North-Central Regional Health Authority
ETHICS COMMITTEE

Data Request Form

Date Requested: ____ | ____ | ____
yyyy mm dd

Request Originated From: ______________________________

Reviewer/Contact Information:

Name: ______________________ Telephone: ______________________

Title: ______________________ Email: ______________________
i.e Senior Executive.

On Behalf Of: ______________________________

Department: ______________________________

Date Requested For: ____ | ____ | ____
yyyy mm dd

Used:

- ☐ Medical
- ☐ Administration
- ☐ Patient Care Program
- ☐ Education
- ☐ Quality Assurance
- ☐ Critical Inquiry

____
Supervisor's Signature For Critical Inquiry

Purpose/Study Name: ____

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Information Requested: ____

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Chart Pull Required: ☐ Yes ☐ No **Hospital:** ☐ ☐

Information On Charts Requested For: | |
yyyy mm dd

Total Number of Charts For Review: ________

Authorized By:

☐ GM Primary Care ☐ Departmental Head
☐ GM Nursing Services ☐ Medical Chief Of Staff
☐ Other ______________________________________

Ethical Approval: ☐ Yes ☐ No

I acknowledge that I have received and understand the note of "Special Instruction" provided to me.

Signature Of Recipient: ________________________________ **Date:** ____________

Special Instruction

Use

The recipient shall use the information only for the purpose as described on the Data Request Form.

Storage

1. Patient Names and Data collected are to be kept separate.
2. Key linking the data to the names is to be kept separate and under lock and key.
3. All data should be sequred within password protected files.

Destruction

When the study has been completed for the purpose stated above all Electronic, Original and Back up files should be deleted. Paper documentation containing personnel information must be destroyed by shredding.