Form Approved Through 9/30/2007 OMB No. 0925-0001

Department of Health and Human Services
Public Health Services

Grant Progress Report

Review Group	Type	Activity	Grant Number

Total Project Period
From: Through:

Requested Budget Period
From: Through:

1. TITLE OF PROJECT

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR (Name and address, street, city, state, zip code)

3. APPLICANT ORGANIZATION (Name and address, street, city, state, zip code)

2b. E-MAIL ADDRESS

4. ENTITY IDENTIFICATION NUMBER

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

5. TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

2d. MAJOR SUBDIVISION

E-MAIL:

6. HUMAN SUBJECTS
☐ No ☐ Yes
6a. Research Exempt ☐ No ☐ Yes
6b. Human Subjects Assurance No.
If Exempt ("Yes" in 6a): Exemption No.
6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes
If Not Exempt ("No" in 6a): IRB approval date
☐ Full IRB **or** ☐ Expedited Review

7. VERTEBRATE ANIMALS
☐ No ☐ Yes
7a. If "Yes," IACUC approval Date
7b. Animal Welfare Assurance No.

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD
8a. DIRECT $
8b. TOTAL $

9. INVENTIONS AND PATENTS
☐ No ☐ Yes If "Yes," ☐ Previously Reported ☐ Not Previously Reported

10. PERFORMANCE SITE(S) *(Organizations and addresses)*

11a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR *(Item 2a)* TEL FAX

11b. ADMINISTRATIVE OFFICIAL NAME *(Item 5)* TEL FAX

11c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 14)*
NAME
TITLE
TEL FAX
E-MAIL

12. Corrections to Page 1 Face Page

13. 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 11c. *(In ink. "Per" signature not acceptable.)*

DATE

Contact Principal Investigator/Program Director:

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR (Name and address, street, city, state, zip code)	2b. E-MAIL ADDRESS	
	2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT	
	2d. MAJOR SUBDIVISION	
2e. TELEPHONE AND FAX *(Area code, number and extension)*		
TEL:	FAX:	

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR (Name and address, street, city, state, zip code)	2b. E-MAIL ADDRESS	
	2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT	
	2d. MAJOR SUBDIVISION	
2e. TELEPHONE AND FAX *(Area code, number and extension)*		
TEL:	FAX:	

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TEL:	FAX:	

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR (Name and address, street, city, state, zip code)	2b. E-MAIL ADDRESS	
	2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT	
	2d. MAJOR SUBDIVISION	
2e. TELEPHONE AND FAX *(Area code, number and extension)*		
TEL:	FAX:	

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

DETAILED BUDGET FOR NEXT BUDGET PERIOD – DIRECT COSTS ONLY	FROM	THROUGH	GRANT NUMBER

PERSONNEL (Applicant organization only)		Months Devoted to Project			DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT	Cal. Mnths	Acad. Mnths	Summer Mnths	SALARY REQUESTED	FRINGE BENEFITS	TOTALS
	Principal Investigator						0
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)*		
SUBTOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD		**$**
CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR NEXT PROJECT PERIOD *(Item 8a, Face Page)*		**$**

BUDGET JUSTIFICATION	GRANT NUMBER

Provide a detailed budget justification for those line items and amounts that represent a significant change from that previously recommended. Use continuation pages if necessary.

CURRENT BUDGET PERIOD	FROM	THROUGH

Explain any estimated unobligated balance (including prior year carryover) that is greater than 25% of the current year's total budget.

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

PROGRESS REPORT SUMMARY	GRANT NUMBER	
	PERIOD COVERED BY THIS REPORT	
PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR	FROM	THROUGH

APPLICANT ORGANIZATION

TITLE OF PROJECT (Repeat title shown in Item 1 on first page)

A. Human Subjects (Complete Item 6 on the Face Page)		
Involvement of Human Subjects	☐ No Change Since Previous Submission	☐ Change
B. Vertebrate Animals (Complete Item 7 on the Face Page)		
Use of Vertebrate Animals	☐ No Change Since Previous Submission	☐ Change
C. Select Agent Research	☐ No Change Since Previous Submission	☐ Change
D. Multiple PI Leadership Plan	☐ No Change Since Previous Submission	☐ Change

SEE PHS 2590 INSTRUCTIONS.

WOMEN AND MINORITY INCLUSION: See PHS 398 Instructions. Use Inclusion Enrollment Report Format Page and, if necessary, Targeted/Planned Enrollment Format Page.

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

GRANT NUMBER

CHECKLIST

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

All applications must indicate whether program income is anticipated during the period(s) for which grant support is requested. 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 of the PHS 398. 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 (except Phase I SBIR/STTR) • Prohibited Research • Select Agent Research • PI Assurance • STTR ONLY: Certification of Research Institution Participation.

3. FACILITIES AND ADMINSTRATIVE (F&A) COSTS

Indicate the applicant organization's most recent F&A cost rate established with the appropriate DHHS Regional Office, or, in the case of for-profit organizations, the rate established with the appropriate PHS Agency Cost Advisory Office.

F&A costs will ***not*** be paid on construction grants, grants to Federal organizations, grants to individuals, and conference grants. Follow any additional instructions provided for Research Career Awards, Institutional National Research Service Awards, Small Business Innovation Research/Small Business Technology Transfer Grants, foreign grants, and specialized grant applications.

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

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

CALCULATION*

Enter Rate as a decimal (e.g., 0.25 for 25%, 0.495 for 49.5%)

Entire proposed budget period: Amount of base $ _____ x Rate applied 0.00% % = F&A costs $ _____

Add to total direct costs from Form Page 2 and enter new total on Face Page, Item 8b.

*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):

KEY PERSONNEL REPORT

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

GRANT NUMBER

All Key Personnel for the Current Budget Period (do not include Other Significant Contributors)

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

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

NEXT BUDGET PERIOD *(Follow instructions carefully)*	**FROM**	**THROUGH**	**GRANT NUMBER**

ITEMIZE DIRECT COSTS REQUESTED FOR NEXT BUDGET PERIOD	DOLLAR AMOUNT REQUESTED (omit cents)
PREDOCTORAL STIPENDS No. Requested:	**$**
POSTDOCTORAL STIPENDS *(Itemize)* No. Requested:	**$**
OTHER STIPENDS *(Specify)*	**$**
TOTAL STIPENDS →	**$**
TUITION and FEES (including Health Insurance when applicable - see new Instructions) *(Itemize)*	**$**
TRAINEE TRAVEL *(Describe)*	**$**
TRAINEE RELATED EXPENSES (including Health Insurance when applicable - see new Instructions)	**$**
TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD *(Also enter on Page 1, Item 8a)*	**$**

Summary of Trainees	GRANT NUMBER

Complete for trainees who have left the program or who have completed their training (during this reporting period)

Name	Degree Earned	Current Position

Complete for *all* trainees for this reporting period.

Distribution of Trainees According to Category: Use the table on the "Inclusion Enrollment Report Format Page." See PHS 398.

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.