OMB# 0925-0667
EXP: 01/31/2016

Burden Disclosure Statement

Public reporting burden for this collection of information is estimated to vary from 15 min to 1.5 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0667). Do not return the completed form to this address.

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NIMH Data Access Request/Use Certification

Date: _____

Type of Application: ___ New ___ Renewal

Data Requested: ___National Database for Autism Research (NDAR)

___NIH Pediatric MRI Data Repository (PedsMRI)

First Name: _____ Last Name: _____

Degree: _____ Academic Position (or Title): _____

Institution: _____ Department: _____

Street Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Telephone: _____ FAX: _____

E-mail Address: _____

Research Project (title):

_____

_____

By signing and dating this DUC as part of requesting access to data in NDAR, my Institutional Officials and I certify that we will abide by the DUC and the NIH principles, policies and procedures for the use of the NDAR Central Repository. I further acknowledge that I have shared this document and the NIH policies and procedures with any research staff who will participate in the use of NDAR. My Institutional Business Official(s) also acknowledges that they have shared this document and the relevant NIH policies and procedures with appropriate institutional organizations.

Signature: _____ Date: _____

Authorized Institutional Business Official (as registered in the NIH eRA Commons: https://commons.era.nih.gov/commons/)

Name: _____

Title: _____

FWA#:_____

Signature: _____Date: _____

Inquiries about NIMH Databases and Repositories should be sent to:
NDAR: Office of the NDAR Program Director
National Institute of Mental Health, National Institutes of Health
6001 Executive Boulevard, Room 7202, MSC 9645
Rockville, MD 20892-9649 (if overnight delivery): Rockville, Maryland 20852
Telephone: 301-443-3265 Email: NDAR@mail.nih.gov

PedsMRI: PedsMRI@mail.nih.gov

Project Director/Principal Investigator Contact Information (if different from above)

First Name: _____ Last Name: _____

Degree: _____ Academic Position (or Title): _____

Institution: _____ Department: _____

Street Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Telephone: _____ FAX: _____

E-mail Address: _____

Authorized Representative (Institutional Official)

First Name: _____ Last Name: _____

Degree: _____ Academic Position (or Title): _____

Institution: _____ Department: _____

Street Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Country: _____

Telephone: _____ FAX: _____

E-mail Address: _____

Other Project Information:

1. Are Human Subjects involved? __ Yes __ No

    If YES to Human Subjects

    Is the Project Exempt from Federal regulations? __ Yes __ No

    If yes, check appropriate exemption number. __1 __2 __3 __4 __5 __6

    If no, is the IRB review pending? __ Yes __ No

    IRB Approval Date: _____

2. Research Use Statement/Project Summary:

Insert here.

OMB# 0925-0667
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Senior/Key Person Profile (Collaborating Investigator)

First Name: ________________________________ Last Name: ______________________________

Degree: _________________ Academic Position (or Title): __________________________________

Institution: ___________________________________ Department: ____________________________

Street Address: ____

City: ____________________________ State/Province: _______________________________

Zip/Postal Code: ____________________ Country: ________________________________

Telephone: ________________________________ FAX: ___________________________

E-mail Address: ____

Project Role: ________________________________ Other Project Role Category: ________________________

Senior/Key Person Profile (Collaborating Investigator)

First Name: ________________________________ Last Name: ______________________________

Degree: _________________ Academic Position (or Title): __________________________________

Institution: ___________________________________ Department: ____________________________

Street Address: ____

City: ____________________________ State/Province: _______________________________

Zip/Postal Code: ____________________ Country: ________________________________

Telephone: ________________________________ FAX: ___________________________

E-mail Address: ____

Project Role: ________________________________ Other Project Role Category: ________________________

Senior/Key Person Profile (Collaborating Investigator)

First Name: ________________________________ Last Name: ______________________________

Degree: _________________ Academic Position (or Title): __________________________________

Institution: ___________________________________ Department: ____________________________

Street Address: ____

City: ____________________________ State/Province: _______________________________

Zip/Postal Code: ____________________ Country: ________________________________

Telephone: ________________________________ FAX: ___________________________

E-mail Address: ____

Project Role: ________________________________ Other Project Role Category: ________________________

Use additional sheets for additional profiles as needed.