Memorial HEALTH

Research Proposal Information Request Form
Date of Request: _____

Please Print Legibly

1. Name: _____ Date: _____

   Telephone: _____ E-Mail: _____

2. Request Authorized by: ☐ Mentor ☐ Research Director ☐ Program Director

   Signature _____ Date _____

3. Type of Request:

   A. ☐ Aggregate data for research proposal development
   B. ☐ IRB approved study data request (IRB letter attached)

4. Data requested:

   CPT Codes: ICD9 Codes:

   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

   Other data requested:
   ☐ Demographics: Gender, Ethnicity, Age
   ☐ Time frame: mm/year
   ☐ From: _____ to _____
   ☐ Other: (List)

   _____
   _____

Date Request Completed/Sent: _____

Send request form to: Sandra Williams, Health Information Services or via e-mail, willisa1@memorialhealth.com or s.williams@coniferhealth.com. Telephone number: (912) 350-8673