Form Approved Through 09/30/2007 OMB No. 0925-0001

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 ☐ NO ☐ YES
(If "Yes," state number and title)
Number: Title:

3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR | **New Investigator** ☐ **No** ☐ **Yes**

3a. NAME (Last, first, middle) | 3b. DEGREE(S) | 3h. eRA Commons User Name

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)*
TEL: FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS RESEARCH
No ☐ Yes ☐

4a. Research Exempt
No ☐ Yes ☐

4b. Human Subjects Assurance No.

4c. Clinical Trial ☐ No ☐ Yes

4d. NIH-defined Phase III Clinical Trial ☐ No ☐ Yes

If "Yes," Exemption No.

5. VERTEBRATE ANIMALS ☐ No ☐ Yes

5a. If "Yes," IACUC approval Date

5b. Animal welfare assurance no.

6. DATES OF PROPOSED PERIOD OF SUPPORT *(month, day, year—MM/DD/YY)*		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
Name
Address

10. TYPE OF ORGANIZATION
Public: → ☐ Federal ☐ State ☐ Local
Private: → ☐ Private Nonprofit
For-profit: → ☐ General ☐ Small Business
☐ Woman-owned ☐ Socially and Economically Disadvantaged

11. ENTITY IDENTIFICATION NUMBER
DUNS NO. | Cong. District

12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE
Name
Title
Address
Tel: FAX:
E-Mail:

13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION
Name
Title
Address
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

Use only if responding to a Multiple PI pilot initiative. See http://grants.nih.gov/grants/multi_pi/index.htm for details.

Contact Principal Investigator/Program Director (Last, First, Middle):

3. PRINCIPAL INVESTIGATOR

3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
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)* TEL: FAX:	E-MAIL ADDRESS:	

3. PRINCIPAL INVESTIGATOR

3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
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)* TEL: FAX:	E-MAIL ADDRESS:	

3. PRINCIPAL INVESTIGATOR

3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
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)* TEL: FAX:	E-MAIL ADDRESS:	

3. PRINCIPAL INVESTIGATOR

3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
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)* TEL: FAX:	E-MAIL ADDRESS:	

DESCRIPTION: See instructions. State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project (i.e., relevance to the **mission of the agency**). Describe concisely the research design and methods for achieving these goals. Describe the rationale and techniques you will use to pursue these goals.

In addition, in two or three sentences, describe in plain, lay language the relevance of this research to **public** health. If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. **DO NOT EXCEED THE SPACE PROVIDED.**

PERFORMANCE SITE(S) (organization, city, state)

KEY PERSONNEL. See instructions. *Use continuation pages as needed* to provide the required information in the format shown below. Start with Principal Investigator(s). List all other key personnel in alphabetical order, last name first.

Name	eRA Commons User Name	Organization	Role on Project

OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project

Human Embryonic Stem Cells ☐ **No** ☐ **Yes**

If the proposed project involves human embryonic stem cells, list below the registration number of the specific cell line(s) from the following list: http://stemcells.nih.gov/registry/index.asp. *Use continuation pages as needed.*

If a specific line cannot be referenced at this time, include a statement that one from the Registry will be used.

Cell Line

The name of the principal investigator/program director must be provided at the top of each printed page and each continuation page.

