REQUEST FOR DATA

State Form 55541 (R / 1-17)

INDIANA STATE DEPARTMENT OF HEALTH
HEALTH AND HUMAN SERVICES
DIVISION OF TRAUMA AND INJURY
PREVENTION 2 North Meridian Street, 6th Floor
Indianapolis, IN 46204
Telephone: (317) 234-7321
E-mail: kgatz@isdh.in.gov

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)

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		

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