**APPLICATION FOR AUTHORISATION TO USE DOCUMENTED PATIENT DATA IN RESEARCH WORK WITHIN THE STUDY PROCESS**

|  |
| --- |
| **INFORMATION ABOUT THE APPLICANT** |
| **Name, surname:** |  |
| **Student card No.:** |  |
| **Study year:** |  | **Faculty:** |  |
| **Group:** |  | **Study programme:** |  |
| **Phone No.:** |  | **E-mail:** | ***@rsu.edu.lv*** |

|  |
| --- |
| **INFORMATION ABOUT THE RESEARCH WORK:** |
| **Title of the Research Work** |
|  |
| **Aims and objectives of the Research Work** |
|  |
| **Topicality of the research topic** |
|  |
| **Medical documentation (for example, patient’s outpatient medical records, patient’s medical history) required for the Research Work and the expected number of documentation items** |
|  |
| **Categories of data to be studied (e.g. diagnosis of disease, cause of death)** |
|  |
| **Medical institutions from which it is intended to request the medical documentation necessary for the Research Work** |
|  |
| **Justification for the use of patient-identifiable data in the Research Work** |
|  |
| **Justification for not being able to obtain a written consent from the patient or his/her legal representative for the use of the medical data in the particular Research Work** |
|  |
| **Expected results of the Research Work, the way they are used and published** |
|  |
| **Time schedule of the Research Work (start and end dates)** |
|  |

|  |
| --- |
| **USE AND SECURITY OF DATA IN CASE OF JOINT DEVELOPMENT OF RESEARCH WORK** |
| **BY INDIVIDUALS WITH ACCESS TO PATIENT MEDICAL DATA** |
| **Name, surname:** |  | **Personal identity No:** |  |
| **Description of tasks to be performed:** |  |
| **Name, surname:** |  | **Personal identity No:** |  |
| **Description of tasks to be performed:** |  |

|  |
| --- |
| **DOCUMENTS TO BE ATTACHED**  |
| **[ ]** Research protocol: an outline of theoretical and methodological prerequisites **[ ]** other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **STATEMENT** |
| Upon signing this application, the applicant shall certify that:1. only such medical data, that the patient or his/her legal representative has not prohibited to transfer to the researcher, will be used;
2. the patient’s medical data will be used only to fulfil the aim of the research;
3. the principle of data security, ethics and confidentiality will be respected in their activity.
 |

|  |
| --- |
| **APPLICANT’S SIGNATURE** |
| **Name, surname:** |  | **Signature:** |  |
| **Date:** |  |
|  |
| **SIGNATURES OF THE RESEARCH PARTICIPANTS (if any)** |
| **Name, surname:** |  | **Signature:** |  |
| **Date:** |  |
|  |
| **Name, surname:** |  | **Signature:** |  |
| **Date:** |  |

|  |
| --- |
| **SIGNATURE OF THE RESEARCH SUPERVISOR** |
| **Name, surname:** |  | **Signature:** |  |
| **Position:** |  |
| **Date:** |  |

Received by the Research Ethics Committee

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_