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| **EMTS Data Request Type Worksheet** |
| **State of NH, Department of Safety**  **Emergency Medical and Trauma Services (EMTS) Data Request Type Worksheet** |

Complete all application fields electronically. This will assist the Division in determining what type of request you have and what forms will be needed to gather further detail about your request. All information provided will be used by the EMTS Records Privacy Committee to approve or deny release of data.

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| **Section 1: Application Dates and Title** | | | | | | |
| **Project Name:** | Click here to enter text. | | | | | |
| **Application Date:** | Click here to enter a date. | | **Desired Date to Receive Data:** | | | Click here to enter a date. |
| **Date Reviewed:** | Click here to enter a date. | | **Internal Use:** | Click here to enter text. | | |
| **Section 2: Requestor and Contact Information** | | | | | | |
| **Requestor Name:** | Click here to enter text. | | | | **Title:** | Click here to enter text. |
| **Email:** | Click here to enter text. | | | | **Phone:** | Click here to enter text. |
| **Address:** | Click here to enter text. | | | | | |
| **Organization:** | Click here to enter text. | | | | | |
| **Section 4: Request Type** | | | | | | |
| **Check the box next to any data element your project requires in the table below.** (Check all appropriate boxes):   * You are not limited to requesting only these data elements or required to use any of them. * This will help us determine the type of request you are making and whether further request forms and detail are required. | | | | | | |
| **De-Identified Data** | | **Identifiable Data Fields** | | | | |
| Age (Min. 5-Year Grouping) | | Home City | | Patient Names | | |
| Incident Year | | Home County | | Relative or Guardian Names | | |
| Zip Code(s) (First 3-digits only) | | Home Zip Code (5-digits) | | EMS Crew Names | | |
| State | | Incident City | | Home Street Address | | |
|  | | Incident County | | Incident Street Address | | |
|  | | Incident Zip Code (5-digits) | | Telephone Numbers | | |
|  | | Patient Date-of-Birth | | Any Incident Number | | |
|  | | Patient Age | | Insurance Information | | |
|  | | Incident Date/Time | | Any other unique identifying number, characteristic or code | | |
| **Section 5: Summary of Request** | | | | | | |
| **Provide a *brief* summary of the purpose and overall goal of your request and a general description of the data you are requesting.** *Please limit your summary to the box below, we just need a general idea to get started.* | | | | | | |
| Click here to enter text. | | | | | | |