**WATERLOO-WELLINGTON RESEARCH ETHICS BOARD (WWREB)**

**Formerly known as Tri-Hospital Research Ethics Board (THREB)**

**APPLICATION FOR RETROSPECTIVE REVIEW OF PERSONAL HEALTH INFORMATION**

**INSTRUCTIONS & GUIDELINES**

*When to use this form?*

*Retrospective review pertains to records that exist at this time. Please use this form ONLY if you plan to conduct research that involves a retrospective review of medical records and if you will NOT collect ongoing or other any other information FROM OR ABOUT the patient. This form is meant to capture the necessary elements of the research plan for this project. If you are proposing to contact patients for consent or for any other purpose, please use the standard “Application Form” instead.*

*Is this Quality Assurance or Research?*

*Research involves a systematic investigation to establish facts, principles or generalizable knowledge. Research requiring ethics review according to the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (Article 1.1) includes all research involving living human subjects, as well as research involving human remains, cadavers, tissues, biological fluids, embryos or fetuses.*

*Quality assurance studies are considered to be internal studies related directly to assessing the performance of the institution or its employees or students within the mandate of the institution. Whenever there is any doubt as to whether a particular study is research or not, the opinion of the Waterloo-Wellington Research Ethics Board (WWREB) should be sought.*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | *When do I use* *this form?* |  |  |  |
|  |  |  |  |
|  |  | *▼* |  |  |  | *▼* |  |  |
|  | *IF RESEARCH, does it involve contacting patients?* |  |  *IF QUALITY ASSURANCE…* |  |
|  | *▼* | *▼* |  |  |  |
|  |  | *YES* |  | *NO* |  |  |  |  |  |
| *▼* |  | *▼* |  |  | *▼* |  |
| *If YES…complete “Application for REB Review” form* |  | *If NO...complete “Application for Retrospective Review”* |  | *…contact Health Information or Health Records directly*  |
|  |  |  |  |  |

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| *Is this Quality Assurance?* | *True / False?* |
| * *The study involves the systematic monitoring, assessment or evaluation of the various aspects of an organization (e.g., a service, program, project or facility of the organization, or performance of its employees or students within the mandate of the organization or according to the terms of employment or training) to ensure that standards of quality are being met, or to correct or enhance the various aspects of the organization and does not seek to establish generalizable knowledge.*
 |  |

*If you answered True to the above statement, there is no need to submit an application to WWREB. Contact Health Records or Health Information directly (see below for contact information) and use their application form. If, however, your retrospective review of records is research, this application form will serve also for Health Information or Health Records. When in doubt contact the WWREB Office.*

*Do I need to get patient consent?*

*Federal and provincial privacy regulations require that all individuals provide informed consent and authorization for the use of their personal health information [For Ontario: Personal Health Information Protection Act (PHIPA - Nov. 1, 2004)]. The provisions of the regulations cannot be waived unless the following criteria are met: (a) the research purposes cannot be achieved without the information; (b) it is impracticable to obtain consent; (c) the information is used in a manner that will ensure its confidentiality; and (d) the public interest in conducting the research exceeds the public interest in protecting the privacy of the individuals. A Research Ethics Board is allowed to waive the requirement for subject consent and authorization if these criteria are met. The WWREB will review this application and determine whether consent is required. However, it is the responsibility of the applicant to provide the justification for waiver of consent.*

*Personal Identifiers*

**Investigators should plan to collect personal data at the lowest level of identifiability necessary to achieve the study objectives.**

The use of personal health information for research is regulated in Ontario by the Personal Health Information Protection Act (PHIPA):

 <http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm>.

The act defines personal health information and for research on personal health information it requires review by a research ethics board and provides some criteria on which the REB should base its decisions.

For further information, consult the “Guidelines for Protecting Privacy and Confidentiality in the Design, Conduct and Evaluation of Health Research: Best Practices” from the Canadian Institutes of Health Research: <http://www.cihr-irsc.gc.ca/e/29072.html>

***Approval Process***

1. For applications involving **Grand River Hospital**, Administrative Approval of this research must be obtained prior to submission to WWREB for ethics review. For information on administrative requirements, contact: Sarah Laferriere at (519) 749-4300 x2876 or email at sarah.laferriere@grhosp.on.ca or research@grhosp.on.ca

2. For applications involving **Cambridge** **Memorial Hospital and St. Mary's General Hospital**, applications are submitted directly to WWREB. Following review and approval by WWREB, the application form will be sent to the appropriate Health Information Manager(s) for further review and final approval.