RESEARCH GRANT

TABLE OF CONTENTS

	Page Numbers
Face Page	1
Description, Performance Sites, Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells	2
Table of Contents	
Detailed Budget for Initial Budget Period (or Modular Budget)	
Budget for Entire Proposed Period of Support (not applicable with Modular Budget)	
Budgets Pertaining to Consortium/Contractual Arrangements (not applicable with Modular Budget)	
Biographical Sketch – Principal Investigator/Program Director (*Not to exceed four pages*)	
Other Biographical Sketches (Not to exceed four pages for each – *See instructions*)	
Resources	
Research Plan	
Introduction to Revised/Resubmission Application *(Not to exceed 3 pages.)*	
Introduction to Supplemental/Revision Application *(Not to exceed one page.)*	
A. Specific Aims	
B. Background and Significance	
C. Preliminary Studies/Progress Report (Items A-D: not to exceed 25 pages)	
D. Research Design and Methods	
E. Human Subjects Research	
Protection of Human Subjects (Required if Item 4 on the Face Page is marked "Yes")	
Data and Safety Monitoring Plan (Required if Item 4 on the Face Page is marked "Yes" ***and*** a Phase I, II, or III clinical trial is proposed)	
Inclusion of Women and Minorities (Required if Item 4 on the Face Page is marked "Yes" and is Clinical Research)	
Targeted/Planned Enrollment Table (for new and continuing clinical research studies)	
Inclusion of Children (Required if Item 4 on the Face Page is marked "Yes")	
F. Vertebrate Animals	
G. Select Agent Research	
H. Literature Cited	
I. Multiple PI Leadership Plan	
J. Consortium/Contractual Arrangements	
K. Resource Sharing	
L. Letters of Support (e.g., Consultants)	
Checklist	
Appendix *(Five collated sets. No page numbering necessary for Appendix.)*	☐ Check if Appendix is Included

Number of publications and manuscripts accepted for publication *(not to exceed 10)* _____

Other items (list):

Principal Investigator/Program Director (Last, First, Middle):

DETAILED BUDGET FOR INITIAL BUDGET PERIOD
DIRECT COSTS ONLY

FROM	THROUGH

PERSONNEL *(Applicant organization only)*		Months Devoted to Project				DOLLAR AMOUNT REQUESTED *(omit cents)*		
NAME	ROLE ON PROJECT	Cal. Mnths	Acad. Mnths	Summer Mnths	INST.BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
	Principal Investigator							
SUBTOTALS →								

CONSULTANT COSTS		
EQUIPMENT *(Itemize)*		
SUPPLIES *(Itemize by category)*		
TRAVEL		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS *(Itemize by category)*		
OTHER EXPENSES *(Itemize by category)*		

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD *(Item 7a, Face Page)*		**$**
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD		**$**

BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
DIRECT COSTS ONLY

BUDGET CATEGORY TOTALS		INITIAL BUDGET PERIOD *(from Form Page 4)*	ADDITIONAL YEARS OF SUPPORT REQUESTED			
			2nd	3rd	4th	5th
PERSONNEL: *Salary and fringe benefits. Applicant organization only.*						
CONSULTANT COSTS						
EQUIPMENT						
SUPPLIES						
TRAVEL						
PATIENT CARE COSTS	INPATIENT					
	OUTPATIENT					
ALTERATIONS AND RENOVATIONS						
OTHER EXPENSES						
CONSORTIUM/ CONTRACTUAL COSTS	DIRECT					
SUBTOTAL DIRECT COSTS *(Sum = Item 8a, Face Page)*						
CONSORTIUM/ CONTRACTUAL COSTS	F&A					
TOTAL DIRECT COSTS						

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD **$**

JUSTIFICATION. Follow the budget justification instructions exactly. Use continuation pages as needed.

Principal Investigator/Program Director (Last, First, Middle):

BUDGET JUSTIFICATION PAGE
MODULAR RESEARCH GRANT APPLICATION

	Initial Period	2nd	3rd	4th	5 th	Sum Total (For Entire Project Period)
DC less Consortium F&A	*(Item 7a, Face Page)*					*(Item 8a, Face Page)*
Consortium F&A						
Total Direct Costs						$

Personnel

Consortium

RESOURCES

FACILITIES: Specify the facilities to be used for the conduct of the proposed research. Indicate the performance sites and describe capacities, pertinent capabilities, relative proximity, and extent of availability to the project. If research involving Select Agent(s) will occur at any performance site(s), the biocontainment resources available at each site should be described. Under "Other," identify support services such as machine shop, electronics shop, and specify the extent to which they will be available to the project. Use continuation pages if necessary.

Laboratory:

Clinical:

Animal:

Computer:

Office:

Other:

MAJOR EQUIPMENT: List the most important equipment items already available for this project, noting the location and pertinent capabilities of each.

