IOWA | Health and Human Services

Bureau of Emergency Medical and Trauma Services
Data Request Form

Requestor Contact Information

Name:	
Email:	
Phone:	
Preferred Contact: Email: ☐	Phone: ☐ Other:
Position:	
Organization:	

Project Information:

Provide an overview of your intended use for the requested information. This overview should provide justification for why each variable requested is needed.

Data Request Information

Select the dataset(s), date range, and geographic area(s) for the request.

EMS Patient Registry: ☐	
Iowa Trauma Registry: ☐	
Date Range From:	To:
Geographic Area: Statewide: ☐	Other (Specify):

List the variables that you are requesting for each dataset:

EMS Patient Registry Data Dictionary Link

Iowa Trauma Registry Data Dictionary Link

Identify any other important parameters related to the data being requested. (For example: request is only for aggregate data, a specific age range, a specific diagnosis (ICD codes), a specific gender, etc.)

Will you link HHS data to any other data? (NOTE: Using data from any other source for comparison purposes, creating linked databases (including geocoding data), or adding Iowa HHS data to an existing study dataset are examples of linking data.)

Yes:		No:	

If linkage to other data is intended, list the datasets you plan to link and the purpose of this linkage.

Will these data be shared outside of your organization?

Yes:		No:	

If yes, explain how these data will be shared and/or who will have access to these data.

Please provide any additional information or clarifications you believe may be helpful for Iowa HHS staff to complete the data request.

For Internal Use Only

Date Request Received:
External Communication Dates:
Does the Data Request Require a Data Sharing Agreement: Yes: ☐ No: ☐
Does the Data Request Include Personally Identifiable Information: Yes: ☐ No: ☐
Does the Data Request Follow the Iowa HHS Disclosure of Confidential Public Health Information, Records, or Data Policy: Yes: ☐ No: ☐
Does the Data Request Comply with the Bureau of Emergency Medical and Trauma Services Data Release SOP: Yes: ☐ No: ☐
Additional Input from Compliance Needed: Yes: ☐ No: ☐
Compliance Communication Dates:
Data Request Fulfilled On:

Please return this form to: iowahhsbemts@hhs.iowa.gov