3. For all three hospitals, once approval by administration (GRH) or the Health Information Manager(s) (CMH, SMGH) is received by WWREB, along with WWREB approval, the final notice of approval will be sent to the investigator.

**E-Mail completed research applications to:** WWREB Administrative Coordinator, wwreb@grhosp.on.ca

**Contacts for Health Information/Health Records:**

|  |  |
| --- | --- |
| **Cambridge Memorial Hospital:** Stephanie PearsallVice President Clinical ProgramsTel. 519-621-2333 ext. 2416Email:spearsall@cmh.org | St. Mary’s General Hospital:Nicole JohnsonManager, Quality, Risk & SafetyChief Privacy Officer Tel: 519- 749-6578 ext 1209Email: njohnson@smgh.ca |
| Grand River Hospital: Hospital RecordsAdministration Manager – Health Information ManagementTel: 519-749-4300 ext. 6757 | Grand River Hospital: Cancer Centre RecordsCarla GirolamettoDirector, Research & InnovationTel: 519-749-4300 x2307Email: Carla.girolametto@grhosp.on.ca  |

**WATERLOO-WELLINGTON RESEARCH ETHICS BOARD**

**(formerly known as THREB)**

**APPLICATION FOR RETROSPECTIVE REVIEW OF PERSONAL HEALTH INFORMATION**

**INSTRUCTIONS**

1. Please email completed form to: WWREB Administrative Coordinator, wwreb@grhosp.on.ca.
2. Handwritten applications will not be accepted; please submit as a MS Word document.
3. All applicable requested information must be provided within the application form itself.
4. If a question is considered “not applicable” to the study, state that.

*Incomplete applications will be returned.*

|  |
| --- |
| *For WWREB Office Use Only***DATE Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WWREB # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

1. **FULL TITLE OF RESEARCH PROJECT (Include Version #, Study Code and Protocol date if applicable)**

Click here to enter text.

**2. RESEARCH TEAM**

1. **Local Responsible Investigator**

**Name:** Click here to enter text.

**Hospital Program:** Click here to enter text.

**University Affiliation & Dept:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone:** Click here to enter text.

**Fax:** Click here to enter text.

1. **Principle Investigator if other than above**

**Name:** Click here to enter text.

**Hospital or Institution Affiliation:** Click here to enter text.

**University Affiliation & Dept:** Click here to enter text.

**Corporate Affiliation:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone:** Click here to enter text.

**Fax:** Click here to enter text.

1. **Co-Investigator(s)**

**Name:** Click here to enter text.

**Hospital or Institution Affiliation:** Click here to enter text.

**University Affiliation & Dept:** Click here to enter text.

**Corporate Affiliation:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone:** Click here to enter text.

**Fax:** Click here to enter text.

**Name:** Click here to enter text.

**Hospital or Institution Affiliation:** Click here to enter text.

**University Affiliation & Dept:** Click here to enter text.

**Corporate Affiliation:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone:** Click here to enter text.

**Fax:** Click here to enter text.

1. **Study Coordinator**

**Name:** Click here to enter text.

**Hospital Affiliation:** Click here to enter text.

**University Affiliation & Dept:** Click here to enter text.

**Corporate Affiliation:** Click here to enter text.

**Email:** Click here to enter text.

**Telephone:** Click here to enter text.

**Fax:** Click here to enter text.

 **e. Approval letter to be sent to the following person and address:**

Click or tap here to enter text.

 **f. Individual who will be reviewing/abstracting records**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Degree** | **Organization Affiliation** | **Profession** | **Precise Role on Project** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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**g. Additional individuals on the research team who will be given access to the collected data:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name/Degree** | **Organization Affiliation** | **Profession** | **Precise Role on Project** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |

**3**. **WHERE WILL THE STUDY BE CONDUCTED**? Identify specific hospital site.

*GRH – KWHC* [ ] yes [ ] no Service area: Click here to enter text.

*GRH – GRRCC* [ ] yes [ ] no Service area: Click here to enter text.

*SMGH* [ ] yes [ ] no Service area: Click here to enter text.

*CMH* [ ] yes [ ] no Service area: Click here to enter text.

*Other* Click here to enter text.