Principal Investigator/Program Director (last, First, Middle):

CHECKLIST

TYPE OF APPLICATION *(Check all that apply.)*

☐ NEW application. *(This application is being submitted to the PHS for the first time.)*

☐ REVISION/RESUBMISSION of application number: _____
(This application replaces a prior unfunded version of a new, competing continuation/renewal, or supplemental/revision application.)

☐ COMPETING CONTINUATION/RENEWAL of grant number: _____
(This application is to extend a funded grant beyond its current project period.)

INVENTIONS AND PATENTS *(Competing continuation/renewal appl. only)*

☐ No

☐ SUPPLEMENT/REVISION to grant number: _____
(This application is for additional funds to supplement a currently funded grant.)

☐ Yes. If "Yes," ☐ Previously reported ☐ Not previously reported

☐ CHANGE of principal investigator/program director.

Name of former principal investigator/program director: _____

☐ CHANGE of Grantee Institution. Name of former institution:

☐ FOREIGN application ☐ Domestic Grant with foreign involvement List Country(ies) Involved: _____

1. PROGRAM INCOME ***(See instructions.)***

All applications must indicate whether program income is anticipated during the period(s) for which grant support is request. If program income is anticipated, use the format below to reflect the amount and source(s).

Budget Period	Anticipated Amount	Source(s)

2. ASSURANCES/CERTIFICATIONS ***(See instructions.)***

In signing the application Face Page, the authorized organizational representative agrees to comply with the following policies, assurances and/or certifications when applicable. Descriptions of individual assurances/certifications are provided in Part III. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

•Human Subjects Research •Research Using Human Embryonic Stem Cells •Research on Transplantation of Human Fetal Tissue •Women and Minority Inclusion Policy •Inclusion of Children Policy •Vertebrate Animals• •Debarment and Suspension •Drug-Free Workplace *(applicable to new [Type 1] or revised/resubmission [Type 1] applications only)* •Lobbying •Non-Delinquency on Federal Debt •Research Misconduct •Civil Rights (Form HHS 441 or HHS 690) •Handicapped Individuals (Form HHS 641 or HHS 690) •Sex Discrimination (Form HHS 639-A or HHS 690) •Age Discrimination (Form HHS 680 or HHS 690) •Recombinant DNA Research, Including Human Gene Transfer Research •Financial Conflict of Interest •Smoke Free Workplace •Prohibited Research •Select Agent Research •PI Assurance

3. FACILITIES AND ADMINSTRATIVE COSTS (F&A)/ INDIRECT COSTS. See specific instructions.

☐ DHHS Agreement dated: _____ ☐ No Facilities And Administrative Costs Requested.

☐ DHHS Agreement being negotiated with _____ Regional Office.

☐ No DHHS Agreement, but rate established with _____ Date _____

CALCULATION* *(The entire grant application, including the Checklist, will be reproduced and provided to peer reviewers as confidential information.)*

a. Initial budget period:	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
b. 02 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
c. 03 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
d. 04 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
e. 05 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
	Enter Rate above as a decimal (e.g., 0.25 for 25%, 0.495 for 49.5%)				TOTAL F&A Costs	$	

*Check appropriate box(es):

☐ Salary and wages base ☐ Modified total direct cost base ☐ Other base *(Explain)*

☐ Off-site, other special rate, or more than one rate involved *(Explain)*

Explanation *(Attach separate sheet, if necessary.):*

Principal Investigator/Program Director (Last, First, Middle):

Place this form at the end of the signed original copy of the application.
Do not duplicate.

PERSONAL DATA ON PRINCIPAL INVESTIGATOR(S)/PROGRAM DIRECTOR(S)

The Public Health Service has a continuing commitment to monitor the operation of its review and award processes to detect—and deal appropriately with—any instances of real or apparent inequities with respect to age, sex, race, or ethnicity of the proposed principal investigator(s)/program director(s).

