**Additional Requirements from the State of California**

All researchers requesting the HCUP CA SID, SASD, and SEDD data year 2018 and later through the HCUP Central Distributor must certify and agree to the following additional terms in order to receive CA data.

1. I am an academic researcher employed by a college or University located in the United States or a US territory.

2. My project and intended use of the CA data is directly related to my employment with my academic institution.

3. My project has undergone review by my academic institution's Institutional Review Board (IRB).

4. I will not attempt to link, and will prohibit others from attempting to link, the discharge records of persons in the data set with individually identifiable information from any other source.

5. I will not release or disclose, and will prohibit others from releasing or disclosing, the data set or any part to any person who is not an employee, or member, or contractor of the organization, except with the express written approval of OSHPD.

6. I agree to certify the destruction of or return the electronic media/hard copy of the data to OSHPD and to certify the destruction of any copies of the patient-level data created from the data provided under this request within three (3) years of the date of this Agreement.

    Direct hard copy media returns to:
    Office of Statewide Health Planning and Development
    Healthcare Data Resources Unit
    2020 West El Camino Avenue, Suite 1100
    Sacramento, CA 95833

*These terms are indicated and enforced by the California Office of Statewide Health Planning and Development and do not represent AHRQ or apply to any other AHRQ HCUP database or product.*

*For questions about these California-specific data use restrictions, please contact* DataandReports@OSHPD.CA.gov.

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| □ By checking this box or accessing or using any part of the HCUP CA State databases data year(s) 2018 and later, I acknowledge that I have read, understand, and agree to comply with the terms of the Additional Requirements from the State of California. |

Signed: _____ Date: _____

Print or Type Name: _____

Title: _____

Organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____Email: _____

The information above is maintained by AHRQ and shared with OSHPD only for the purpose of enforcement of this Agreement.