**5. IS THIS STUDY PART OF A STUDENT PROJECT OR THESIS?** [ ] **Yes** [ ] **No**

**6. FUNDING**

**(a) Status of Funding**

[ ] Industry Sponsored (private, for-profit organizations)

[ ] Applied - Date submitted (yyyy-mm-dd): Click here to enter a date.

 [ ] Funded - Date of decision (yyyy-mm-dd): Click here to enter a date.

 [ ] None

 [ ] In-Kind support

Specify contribution: Click here to enter text.

**(b) Name(s) of Research Sponsor/Funding Agency/Industry Partner (state full name):**

Click here to enter text.

**(c) Budget (attach budget summary)**

 **Global $** Click here to enter text.

 **Local $** Click here to enter text.

**(d) Will there be a signed contract/agreement with a study-related funding source?**

[ ] **Yes** [ ] **No**

**(e) Will the institution be named in the contract/agreement with the study-related funding source?** [ ] **Yes** [ ] **No**

**7.** **Expected start date** (yyyy-mm-dd)**:** Click here to enter a date.

 **Expected completion date** (yyyy-mm-dd) **:** Click here to enter a date.

**8a. Does this research involve institutions other than WWREB sites?** [ ] **Yes** [ ] **No**

**NOTE:** Research involving investigators from other universities or hospitals will need also to have been submitted for review to those organizations.

**8b. HAS THIS STUDY BEEN OR WILL IT BE REVIEWED BY ANOTHER RESEARCH ETHICS BOARD OR INSTITUTION?** [ ] **YES** [ ] **NO**

If YES, indicate [ **x** ] which of the following:

 [ ] University of Waterloo: [ ] Attached [ ] To follow

[ ] Wilfrid Laurier University [ ] Attached [ ] To follow

 [ ] McMaster University (HIREB) [ ] Attached [ ] To follow

 [ ] Guelph University [ ] Attached [ ] To follow

 [ ] London Health Sciences [ ] Attached [ ] To follow

 [ ] University Health Network (UHN) [ ] Attached [ ] To follow

 [ ] Sunnybrook [ ] Attached [ ] To follow

 [ ] Other Click here to enter text. [ ] Attached [ ] To follow

**SUMMARY OF PROPOSED RESEARCH**

**9.** **PURPOSE AND/OR RATIONALE:**  Summarize (**10 lines maximum):**

a) the main research question, b) what is being studied, and c) why the research is important.

Click here to enter text.

**10. HYPOTHESES/OBJECTIVES**: (must be filled out in entirety)

Click here to enter text.

**11**. **HOW WILL RELEVANT PATIENT RECORDS BE IDENTIFIED FOR INCLUSION IN THE STUDY (e.g inclusion/exclusion criteria, Decision Support query, office case list, etc):**

Click here to enter text.

**12. HISTORICAL TIME PERIOD DATA TO BE ABSTRACTED**

Start Date (yyyy-mm-dd): Click or tap to enter a date.

End Date (yyyy-mm-dd): Click or tap to enter a date.

**13. HOW MANY PATIENT RECORDS WILL BE REVIEWED**

Click or tap here to enter text.

**14.** **WHAT METHODS WERE USED TO CALCULATE SAMPLE SIZE?** (must be filled out in entirety)

Click here to enter text.

**15.** **DESCRIBE HOW THE DATA WILL BE ANALYZED (Statistically, or by whatever other means** (must be filled out in entirety)

Click here to enter text.

**16.** **BRIEFLY OUTLINE THE POTENTIAL BENEFITS OF YOUR RESEARCH:** Participants, hospital and/or broader community)

Click here to enter text.

**17.** **BRIEFLY OUTLINE THE POTENTIAL HARMS/RISK IF RESEARCHDATA WAS INAPPROPRIATELY RELEASED? HOW WILL YOU MANAGE THIS RISK:**

Click here to enter text.

**18. WHAT TYPE OF DATA DO YOU NEED**

 [ ]  Person level data (you need to view individual records) – Continue to question 19

[ ]  Aggregate (you do not need to view individual medical charts/health records) – Application is now complete, no further information is required

|  |
| --- |
| **FOR AGGREGATE DATA ONLY:****There is no further information required at this time if you require only aggregate data and no access to identifiable information.** 1. Sign here to verify that you will not be abstracting personally identifiable information from patient charts
2. Sign confidentiality agreement at end of application
3. Submit the application
 |
|  |  |  |
| **Local Responsible Investigator** |  | **Date** |

**19. WHAT INFORMATION SOURCES ARE BEING ACCESSED?**

[ ]  Paper Files (e.g.) Health Records/Clinic Charts/Office Files/Other

 Specify which: Click or tap here to enter text.