To provide the PHS with the information it needs for this important task, complete the form below and attach it to the signed original of the application after the Checklist. When multiple PIs/PDs are proposed, complete a form for each. **Do not attach copies of this form to the duplicated copies of the application.**

Upon receipt of the application by the PHS, this form will be separated from the application. This form will **not** be duplicated, and it will **not** be a part of the review process. Data will be confidential, and will be maintained in Privacy Act record system 09-25-0036, "Grants: IMPAC (Grant/Contract Information)." The PHS requests the last four digits of the Social Security Number for accurate identification, referral, and review of applications and for management of PHS grant programs. Although the provision of this portion of the Social Security Number is voluntary, providing this information may improve both the accuracy and speed of processing the application. Please be aware that no individual will be denied any right, benefit, or privilege provided by law because of refusal to disclose this section of the Social Security Number. The PHS requests the last four digits of the Social Security Number under Sections 301(a) and 487 of the PHS Acts as amended (42 U.S.C 241a and U.S.C. 288). All analyses conducted on the date of birth, gender, race and/or ethnic origin data will report aggregate statistical findings only and will not identify individuals. If you decline to provide this information, it will in no way affect consideration of your application. Your cooperation will be appreciated.

DATE OF BIRTH (*MM/DD/YY*)	SEX/GENDER
SOCIAL SECURITY NUMBER (last 4 digits only) XXX-XX-	☐ Female ☐ Male

ETHNICITY

1. Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

☐ **Hispanic or Latino**

☐ **Not Hispanic or Latino**

RACE

2. What race do you consider yourself to be? Select one or more of the following.

☐ ***American Indian or Alaska Native.*** A person having origins in any of the original peoples of North, Central, **or** South America, and who maintains tribal affiliation or community attachment.

☐ ***Asian.*** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian **subcontinent**, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. (Note: Individuals from the Philippine Islands have been recorded as Pacific Islanders in previous data collection strategies.)

☐ ***Black or African American.*** A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black" or African American."

☐ ***Native Hawaiian or Other Pacific Islander.*** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or **other** Pacific Islands.

☐ ***White.*** A **person** having origins in any of the original peoples of Europe, the Middle East, or North Africa.

☐ Check here if you do not wish to provide some or all of the above information.

Targeted/Planned Enrollment Table

This report format should NOT be used for data collection from study participants.

Study Title: _____

Total Planned Enrollment: _____

TARGETED/PLANNED ENROLLMENT: Number of Subjects			
Ethnic Category	**Sex/Gender**		
	Females	**Males**	**Total**
Hispanic or Latino			
Not Hispanic or Latino			
Ethnic Category: Total of All Subjects *			
Racial Categories			
American Indian/Alaska Native			
Asian			
Native Hawaiian or Other Pacific Islander			
Black or African American			
White			
Racial Categories: Total of All Subjects *			

* The “Ethnic Category: Total of All Subjects” must be equal to the “Racial Categories: Total of All Subjects.”

Principal Investigator/Program Director (Last, First, Middle):

Inclusion Enrollment Report

This report format should NOT be used for data collection from study participants.

Study Title: _____

Total Enrollment: _____ **Protocol Number:** _____

Grant Number: _____

PART A. TOTAL ENROLLMENT REPORT: Number of Subjects Enrolled to Date (Cumulative) by Ethnicity and Race				
Ethnic Category	**Sex/Gender**			
	Females	**Males**	**Unknown or Not Reported**	**Total**
Hispanic or Latino				**
Not Hispanic or Latino				
Unknown (individuals not reporting ethnicity)				
Ethnic Category: Total of All Subjects*				*
Racial Categories				
American Indian/Alaska Native				
Asian				
Native Hawaiian or Other Pacific Islander				
Black or African American				
White				
More Than One Race				
Unknown or Not Reported				
Racial Categories: Total of All Subjects*				*

PART B. HISPANIC ENROLLMENT REPORT: Number of Hispanics or Latinos Enrolled to Date (Cumulative)				
Racial Categories	**Females**	**Males**	**Unknown or Not Reported**	**Total**
American Indian or Alaska Native				
Asian				
Native Hawaiian or Other Pacific Islander				
Black or African American				
White				
More Than One Race				
Unknown or Not Reported				
Racial Categories: Total of Hispanics or Latinos**				**

* These totals must agree.
** These totals must agree.

CDA TOC Substitute Page Candidate (Last, first, middle):

Use this substitute page for the Table of Contents of Research Career Development Awards. Type the name of the candidate at the top of each printed page and each continuation page.

