



DANIEL STALEY  
*Director, Division of Public Health*

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*Chief Medical Examiner*

DATA REQUEST FORM		
Requestor:		
Title/Position:		
Agency/Organization/Affiliation:		
CONTACT INFORMATION		
Name/Title/Affiliation:		
Telephone Number:		Fax Number:
City:	State:	Zip Code:
Email Address:		
Signature of Requestor:		Date Signed:
DATA REQUESTED		
Timeframe/Year(s) Requested:		
Please provide a brief description of the purpose of this request and how the data will be used:		
If applicable, please provide a brief description of the research protocol and the title of the study:		
Provide a brief account of security measures, including the conditions under which the data will be used, stored, and disposed of and any other security precautions in place to ensure the confidentiality of the data:		
Does this request involve linking OCME data to other sources? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If yes, please state other sources:		

TIME FRAME FOR USE OF DATA					
Study Start Date		Study End Date		Date of Destruction	
FILE TYPE & FORMAT REQUESTED					
File Type (Check One)	<input type="checkbox"/> CD <input type="checkbox"/> SAS <input type="checkbox"/> Secure FTP <input type="checkbox"/> xls <input type="checkbox"/> Other	Other			
FIELDS REQUESTED					
Please list any specific fields requested (for example: age, sex, cause of death, manner of death, date of death, county of death, county of residence).					
FOR OCME USE ONLY					
OCME Staff: If you are completing this form, type your name and then initial and date the form after printing.		Name:		Initial & Date:	
		Alison Miller			
<b>DECISION</b> (Check One)	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Pending	Decision Date		If pending or denied, provide reason in the comments section below.	
Date Material Delivered		Date Material Destroyed			
COMMENTS					
Signature of Reviewer/Approver:				Date:	

Once you have completed this form, please email it to [ocme.data.request@dhhs.nc.gov](mailto:ocme.data.request@dhhs.nc.gov) or fax it to (919) 743-9099.

<b>CHIEF MEDICAL EXAMINER</b> Review & Initial:
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