MINISTRY OF HEALTH AND MEDICAL SERVICES: DATA REQUEST FORM

Reference Number:

Date Received:

REQUEST FORM

1. Email Address*

2. Full Name *

3. Type of Application* *Mark only one box*
   - ☐ Organizational *Skip to question 4*
   - ☐ Individual   *Skip to question 5*

Application by Organization/ Institution

4. Types of Organization or Institution* *Mark only one box*

   - ☐ within MHMS
   - ☐ Government Departments/Public Sector
   - ☐ Private Sector
   - ☐ NGO/CSOs
   - ☐ Educational Institution
   - ☐ Media
   - ☐ Agencies
   - ☐ Donor
   - ☐ other and please specify_____

   ### Application by Organization/ Institution

5. Individual Status* *Mark only one box*

   - ☐ Student
   - ☐ Health worker
   - ☐ Researcher
   - ☐ Lobbyist/activist
   - ☐ Journalist

Forward data request form to mrokovutoro@health.gov.fj or varanisese.saumaka@ag.gov.fj Phone Contact 3215772

☐ other, please specify_____

6. Application country of origin *

[   ]

7. Phone Contact *

[   ]

This section relates to the specific request for data/information. Please provide detailed descriptions, specific questions and preferred arrangement of the data. Also outline the type of information that is requested, for example, geographical area, population group (age groups/range, sex), specific condition, comparison group, time period, statistical measures, etc. If you have submitted a similar request previously, please include the year, name(s) of person(s) who completed your request and Reference number, if available. No data is available by address or ethnicity, and all de-identified

If unsure, please provide details of the question you are trying to answer:

8. What data or information is requested? *

Please give a detailed description of the type of data requested with time periods, database or source, relevant

disaggregation, geographical area by, facility level. Please provide a clear indication of data elements/fields required.

_____

_____

_____

_____

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_____

9. What is the purpose for the request?*

Give a detailed description of what the data/information will be used for. Indicate clearly if this is for research, publication or any other purpose.

_____
_____
_____
_____
_____

10. Indicate the planned outputs from your end?*

Mark only one box

☐ Report

☐ Scoping or planning process

Briefing note

 Ministerial request (internal)

 Ministerial request (external)

 Academic (non-publication – assignment, etc)

 Academic (Research and publication)

 Presentation

 External media request

 Cabinet/ Parliamentary request

 Risk communications, awareness, advocacy, media release (internal) and general communications

 Grant proposals

 Operations and program M & E

 Other, please specify

_____

11. **If the data is utilized for any of the following, please attach supporting documents as listed below**:* *Mark only one box*

 Research & Publication - Fiji Human Research Ethics Approval

  o   Yes, attach/ add ethic approval letter

 School Activity - Letter from Supervisor or School

  o   Yes, attach/ add ethic approval letter

 Organization or institution- Copy of MOU or Letter with official letterhead

  o   Yes, attach/ add ethic approval letter

 Media - Email approval from Media Liaison Officers of MHMS

  o   Yes, attach/ add ethic approval letter

 Others (as specified by the DAMU)

12. **Statement***

 I will include the following statements on any report, publication, information, documentation or other works created using the Data Analysis Management Unit of the Ministry of Health and Medical Services data: *"The Data Analysis Management Unit of the Ministry of Health and Medical Services has provided non-confidential information used in this file, report, publication, or database which it has compiled in accordance with Information Act of 2018 of the Republic of Fiji but which it has no authority to independently verify. By using this file, report, publication, or database, the user agrees to assume all risks that may be associated with or arise from the use of inaccurate data. The Data Analysis Management Unit of the Ministry of Health and Medical Services cannot and does not represent that the data was appropriate for this file, report, publication, or database or endorse or support any conclusions of interference that may be drawn from the use of* this data." Violation of any terms stated above will result in limitations of future access to data and access may be revoked and in accordance with MoHMS policies. All conditions are as per the Information Act of 2018 of the Republic of Fiji

13. Agreement for information/ data delivery *

☐ *I understand I am permitted to use the data for this particular request and purpose only, data will not be shared unless further consulted with DAMU of the Ministry of Health & Medical Services, I will protect the data and ensure it is securely stored. I understand that no data, or any information or documentation generated from this request may be licensed, rented, leased, distributed, transferred, or otherwise shared without permission from the Data Analysis Management Unit of the Ministry of Health and Medical Services, data may not be used for research unless Human research ethics has approved.*

☐ *For any publications and presentations, I understand and agree to abide by all the terms and restrictions described regarding the use of any data/ information as prescribed under the Information Act of 2018 of the Republic of Fiji and agree to provide a complete outputs specified in this application i.e. No. 10 above within 6 - 12 months.*

Signature* _____

Approvals Section *(To follow the online approval process outlined in the earlier section of this report)*

Action: Senior Statistician

- ☐ Approved
- ☐ Not Approved
- ☐ Refer to HRIDAM

Remarks:………
………

Signature: Senior Statistician

………………………………………………….

Date:

Action: Head of Research, Innovation, Data Analysis and Management Unit

- ☐ Approved
- ☐ Not Approved
- ☐ Refer to PSHMS

Remarks:………
………

Signature: Head of Research, Innovation, Data Analysis and Management Unit

…………………………………………………..

Date:

Action: Permanent Secretary for Health and Medical Services

- ☐ Approved
- ☐ Not Approved

Remarks:………
………

Signature: Permanent Secretary for Health and Medical Services

……………………………………………………

Date:

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