 [ ]  Electronic Files (e.g.) Database, EMR

 Specify which: Click or tap here to enter text.

 [ ]  Outside Institution

 Specify which: Click or tap here to enter text.

 [ ]  Other

 Specify which: Click or tap here to enter text.

**20. WAIVER OF CONSENT**

Provide justification for the waiver of informed consent for access of personal health information (see Instructions under “Do I need to get patient consent”)

Click here to enter text.

**21. SENSITIVE CONTENT**

Does the research raise sensitive issues (e.g. HIV status, mental health problems/diagnosis, subjects identifiable)?

 [ ]  No

 [ ]  Yes. If yes, justify not getting patient consent and specify additional safeguards for confidentiality

Click here to enter text.

**PROTECTION OF PERSONAL INFORMATION AND PERSONAL HEALTH INFORMATION**

Investigators must comply with the duties set out for researchers in the Ontario Personal Health Information Protection Act, 2004 (PHIPA).

**22. PERSONAL INFOMRATION AND/OR PERSONAL HEALTH INFORMATION:** List all personal information and personal health information, personal identifiers (e.g. name, DOB) required to be collected, and identify all potential sources of this information. For all non-clinical trials, attach data collection forms.

***NOTE:*** *Under Ontario privacy legislation, personal health information (PHI) includes identifying information about the health and health-related treatment of an individual. Identifying information can be both direct and indirect, meaning that it includes information that either identifies an individual or for which it is reasonably foreseeable in the circumstances that it could be utilized, either alone or with other information, to identify an individual. (For example, a coded data collection form is PHI as long as a key linking the coded data to an identified individual exists.)*

**a) Personal Information and Personal Health Information (identifiers)? (Please check all applicable):**

**Direct Identifiers: Indirect Identifiers:**

[ ] Full Name [ ] Initials

[ ] Address [ ] Full Date of Birth (day/month/year

[ ] Telephone Number [ ] Age at time of data collection or year of birth

[ ] Email [ ] Full Postal Code

[ ] OHIP# [ ] Partial Postal Code

[ ] Social Insurance Number [ ] Healthcare Provider

[ ] Medical Record Number [ ] Discharge Date

[ ] Full Face Photography [ ] Other Date (e.g. date of service)

[ ] Other Direct or Indirect Identifiers (please specify)

 Click or tap here to enter text.

Investigators should plan to collect personal data at the lowest level of identifiability necessary to achieve the study objectives. Even a dataset without direct identifiers may present a risk of indirectly identifying data subjects if the dataset contains sufficient information about the individuals concerned. For advice, consult the CIHR Best Practice Guidelines for Protecting Privacy and Confidentiality: <http://www.cihr-irsc.gc.ca/e/29072.html>

**b) If you are collecting any of the above identifiers, justify why they are required:**

Click here to enter text.

**23. DATA COLLECTION FORM (MANDATORY):**

 Attach to the application a data collection form and list below all data fields to be abstracted

Click or tap here to enter text.

**24. PARTICIPANT IDENTIFICATION:**

a) Will study participants will be identified on data collection forms and how (e.g. study number, initials).

Click here to enter text.

b) Will a study “key” be kept that links participant identity to the coded data collection forms? [ ] Yes [ ] No

c) If yes:

 Where will it be stored: Click or tap here to enter text.

 Who will have access: Click or tap here to enter text.

**25. DATA STORAGE:** How will data be stored?

[ ] Computerized files (specify): [ ] Server [ ] Desktop [ ] Laptop [ ] Other device (e.g. USB key)

[ ] Hard copy

[ ] Other (e.g. PDA): Click here to enter text.

[ ] If a portable device is to be used, justify: Click here to enter text.

**26. SECURITY:**

**a) Indicate the steps to be taken to ensure security of data with personal identifiers. Please check all that apply.**

Procedural:

* Access to identified data will be limited study team members identified within [ ] Yes [ ] No

Sections 2 of this application

* There will be an audit trail of access to electronic records [ ] Yes [ ] No

Physical

* Storage location for paper study documents: Click here to enter text.
* Storage location of study computers: Click here to enter text.
* Other: Click here to enter text.

