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? ☐ Yes ☐ No ☐ 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)	☐ CD ☐ SAS ☐ Secure FTP ☐ xls ☐ Other	Other	

FIELDS REQUESTED

Please list any specific fields requested (for example: age, sex, 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	

DECISION (check one)	☐ Approved ☐ Denied ☐ 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** or fax it to (919) 743-9099.

CHIEF MEDICAL EXAMINER
Review & Initial:

Revised 04/18/2018