

**Maryland Department of Health
Maryland Cancer Registry (MCR) Data Request Form**

Date of Request _____

Office Use--
Person Receiving Request:

Person Requesting Data _____

Title: _____

From (agency, facility, general public, etc.) _____

Address: _____

City, State: _____

Zip: _____

Telephone: _____

Fax: _____

e-mail: _____

Purpose of Request

Diagnosis Years: _____

Sites of Cancer: _____

Geographical area of residence at diagnosis: _____

Information Requested (for example, number of cases, rates of cases, age groups, stage of cancer)

Requesting what type of data?

Are you requesting confidential information? Yes No ←

Do you want to contact cancer patients? Yes No

What format do you need the data in? Electronic Hard Copy Other: _____

Tables: (You may give shells of tables needed.)

Response requested by (month/day/year): _____

Signature of Data Requester: _____

Note: Certain data may be considered confidential, e.g., name, date of birth, address, rare cancers, small numbers within a cell.

Note: Requesters may be charged. Call the MCR for information.

Submit MCR Data Request Form
by fax, e-mail, or mail to:

Maryland Cancer Registry
Room 400
201 West Preston Street
Baltimore MD 21201

fax: 410-333-5218
telephone: 410-767-4055
e-mail: To submit by e-mail, call the MCR for e-mail address.