**APPLICANT INFORMATION**

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| *Principal Investigator Name & Title: {First M. Last, title(s)}*       | *Date of Request:*      |
| *Agency/Institution Name:*        |
| *Mailing Address, City, State, Zip:*       |
| *Email:*      | *Telephone:*      | Ext       |

1. **PROJECT TITLE**

*Summarize the purpose of your study and its benefits to public health.*

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1. **DURATION OF PROJECT**

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| *Intended Start Date:*       | *Intended Stop Date:*       |

1. **PROJECT DESCRIPTION OVERVIEW**

*What is your project’s objective? Include any question(s) your project is seeking to answer.*

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*What is the methodology for the project?*

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*What demographics will be used for this project (e.g. age groups, sex, race, etc.)?*

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*Do you intend to disseminate the results of this project (e.g. publication in a professional journal, poster presentation, newsletter, web page, etc.)? [ ]  No [ ]  Yes*

If **yes**, *please describe how you plan to disseminate the results.*

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*What is the lowest geographical level of analysis of data that is anticipated for publication or presentation (e.g. state level, county, city/town level, zip code level, etc.)?*

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*Will maps be presented?* *[ ]  No* *[ ]  Yes*

*If* ***yes****, what will be displayed?*

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1. **DHSS DATA**

*Indicate all datasets and which years you are requesting.* ***Refer to the*** [***Fee Schedule***](https://health.mo.gov/data/pdf/feeschedule.pdf) ***for associated fees.***

√ Data Set Requested: Years Requested: Breakout By:

[ ]  Behavioral Risk Factor Surveillance System (BRFSS) (     )

[ ]  Communicable Disease (     )

[ ]  County Level Study (CLS) (     )

[ ]  HIV/AIDS (     )

[ ]  Missouri Violent Death Reporting System (MoVDRS) (     )

[ ]  Patient Abstract System (ASC/ED/Inpatient/Outpatient) (     )

[ ]  Pregnancy-Associated Mortality Review (PAMR) (     )

[ ]  Pregnancy Risk Assessment and Monitoring System (PRAMS) (     )

[ ]  Sexually Transmitted Diseases (STDs) (     )

[ ]  ShowMeVax (     )

[ ]  Syndromic Surveillance (ESSENCE) (     )

[ ]  Vital Statistics (Birth/Death/Fetal Death/Marriage/Divorce) (     )

[ ]  Youth Risk Behavior Surveillance System (YRBS) (     )

[ ]  Other, please **specify**  (     )

***Please be advised data with small cell counts will not be released without suppression. Cutoffs may vary based on the sensitivity/detail of the data requested. Counts of less than 5 will not be released.***

*Indicate which geographical region or location should be included in the requested records.*

[ ]  Statewide

[ ]  Region(s), please specify:

[ ]  County(ies), please specify:

[ ]  City(ies), please specify:

[ ]  Zip Code(s), please specify:

[ ]  Census Tract

*Indicate data file specifications (e.g. format type, method of delivery, etc.):*

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1. **PROJECT PERSONNEL**

*Below please list the names, titles, and Institutions of others involved in the project who will have access to the DHSS provided data.*

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| **Name** | **Title(s)** | **Agency/Institution** |
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1. **ADDITIONAL COMMENTS**

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| **FOR DHSS USE ONLY:**  |
| Assigned Unit | [ ]  BDMI | [ ]  OOE | [ ]  BHCADD |
| Data Steward Signature/Date | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Staff Assigned To Fill Request | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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**COMPLETED FORMS SHOULD BE SUBMITTED TO THE CONTACT DESIGNATED ON THE** [**CONTACT US**](https://health.mo.gov/data/pdf/survcontactus.pdf) **PAGE FOR THE SYSTEM YOU ARE REQUESTING DATA**