weight |  Need: |
|  | Birth Plurality |  Need: |
|  | Birth Order |  Need: |
|  | APGAR Score at Five Minutes |  Need: |
|  | Mother Transferred Prior to Birth |  Need: |
|  | Hospital Mother Transferred From |  Need: |
|  | Mother Transferred After to Birth |  Need: |
|  | Hospital Mother Transferred To |  Need: |
|  | Child Transferred After to Birth |  Need: |
|  | Hospital Child Transferred To |  Need: |
|  | Child Live at Time of Report |  Need: |
|  | Medical Risk Factors |  Need: |
|  | Tobacco Use |  Need: |

|  |  |  |
| --- | --- | --- |
| **Check to Request Element** | **Data Element** | **Where Indicated by “Need”, Provide Justification. Also supply any filtering or grouping for the element.** |
|  | Avg # of Cigarettes Smoked/Day 3rd Trimester |  Need: |
|  | Obstetric Procedures |  Need: |
|  | Complications of Labor and Delivery |  Need: |
|  | Method of Delivery |  Need: |
|  | Abnormal Conditions of the Newborn |  Need: |
|  | Congenital Anomalies of the Newborn |  Need: |
|  | Number of Previous Cesarean Deliveries |  Need: |
|  | Infant Being Breast Fed |  Need: |
|  | Years Mother Lived in Residence |  Need: |
|  | Mother’s Pre-pregnancy Weight |  Need: |
|  | Mother’s Weight at Delivery |  Need: |
|  | Mother Received WIC |  Need: |
|  | Mother’s Height |  Need: |
|  | Avg # of Cigarettes Smoked/Day 3 Months Before Pregnancy |  Need: |
|  | Avg # of Cigarettes Smoked/Day 1st Trimester |  Need: |
|  | Avg # of Cigarettes Smoked/Day 2nd Trimester |  Need: |
|  | Avg # of Cigarette Packs Smoked/Day 3rd Trimester |  Need: |
|  | Avg # of Cigarette Packs Smoked/Day 3 Months Before Pregnancy |  Need: |
|  | NB Avg # of Cigarette Packs Smoked/Day 1st Trimester |  Need: |
|  | Avg # of Cigarette Packs Smoked/Day 2nd Trimester |  Need: |
|  | Date First Prenatal Visit |  Need: |
|  | Date Last Prenatal Visit |  Need: |
|  | APGAR Score at Ten Minutes |  Need: |
|  | Onset of Labor |  Need: |
|  | Infections Present |  Need: |
|  | Characteristics of Labor/Delivery | Need: |