Technical

* Electronic files will be backed-up and stored in a separate location [ ] Yes [ ] No
* Electronic files will be stored on a computer which is password protected [ ] Yes [ ] No
* Electronic files will be stored in a computer file which is password protected [ ] Yes [ ] No
* Electronic files will be encrypted with a minimum 128 bit encryption protocol [ ] Yes [ ] No
* Data will be stored on a computer system with virus protection [ ] Yes [ ] No
* Data will be stored on a computer system with uninterrupted power source [ ] Yes [ ] No

**b) What are the possible harms/risks to patients if personal health information was inappropriately released and how will you manage the risks? (Describe briefly)**

Click here to enter text.

**27. TRANSFER OF INFORMATION:**

1. **Will any of the collected data be sent outside of the institution where it was collected?** [ ] YES [ ] NO

If “No”,go to Question 28.

1. **Why is it necessary to send data outside of the institution where it was collected?**

Click here to enter text.

1. **Where will data be sent?**

Click here to enter text.

1. **How will the data be sent?**

 [ ] Fax (Describe security at the receptor site) Click here to enter text.

 [ ] Private Courier (must be able to trace delivery)

 [ ] Canada Post – Xpresspost or Priority Courier (Regular mail may not be used.)

 [ ] Other (Please specify): Click here to enter text.

**e) Has a contract or Research Data Agreement or Data Transfer Agreement been approved by the “Data Custodian” (hospital)?**

 [ ] YES

 [ ] NOT REQUIRED

 [ ] IN PROCESS **(A finalized Agreement must be reached before research begins.)**

.

**28. LINKAGE:** Do you plan to link the locally collected data [ ] **YES** [ ] **NO**

with any other data set(s) *(e.g. OHIP data, census tract data)*?

**If YES,** a) identify the data set, b) justify why the linkage is necessary, c) explain how it will occur and d) provide a list of data items used:

Click here to enter text.

**29. ONGOING USE:** Will this data be entered into an ongoing electronic[ ] **YES**[ ] **NO**

database for future use in another research study? *(Please note: Any*

*secondary analysis must be approved by the REB prior to implementation.)*

**If YES,** specify where it will be stored, who will be the custodian (i.e. the person responsible for data storage and integrity), who will have access to it, and security measures:

Click here to enter text.

**30. STORAGE TIME:**

**a) How long do you plan to keep the data?** *(Please note: You are required to destroy identifiers [or links] at the earliest possible time.)*

Click here to enter text.

**b) Will data be:**

[ ] destroyed

[ ]  irreversibly anonymized *(i.e. the key identifying the link between data and the individual’s identity is deleted)*?

 **c) When will the following be destroyed?**

**Study Key (should be destroyed at the earliest possible time)** (yyyy-mm-dd)**:** Click or tap to enter a date.

**Collected data: Anonymized**(yyyy-mm-dd)**:**Click or tap to enter a date.

**Destroyed**(yyyy-mm-dd)**:** Click or tap to enter a date.

 **d) Additional comments or explanations**

Click or tap here to enter text.

**31. PRIVACY TUTORIAL:** Have all those who have access to personal health information completed a privacy tutorial acceptable to the hospitals/institutions?

**NOTE:** Those requiring access to personal health information must successfully complete a privacy tutorial acceptable to the institution(s) involved.

Grand River Privacy Tutorial: [ ] YES [ ] NO [ ] IN PROGRESS

McMaster tutorial: (<http://ethics.mcmaster.ca/chart/>) [ ] YES [ ] NO [ ] IN PROGRESS

Other: Click here to enter text. [ ] YES [ ] NO [ ] IN PROGRESS

**Confidentiality Agreement**

THE FOLLOWING REPRESENTS THE TERMS AND CONDITIONS UNDER WHICH THE HANDLING OF CONFIDENTIAL INFORMATION FOR THE PROJECT SHALL PROCEED. THESE TERMS AND CONDITIONS HAVE BEEN DRAFTED IN COMPLIANCE WITH THE *PERSONAL HEALTH INFORMATION PROTECTION ACT* AND OTHER PRIVACY LEGISLATION.

