[ USE OFFICIAL LETTERHEAD ]

Dear Dr. [PO Surname],

This is in reference to project [GRANT NUMBER], under RFA [RFA NUMBER].

I’m writing to you to respectfully request your assistance in submitting for approval our study’s revisions to the final RADx Executive Committee minimum Common Data Elements (CDEs).

[OVERVIEW OF COMPELLING REASONS CDES CANNOT BY OBTAINED. REASON MUST NOT BE TRIVIAL OR SIMPLY BE A MATTER OF CONVENIENCE SINCE THE MINIMUM CDEs ARE REQUIRED BY THE NIH RADx EXECUTIVE COMMITTEE AFTER SUBSTANTIAL DELIBERATION.]

What follows is a summary of the changes to the minimum CDEs that we propose:

|  |  |  |  |
| --- | --- | --- | --- |
| **Concept** | **Original Question Text** | **Original Responses** | **Proposed Responses** |
| **2A. Race** |  |
|  | What is your race? Mark one or more boxes. | * American Indian or Alaska Native
* Black or African American
* Asian
* Native Hawaiian or Other Pacific Islander
* White
* Some other race
 | * VALUE(S)

Or:**Will not collect** |
| **2B. Ethnicity** |  |
|  | Are you of Hispanic or Latino origin?  | * Yes, of Hispanic or Latino origin
* No, not of Hispanic or Latino origin
 | * VALUE(S)
 |
| **3. Age** |  |
|  | What is your age? | A*ge in years. For babies less than 1 year old, write 0 as the age* | VALUE(S) |
| **4. Sex** |  |
|  | What is your biological sex assigned at birth? | * Male
* Female
* Intersex
* None of these describe me
 | * VALUE(S)
 |
| **5. Education** |  |
|  | How many years of education have you completed? | *Years of education from 0 – 20+* | VALUE(S) |
| **6. Domicile** |  |
|  | What is your zip code? | *5-digit zip code* | VALUE(S) |
| **7. Employment** |  |
|  | Are you employed? | * Employed in a permanent position
* Employed in a temporary position
* Not currently employed
 | * VALUE(S)
 |
| **8. Insurance status** |  |
|  | What kind of health insurance do you have? | * Private insurance
* Public insurance
* None
 | * VALUE(S)
 |
| **9. Disability status**  |  |
|  | Are you deaf or do you have serious difficulty hearing? | * Yes
* No
 | * VALUE(S)
 |
| Are you blind or do you have serious difficulty seeing, even when wearing glasses? | * Yes
* No
 | * VALUE(S)
 |
| Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? | * Yes
* No
 | * VALUE(S)
 |
| Do you have serious difficulty walking or climbing stairs? | * Yes
* No
 | * VALUE(S)
 |
| Do you have difficulty dressing or bathing? | * Yes
* No
 | * VALUE(S)
 |
| Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor’s office or shopping? | * Yes
* No
 | * VALUE(S)
 |
| **10. Medical history**  |  |
|  | Vaping use | * Yes
* No
 | * VALUE(S)
 |
| Nicotine use | * Yes
* No
 | * VALUE(S)
 |
| Alcohol use | * Yes
* No
 | * VALUE(S)
 |
| Asthma | * Yes
* No
 | * VALUE(S)
 |
| Cancer | * Yes
* No
 | * VALUE(S)
 |
| Cardiovascular disease | * Yes
* No
 | * VALUE(S)
 |
| Chronic kidney disease | * Yes
* No
 | * VALUE(S)
 |
| Chronic lung disease | * Yes
* No
 | * VALUE(S)
 |
| Diabetes | * Yes
* No
 | * VALUE(S)
 |
| Hypertension | * Yes
* No
 | * VALUE(S)
 |
| Immunosuppressive condition | * Yes
* No
 | * VALUE(S)
 |
| Serious mental illness | * Yes
* No
 | * VALUE(S)
 |
| Sickle cell disease | * Yes
* No
 | * VALUE(S)
 |
| Pregnancy status | * Currently pregnant
* Not pregnant
 | * VALUE(S)
 |
| **11. Symptoms**  |  |
|  | Cough | * Yes
* No
 | * VALUE(S)
 |
| Fever | * Yes
* No
 | * VALUE(S)
 |
| Shortness of breath or difficulty breathing | * Yes
* No
 | * VALUE(S)
 |
| Headache | * Yes
* No
 | * VALUE(S)
 |
| Muscle ache | * Yes
* No
 | * VALUE(S)
 |
| New loss of taste or smell | * Yes
* No
 | * VALUE(S)
 |
| Chills | * Yes
* No
 | * VALUE(S)
 |
| Excessive fatigue | * Yes
* No
 | * VALUE(S)
 |
| Nausea/vomiting | * Yes
* No
 | * VALUE(S)
 |
| Diarrhea | * Yes
* No
 | * VALUE(S)
 |
| Abdominal pain | * Yes
* No
 | * VALUE(S)
 |
| Skin rash | * Yes
* No
 | * VALUE(S)
 |
| Conjunctivitis | * Yes
* No
 | * VALUE(S)
 |
| **12. Health status** |  |
|  | What is your height? | *Height in feet and inches* | VALUE(S) |
| What is your weight? | *Weight in pounds* | VALUE(S) |
| Would you say that (your) health in general is excellent, very good, good, fair or poor? | * Excellent
* Very good
* Good
* Fair
* Poor
 | * VALUE(S)
 |

We are requesting that these changes be approved. We will keep the RADx-rad Data Coordinating Center (DCC) apprised of these and any other updates to our data as we maximize our compliance with the RADx data standards.

Please don’t hesitate to reach out to me if you have any questions, concerns, or if you require additional information.

Thank you for your consideration.

Best,

[SIGNATURE]

[NAME]

[INSTITUTION]