DATA USE APPLICATION
SYNDROMIC SURVEILLANCE

Date of Application	Title of Project

Principal Investigator - Name and Title

Name of Organization/Affiliation

Address of Organization/Affiliation

Email	Phone Number (Include area code)

Co-Principal Investigator (if applicable) - Name and Title

Name of Organization/Affiliation

Address of Organization/Affiliation

Email	Phone Number (Include area code)

DATA REQUEST CRITERIA

Instructions:

Answer every question (use N/A as needed) and request only the minimum amount of information needed to complete your study. If you are a student, you **must** add your academic advisor as a co-investigator. Responses requesting all data fields will be returned for a specific description of the data fields required. Attach and label all documentation requested, including any consent forms, questionnaires, Institutional Review Board (IRB) approvals, etc.

Abstract: Provide an abstract or brief summary of your study (maximum of 300 words):

Purpose: What is the data recipient's purpose for, and specified use of the data? Describe why these data are requested, (for example, research, statistics, public health practice, health care operations.)

Use of Data: Describe how the data will be used and disclosed, or incorporate by reference and attach a copy of the research protocol, work plan, or request letter that details the purpose and use of the data, etc.

Data Requested:
a. Itemize and describe the variables requested, specifying all specific data elements (for example, birth date, gender, geographic area(s), disease, symptoms, treatment, vaccine types) and time periods (for example, January 1, 2015 through December 31, 2017).

b. Specify the medium requested (for example, electronic, hard copy). If electronic, specify acceptable file format(s).

Other Data Sources: List any other data sets that will be used for your study (for example, birth records, immunization records, program participant or treatment data).

Time Line:

a. Intended start date _____

b. Intended completion date _____

Access to Data: Specify all individuals who will have access to the data. Please list names, organization, title, and reason for access to the data.

IRB Approval: Does this project have a current approval from an IRB? If so, provide complete documentation of application and approval. ☐ Yes ☐ No

If no, indicate why IRB review was not sought or was not required. If exempt, provide documentation of this decision.

Security and Storage: How will you store and secure paper and electronic copies of the Department's confidential data? What security protection mechanisms and data access restrictions will you implement to ensure the data will not be re-released or accessed by unauthorized individuals?

What mechanism do you have in place to notify the Department if a breach occurs?

Study Personnel: Name all individuals for whom you will be requesting authorization to access Department confidential data, including all personnel, subcontractors and affiliated agencies. List only the minimum necessary number of individuals who must have access in order to complete the study. Anyone serving in an advisory capacity that will see aggregate data without cell size suppression must also be listed; indicate differing levels of access.

Levels of access:
Full access: Access to all data provided by DPH or collected for the study
Analytic files: Access only to analytic files without direct identifiers
Aggregate confidential data: Access to only aggregate data without cell size suppression

Attach additional sheet if needed.

Name	Title	Role	Level of access	Institution	Phone number

Study Results
How do you intend to disseminate the results of this project (for example, publication in professional journal, poster presentation, newsletter, web page)? **Note:** Review by the Department is required prior to submission for publication.
What will be the lowest geographic level of data analysis that will be released for publication or presentation (for example, state level, city/town level, ZIP Code level)?

Will maps be presented? ☐ Yes ☐ No If yes, what methods will be used to ensure that individuals cannot be identified?

Study Completion: Do you expect to maintain Department data beyond the completion of the study? If yes, how and for how long will the data be stored?

When will direct identifiers (if any) be destroyed?

Describe how you plan to destroy the Department's data at the end of the study and what method(s) you will use to ensure that all electronic and paper copies are destroyed or returned.

Return complete documentation to dhssyndromicsurveillance@wi.gov.