1. All information received or exchanged will be held in strict confidence.
2. Information will not be used for any purpose other than for the project for which it was provided. The information will be shared only with those individuals listed on this form, who are working directly on the project, except for authorized oversight of the study.
3. No attempt will be made to contact any individual to whom the information relates, directly or indirectly.
4. Information will be stored in a location that is physically and/or technically secure and to which access is given only to the individual(s) listed on this form.
5. All direct identifiers will be segregated/stripped from clinical data; a unique study identifier (i.e. a randomly generated or unique identifying number) will be assigned to each patient record; the Master list linking the ID with identifiable material will be stored in a separate computer file and/or physical location; the Master list will be locked, and password protected and encrypted if information is to be put on any portable device.
6. Data sent outside of the institution will require that the parties enter into an information transfer agreement before the data transfer takes place.
7. Policies and procedures on the retention and destruction of information must be in place by the party undertaking the project.
8. It is strongly recommended that members of the research team and any individual(s) listed below read the *Personal Health Information Protection Act*.
9. Publication of confidential information regarding the institution requires adherence to the following principles:
10. The institution agrees to allow the publication of the information as it pertains to the project providing that the institution or its practices are not the main focus of the publication.
11. In cases where the publication focuses on the institution, the institution reserves the right to review and approve the use of this information prior to publication.
12. The institution will be acknowledged within any publication as providing the source information.
13. A copy of the publication will be given to the institution.
14. Information that is lost or stolen must be reported to the Chief Privacy Officer of the appropriate institution at the first reasonable opportunity.
15. A breach of institutional policy regarding access to information and protection of privacy may have serious consequences or be just cause for termination of my employment and/or affiliation with the institution.

|  |  |
| --- | --- |
|  | Click here to enter a date. |
| Signature of Local Responsible Investigator | Date |

**Signatures of Research Team Member:**

By my signature, I acknowledge that I have read, understand, and agree to the confidentiality agreement of the Waterloo-Wellington Research Ethics Board as noted within this application document.

|  |  |  |
| --- | --- | --- |
| **Print Name** | **Signature** | **Date Signed** |
| Click or tap here to enter text. |  |  |
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| **For Health Records Research at** **Cambridge Memorial Hospital and St. Mary’s General Hospital** |

**WWREB Project #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 will be assigned by WWREB

Title: Click or tap here to enter text.

Local Responsible Investigator: Click or tap here to enter text.

|  |
| --- |
| The following section is for REB/Health Information/Health Records Use Only (when patient record source is Health Records of Health Information Department |

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | Requires further review by Research Ethics Board |  |  |
|  |  | WWREB Chair | Date |
| [ ]  | Approved by REB – forward to Manager Health Records/Health Information Management |  |  |
|  |  | WWREB Chair | Date |
|[ ]  Approved by Health Records/Health Information Management |  |  |
|  |  | Signature | Date |
|  |  |  |  |
|  |  | Name |  |

Comments:

|  |
| --- |
| FINAL APPROVAL: Following approval by WWREB, the application form with the signature of the Chair will be sent to the appropriate Manager for further review and final approval. Once approval is given by the Manager, a copy of the application form signed by both WWREB and Health Records/Information will be returned to WWREB to complete their records and WWREB will send out a final letter of approval. |

|  |
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| **For Health Records Research at** **Grand River Hospital** |

**Administrative Approval**

(approval must be sought from GRH Research Committee prior to sub mission of application to WWREB)

**WWREB Project #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 will be assigned by WWREB

**1. Local Responsible Investigator:** Click here to enter text.

**2. Principal Investigator** (if different from local): Click here to enter text.

**3. Project title** (max 400 characters)**:**

Click or tap here to enter text.

**4. Executive Summary**

 a. Research Question (max 350 characters):

Click or tap here to enter text.

b. Expected number of records to be accessed: Click here to enter text.

**5. Staff Involvement**

 [ ] Decision Support – Generation of patient list

 [ ] Decision Support – Report Generation

 [ ] Helpdesk – Network Access

 [ ] Health Information Management – Chart Pull

 [ ] Other: Click or tap here to enter text.

**6. Research Data Sharing Agreement**

 [ ] YES

 [ ] NOT REQUIRED

 [ ] IN PROCESS **(A finalized Agreement must be reached before research begins.)**

|  |
| --- |
| **7.** **Administrative Approval**I have reviewed the attached protocol and confirm that resource and contract issues at this institution have been or are being satisfactorily addressed and I give Administrative Approval for the WWREB review of this project. |
| **For GRH:**Carla Girolametto, Director Research & Innovation |  |  |
| Signature | Date |
|  |  |
| Print Name |  |

|  |
| --- |
| **FINAL APPROVAL:** Once administrative approval has been forwarded to WWREB, the application will be reviewed by WWREB, normally by delegated review. Once approved by WWREB, WWREB will send out a final letter of approval. |