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| Seal | **REQUEST FOR DATA**State Form 55541 (R2 / 6-17) | **INDIANA STATE DEPARTMENT OF HEALTH****HEALTH AND HUMAN SERVICES****DIVISION OF TRAUMA AND INJURY PREVENTION**2 North Meridian Street, 2nd FloorIndianapolis, IN 46204Telephone: (317) 234-7321E-mail: kgatz@isdh.in.gov |

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| **Data Request Sent:*****(month, day, year)*** |       | **Proposed Request Deadline\*:*****(month, day, year)*** |       |
| ***\*NOTE:*** *Please see second page for processing times.* |
| **Requestor Information** |
| **Name**  |       | **Title and Organization** |       |
| **Telephone**  |       | **E-mail Address** |       |
| **Description of Data Request** |
| **Background****Information and/or Question**  |       |
| **Intended Audience** |       |
| **Data Set** | [ ]  Trauma Registry [ ]  Indiana Violent Death Recording System (INVDRS) [ ]  OptIN Registry |
| **Purpose of Request** |
|  | [ ]  Analysis or support for decision-making activities (i.e., policies, program changes) [ ]  Grant materials and evidence[ ]  Quarterly, semi-annual or annual report  | [ ]  Presentation[ ]  Research project [ ]  Sharing with outside entity [ ]  Other - *specify* |
| Please describe the purpose in detail:      |
| **Parameters for Data** |
| **Time Period** |       | **CY** = Calendar Year (e.g., CY14 = 01/01/14 – 12/31/14)**SFY** = State Fiscal Year (e.g., SFY14 = 07/01/13 – 06/30/14)**FFY** = Federal Fiscal Year (e.g., FFY14 = 10/01/13 – 09/30/14) |
| **Geography** |       | Statewide (aggregate), by County, OTHER |
| Specific Demographics |       | Age, Sex, Race, Ethnicity, Other |
| Procedure/Diagnosis Codes |       | List ICD codes as appropriate |
| OTHER NOTES |       |

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| **FOR TRAUMA SERVICES USE ONLY:** |
|  Date request received *(month, day, year)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed *(month, day, year)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Total time used: \_\_\_\_\_\_ Date information given to requestor *(month, day, year)*: \_\_\_\_\_\_\_\_\_\_\_ | Trauma Program Manager Determination: [ ]  Approved [ ]  Approved with conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Deny release of information / data\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Trauma Program Manager Signature and Date *(month, day, year)* |

Thank you for submitting your request. Our goal is to send data requests within five (5) days for aggregate requests and seven (7) days for identifiable requests from the time your request is received and processed. Please note that identifiable requests will be reviewed by the Data Release Committee, which meets every two (2) weeks. If you have any questions, please e-mail or call.

Signature of Data requester:

Submit to: Director, ISDH Division of Trauma & Injury Prevention

 indianatrauma@isdh.in.gov, 317-234-2865

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Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total time used: \_\_\_Insert drop-down box with hours\_\_

Date information given to requestor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Reviewed and approved by Privacy officer (if deemed necessary by Trauma Program Manager): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma Program Manager Determination:

* Approved
* Approved with conditions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Needs review and approval of Privacy Officer
* Deny release of information/data

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