



OVS #

# Application for Use of Vital Statistics Data

## Section A: Administrative Information

### APPLICATION/STUDY TITLE:

#### Primary Contact for this Application

Full Name: \_\_\_\_\_ DOHMH Employee  
 No  Yes  
*Last* *First*

Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *State* *ZIP Code*

Office Phone: \_\_\_\_\_ Email: \_\_\_\_\_

#### Principal Investigator

Full Name: \_\_\_\_\_ DOHMH Employee  
 No  Yes  
*Last* *First*

Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *State* *ZIP Code*

Office Phone: \_\_\_\_\_ Email: \_\_\_\_\_

#### Co-Principal Investigator

Full Name: \_\_\_\_\_ DOHMH Employee  
 No  Yes  
*Last* *First*

Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address* *Apartment/Unit #*

\_\_\_\_\_ *City* *State* *ZIP Code*

Office Phone: \_\_\_\_\_ Email: \_\_\_\_\_



## Section B: General Study Information

### 1. Study Type/Data Use(s) Check all that apply.

- |  |   |
|--|---|
| <input type="checkbox"/> Ecological            | <input type="checkbox"/> Case-Control   |
| <input type="checkbox"/> Clinical Trial        | <input type="checkbox"/> Cohort   |
| <input type="checkbox"/> Administrative/Legal* | <input type="checkbox"/> Surveillance/Intervention*                               |
|  | <input type="checkbox"/> Other Specify: <a href="#">Click here to enter text.</a> |

### 2. List the reporting requirement, regulation, policy or law that provides the authority to conduct this project. (if applicable; be specific as to exact section of policy or health code and/or provide text)

Indicate how the reporting requirement, regulation, policy or law supports your proposed data use:

### 3. Funding: Is your project sponsored by an external source of funding?

- No
- Yes, please provide the full name of the funding source, grant or contract:
- Funding Source 1
- Funding Source 2
- Funding Source 3

\*Data preparation requiring two or more hours of DOHMH personnel necessitate remuneration. Do you have funding to cover potential costs?

- No  Yes

### 4. IRB Requirement:

Does your project involve any direct (e.g., phone contact or personal interview) or indirect (e.g., review of medical or other individual records) contact with a living person (e.g., next of kin, certificate informants, physicians, or other individuals)?

- No Skip to question #4
- Yes **If Yes, please describe:**

(300 character maximum)

Has your project received IRB determination(s)?

No

Yes *Please attach copy of current determination letters.*

IRB Name(s) and contact (address and telephone number):

Date(s) of IRB Determination and Expiration:

Indicate IRB Determination (e.g., approval, exemption from IRB oversight, etc. with corresponding Code of Federal Regulations (CFR) reference, if available:

*For study modifications affecting vital data and/or multi-year projects that require Vital Statistics data not yet available at the time of this application, IRB determination letter updates will be required.*

## **5. Data Matching/Linkage**

Will you be requesting the vital data to be matched or linked to existing records?

No

Yes, *In addition to the remainder of this application, please complete Section F.*

*NYC Vital Records must be linked/matched by DOHMH  
Arrangements to conduct matches on the premises are permissible and fees may apply*

## Section C: Data Request

### 1. Paper certificates/pdfs and/or Electronic datasets

Are you requesting paper copies of vital event certificates? Note, almost all data elements found on the paper copy vital event certificates may be provided electronically.

No

Yes, indicates your acknowledgement that there is a \$15 fee for certified copies or images of certificates (regardless of redaction criteria). Applicants will be invoiced at the time the certified copies/images are delivered,

If yes, why are paper copies needed?

### 2. Vital Data Type/Years

Check vital data type and years needed to conduct this project.