RESEARCH CAREER DEVELOPMENT AWARD
TABLE OF CONTENTS (Substitute Page)

Page Numbers

Letters of Reference* (*attach unopened references to the Face Page*)

Section I: Basic Administrative Data

Face Page (Form Page 1) 1

Description, Performance Sites, Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells (Form Page 2) 2

Table of Contents (this CDA Substitute Form Page 3) .....

Budget for Entire Proposed Period of Support (Form Page 5) .....

Biographical Sketches *(Candidate, Sponsor[s],* Key Personnel and Other Significant Contributors**
—Biographical Sketch Format page) (Not to exceed four pages) .....

Other Support Pages (not for the candidate) .....

Resources (Resources Format page) .....

Section II: Specialized Information

Introduction to Revised/Resubmission Application* (Not to exceed 3 pages) .....

1. The Candidate

A. Candidate's Background .....

B. Career Goals and Objectives: Scientific Biography ..... *(Items A-D included in 25 page limit)*.....

C. Career Development/Training Activities during Award Period .....

D. Training in the Responsible Conduct of Research .....

2. Statements by Sponsor, Co-Sponsor(s),* Consultant(s),* and Contributor(s)* .....

3. Environment and Institutional Commitment to Candidate

A. Description of Institutional Environment .....

B. Institutional Commitment to Candidate's Research Career Development. .....

4. Research Plan

A. Specific Aims .....

B. Background and Significance ..... *(Items A-D included in 25 page limit)* .....

C. Preliminary Studies/Progress Report .....

D. Research Design and Methods .....

E. Human Subjects Research .....

Targeted/Planned Enrollment Table (for new and continuing clinical research studies) .....

F. Vertebrate Animals .....

G. Select Agent Research.....

H. Literature Cited. .....

I. Consortium/Contractual Arrangements* .....

J. Resource Sharing.....

Checklist .....

Appendix (Five collated sets. No page numbering necessary.) ☐ Check if Appendix is included

Number of publications and manuscripts accepted for publication *(not to exceed 5)* _____

Note: Font and margin requirements must conform to limits provided in the Specific Instructions.

*Include these items only when applicable.

CITIZENSHIP

☐ U.S. citizen or non-citizen national

☐ Permanent resident of U.S. (If a permanent resident of the U.S., a notarized statement must be provided by the time of award.)

☐ Non-citizen with temporary visa (Applicable for only the K99 program)

CAREER DEVELOPMENT AWARD REFERENCE REPORT GUIDELINES (Series K)

Title of Award:

Type of Award: **Application Submission Deadline:** _____

Name of Candidate (Last, first, middle):

Name of Respondent (Last, first, middle):

The candidate is applying to the National Institutes of Health for a Career Development Award (CDA). The purpose of this award is to develop the research capabilities and career of the applicant. These awards provide up to five years of salary support and guarantee them the ability to devote at least 75–80 percent of their time to research for the duration of the award. Many of these awards also provide funds for research and career development costs. The award is available to persons who have demonstrated considerable potential to become independent researchers, but who need additional supervised research experience in a productive scientific setting.

We would appreciate receiving your evaluation of the above candidate with special reference to:

- potential for conducting research;
- evidence of originality;
- adequacy of scientific background;
- quality of research endeavors or publications to date, if any;
- commitment to health-oriented research; and
- need for further research experience and training.

Any related comments that you may wish to provide would be welcomed. These references will be used by PHS committees of consultants in assessing candidates.

Complete the report in English on 8-1/2 x 11" sheets of paper. Return your reference report to the candidate sealed in the envelope as soon as possible and in sufficient time so that the candidate can meet the application submission deadline. References must be submitted with the application.

We have asked the candidate to provide you with a self-addressed envelope with the following words in the front bottom corner: “DO NOT OPEN—PHS USE ONLY.” Candidates are not to open the references. Under the Privacy Act of 1974, CDA candidates may request personal information contained in their records, including this reference. Thank you for your assistance.

Type the name of the principal investigator/program director at the top of each printed page and each continuation page. (For type specifications, see PHS 398 Instructions.)

