
DATA USE AGREEMENT (DUA) ADDENDUM for Data Acquired from the CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

The following individual(s) requests access to CMS data. Their signature(s) attest to their agreement with the terms and conditions defined in the original documentation for Data Use Agreement (DUA) _____ or for new DUA study/project name _____

Part A _____ **Requester** _____ **Custodian** _____ **Subcontractor** _____ **Recipient**

Printed Name _____ Phone _____ Ext _____

Organization _____

Street Address _____

City _____ State _____ Zip _____

E-mail _____

Signature _____

(if applicable) Courier name _____ Account number _____

Part B _____ **Requester** _____ **Custodian** _____ **Subcontractor** _____ **Recipient**

Printed Name _____ Phone _____ Ext _____

Organization _____

Street Address _____

City _____ State _____ Zip _____

E-mail _____ Signature _____

(if applicable) Courier name _____ Account number _____

Contracting Officer Representative (COR)/Government Task Lead (GTL) or CMS Privacy Staff

Printed Name _____

Signature _____

Organization _____

Please send as an email attachment to DataUseAgreement@cms.hhs.gov, and see our website at www.cms.gov/privacy

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Md. 21244-1850.