Vital Data Type	Years/Dates Needed
<input type="checkbox"/> Birth	
<input type="checkbox"/> Death <small>If you are requesting Date of Death <i>only</i> or Date and Cause of Death <i>only</i> since 1979 for select individuals, please obtain these data from the National Death Index (See Application Instructions for contact information).</small>	
<input type="checkbox"/> Matched births to infant deaths (Composite)	
<input type="checkbox"/> Spontaneous Termination of Pregnancy	
<input type="checkbox"/> Other (Describe)	

### 3. What data elements are you asking for? Please provide justification for *individually identifiable data*\*. (If fewer than 15 data elements, please list here):

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\*See IDA Instructions: What is individually identifiable information

If your list(s) of data element is longer or you wish to see copies of data elements potentially available, please contact [VSdata@health.nyc.gov](mailto:VSdata@health.nyc.gov) to obtain the following forms: **Births Data Element List** and/or **Death Data Element List**, as applicable to indicate *all* data elements required in the *final data product(s)* disclosed to you. Please provide justification for the individually identifiable data elements included in your final data product.

If identifiers are needed for matching/linkage purposes, but will not be included in your final data product, do not list them here. Use Application Section F for Matching/Linkage information. Please explain intended use for each data element.

The DOHMH is permitted to “impose reasonable conditions as to the use and re-disclosure of information (data)” and “may limit access to the minimum necessary (data elements) to fulfill the purpose for which information is requested.” (New York City Health Code §207.11).

Vital statistics information collected by the Health Department has remained relatively constant overtime. However, specific variables have been added or deleted over time and file layouts have changed. Line item data can be drawn from electronic data files starting in 1978. If you need data elements not found in these listings, please contact **[vsdata@health.nyc.gov](mailto:vsdata@health.nyc.gov)**.

If you need either Date of Death *only* or Date and Cause of Death *only* since 1979 for select individuals, contact the National Death Index (See Application Instructions for contact information).

**4. Time period you intend to maintain and use the data?**

Please enter period of time using dates or # of years/months/days from data delivery or briefly explain

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Please note, modifications to the protocol or variables needed may require a new application, amendments to a Data Use Agreement and/or IRB determination updates. Please contact **[VSdata@health.nyc.gov](mailto:VSdata@health.nyc.gov)** with questions.

## Section D: Data Security and Confidentiality

### 1. Data Storage/Location/Security

All identifiable data provided by (with) OVS (data) must be stored and accessed only in areas approved by OVS and by persons authorized via corresponding Data Use Agreement, if applicable. Indicate name(s) and address(es) of the organization(s) and their role(s), including the physical addresses of storage and/or data access location(s). *You must notify OVS if your response to this item changes at any time during your project.*

List each organization where data will reside and describe the organization's role and security measures that will be undertaken i.e. how such data will be transferred and stored.

Organization Name and Address and name of authorized individual who will bind organization for accountability.	Role in Project and facility-specific data security transfer/storage methods

### 2. Organization policy concerning data privacy and security

For each organization, describe organizational policies addressing data privacy and security that will also apply to the DOHMH identifiable data obtained from OVS for this project. How will data be stored and what security measures you will take to ensure its confidentiality. (Please attach additional pages if needed).

### 3. Data Breach History

For each organization, indicate whether the organization ever experienced a data breach? (This includes the loss and/or theft of a mobile device). (Please attach additional pages if needed).

No,       Yes

If yes, please briefly summarize the nature of the breach/breaches.

4. **Organization Security Assessment**

For each organization, please attach a recent Security Assessment report such as the SSAE-16, SYSTRUST, or other industry recognized audit report.

Attached

We do not have such an audit report.

5. **Data Destruction**

How and when do you plan to destroy the identifiable data obtained from DOHMH for this project? What is your plan for purging confidential/sensitive data sets from backup archives as well as active storage?

## Section E: Project Protocol and Objectives

**NOTE:** The information provided below should be self-contained and serve as an independent description of the project.

1. **Primary focus:** The primary project focus, including specific health or medical problems addressed. (1000 character maximum)

2. **Objectives:** How the requested data will be used and, if applicable, a description of hypotheses to be tested. (1000 character maximum)

### Data Needed for Protocol

Section C: Data Request - list analytic vital data you are requesting.

Section F: complete ONLY if your project requires either matching or linkage of databases to NYC vital data.

3. **Analyses:** Analyses to be performed; specify use of vital data in analyses. (1000 character maximum)

4. **Expected and/or planned release of results:** Planned release of results, including interim and final reports and publications (when, how, to whom). *(500 character maximum)*

5. **Potential benefits:** Potential benefits include benefits to project subjects or to the population in general. *(500 character maximum)*