INSTITUTIONAL RUTH L. KIRSCHSTEIN NATIONAL RESEARCH SERVICE AWARD TABLE OF CONTENTS (Substitute Page)

Page Numbers

Face Page (*Form Page 1*) 1

Description, Performance Sites, Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells (*Form Page 2, Form Page 2-continued, and additional continuation page, if necessary*) 2

Table of Contents (*this Kirschstein-NRSA Substitute Form Page 3*) .....

Detailed Budget for Initial Budget Period *(Kirschstein-NRSA Substitute Form Page 4)* .....

Budget for Entire Proposed Period of Support *(Kirschstein-NRSA Substitute Form Page 5)* .....

Biographical Sketch—Principal Investigator/Program Director *(Not to exceed four pages)* .....

Other Biographical Sketches *(Not to exceed four pages for each)* .....

Resources .....

Research Training Program Plan

Introduction to Revised/Resubmission Application, *if applicable (Not to exceed 3 pages)* .....

Introduction to Supplemental/Revision Application, *if applicable (Not to exceed one page)* .....

A. Background .....

B. Program Plan .....

1. Program Administration .....
2. Program Faculty .....
3. Proposed Training .....
4. Training Program Evaluation .....
5. Trainee Candidates .....

(Items A-D: not to exceed 25 pages, ... excluding tables)*

C. Minority Recruitment and Retention Plan .....

D. Plan for Instruction in the Responsible Conduct of Research .....

E. Progress Report (Competing Continuation Applications Only) .....

F. Human Subjects .....

G. Vertebrate Animals .....

H. Select Agent Research .....

I. Multiple PI Leadership Plan (if applicable) .....

J. Consortium/Contractual Arrangements .....

Checklist .....

Appendix *(Five collated sets. No page numbering necessary for Appendix.)*

☐ Check if Appendix is included

* Font and margin requirements must conform to limits provided in PHS 398 Specific Instructions.

Kirschstein-NRSA Initial Budget Period Substitute Page

Principal Investigator/Program Director: (Last, first, middle)

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY (Kirschstein-NRSA Substitute Page)	FROM	THROUGH
STIPENDS		**DOLLAR TOTAL**
PREDOCTORAL No. Requested:		
POSTDOCTORAL *(Itemize)* No. Requested:		
OTHER *(Specify)* No. Requested:		
TOTAL STIPENDS ⟶		
TUITION and FEES *(Itemize)*		
TRAINEE TRAVEL *(Describe)*		
TRAINEE RELATED EXPENSES (including Health Insurance)		
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD *(Also enter on Face Page, Item 7)*		**$**

BUDGET FOR ENTIRE PROPOSED PERIOD OF SUPPORT
DIRECT COSTS ONLY (Kirschstein-NRSA Substitute Page)

BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD *(from Form Page 4)*		ADDITIONAL YEARS OF SUPPORT REQUESTED							
			2nd		3rd		4th		5th	
	No.		No.		No.		No.		No.	
PREDOCTORAL STIPENDS										
POSTDOCTORAL STIPENDS										
OTHER STIPENDS										
TOTAL STIPENDS										
TUITION AND FEES										
TRAINEE TRAVEL										
TRAINEE RELATED EXPENSES (including Health Insurance)										
TOTAL DIRECT COSTS										

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD *(Item 8a, Face Page)* **$**

JUSTIFICATION. For all years, explain the basis for the budget categories requested. Follow the instructions for the Initial Budget Period and include anticipated postdoctoral levels.

DO NOT SUBMIT UNLESS REQUESTED
Competing Continuation Applications
KEY PERSONNEL REPORT

All Key Personnel for the Current Budget Period

Name	Degree(s)	SSN (last 4 digits)	Role on Project (e.g. PI, Res. Assoc.)	Date of Birth (MM/DD/YY)	Months Devoted to Project		
					Cal	Acad	Summer

Mailing address for application

Use this label or a facsimile

All applications and other deliveries to the Center for Scientific Review must come either via courier delivery or via the United States Postal Service (USPS.) Applications delivered by individuals to the Center for Scientific Review will no longer be accepted.

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SBIR

RFA No. _____(if applicable)

STTR

RFA No. _____(if applicable)