

**MONTANA CENTRAL TUMOR REGISTRY DATA USE for RESEARCH
APPLICATION**

Date _____

Principle Investigator _____

Affiliation _____

Address _____

Telephone: _____ E-mail _____

Primary Contact (if different from PI) _____

Title of Project _____

If Investigator is a graduate student, name of Graduate Chair _____

Instructions: Please provide a complete answer to the following statements. Attach supporting documents as necessary to the application.

1. Brief summary of project (Research Proposal): *Please attach copy of your study protocol (or selected sections) including the following information:*
 - a) State the specific health or medical problems addressed, or other conditions or concerns of the study.
 - b) State the objectives or hypothesis to be tested, if any.
 - c) Analyses to be performed, indicating specifically how data obtained from the Montana Central Tumor Registry will be used.

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2. Protocols that include a request for confidential level data must be approved by a Committee for Protection for Human Research Subjects Institutional Review Board (IRB) established in accordance with 45 C.F.R. 46. Please indicate whether or not this proposal has already been approved by an IRB.

_____ Yes, if your proposal has been approved by an IRB, please attach a copy of the approval.

_____ No

3. Protocols that include a request for case matching, linking to external data sets, or patient contact from data provided by the MCTR requires explicit informed consent from the patients in the study. Please provide a copy of the Informed Consent Document. Please describe how you will provide documentation to the MCTR that each living participant has provided informed consent. Please also describe how you will provide documentation that legally authorized next-of-kin have provided consent for deceased individuals.

4. Please provide a list of the specific data items you are requesting from the Montana Central Tumor Registry along with justification of the need for confidential level data:

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10. Describe the form of the final report or other product(s) of this project and list the people or entities who will receive copies, whether paper or electronic. Copies must be furnished to the Montana Central Tumor Registry upon request.

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I attest that the information in this Data Use for Research Application and attachments are true and complete.

Name (type or print): _____

Signature: _____

Title: _____

Affiliation: _____

If investigator is a graduate student,

Name (type or print) of chair of graduate committee: _____

Signature of chair of graduate committee: _____

Title: _____

Affiliation: _____

Address: _____

Phone: _____ **e-mail:** _____

Return completed application to:

Email: lwilliamson@mt.gov

or

Mail:

Laura L. Williamson, MPH
MT Central Tumor Registry, DPPHS
PO Box 202951
Helena, MT 59620-2951