

Department of Health and Human Services  
Public Health Services

**Grant Application**

Do not exceed character length restrictions indicated.

**LEAVE BLANK—FOR PHS USE ONLY.**

Type	Activity	Number
Review Group		Formerly
Council/Board (Month, Year)		Date Received

1. TITLE OF PROJECT (Do not exceed 81 characters, including spaces and punctuation.)				
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input type="checkbox"/> NO <input type="checkbox"/> YES (If "Yes," state number and title)				
Number: Title:				
3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR				
3a. NAME (Last, first, middle)		3b. DEGREE(S)		
3c. POSITION TITLE		3d. MAILING ADDRESS (Street, city, state, zip code)		
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT				
3f. MAJOR SUBDIVISION				
3g. TELEPHONE AND FAX (Area code, number and extension)		E-MAIL ADDRESS:		
TEL: FAX:				
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes		
4b. Federal-Wide Assurance No.		4c. Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes		
4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes				
5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes		5a. Animal Welfare Assurance No.		
6. DATES OF PROPOSED PERIOD OF SUPPORT (month, day, year—MM/DD/YY) From _____ Through _____		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD	8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
		7a. Direct Costs (\$)	7b. Total Costs (\$)	8a. Direct Costs (\$)
		8b. Total Costs (\$)		
9. APPLICANT ORGANIZATION Name Address			10. TYPE OF ORGANIZATION Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local 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	
			11. ENTITY IDENTIFICATION NUMBER DUNS NO. <input type="checkbox"/> Cong. District	
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name Title Address			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name Title Address	
Tel: FAX: E-Mail:			Tel: FAX: E-Mail:	
14. 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. (In ink. "Per" signature not acceptable.)	
			DATE	