

Department of Health and Human Services Public Health Services <h2 style="margin: 0;">Grant Application</h2> <p style="font-size: small; margin: 0;"><i>Do not exceed 56-character length restrictions, including spaces.</i></p>		LEAVE BLANK—FOR PHS USE ONLY.			
		Type	Activity	Number	
		Review Group		Formerly	
		Council/Board (Month, Year)		Date Received	
1. TITLE OF PROJECT					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(If "Yes," state number and title)</i>					
Number:		Title:			
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR			New Investigator <input type="checkbox"/> No <input type="checkbox"/> Yes		
3a. NAME <i>(Last, first, middle)</i>			3b. DEGREE(S)		
3c. POSITION TITLE			3d. MAILING ADDRESS <i>(Street, city, state, zip code)</i>		
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT					
3f. MAJOR SUBDIVISION					
3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i>					
TEL:		FAX:			
4. HUMAN SUBJECTS RESEARCH		4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes," Exemption No. _____		5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes	
<input type="checkbox"/> No <input type="checkbox"/> Yes		4b. Human Subjects Assurance No.	4c. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes	5a. If "Yes," IACUC approval Date	5b. Animal welfare assurance no
6. DATES OF PROPOSED PERIOD OF SUPPORT <i>(month, day, year—MM/DD/YY)</i>		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
From	Through	7a. Direct Costs (\$)	7b. Total Costs (\$)	8a. Direct Costs (\$)	8b. Total Costs (\$)
9. APPLICANT ORGANIZATION			10. TYPE OF ORGANIZATION		
Name			Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local		
Address			Private: → <input type="checkbox"/> Private Nonprofit		
			For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business		
			<input type="checkbox"/> Woman-owned <input type="checkbox"/> Socially and Economically Disadvantaged		
Institutional Profile File Number (if known)			11. ENTITY IDENTIFICATION NUMBER		
			DUNS NO. <i>(if available)</i>		
			Congressional District		
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION		
Name			Name		
Title			Title		
Address			Address		
Tel			Tel		
FAX			FAX		
E-Mail			E-Mail		
14. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.			SIGNATURE OF PI/PD NAMED IN 3a. <i>(In ink. "Per" signature not acceptable.)</i>		DATE
15. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.			SIGNATURE OF OFFICIAL NAMED IN 13. <i>(In ink. "Per" signature not acceptable.)</i>		DATE