|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Form Approved Through 10/31/2011 OMB No. 0925-0002 | | | | | | | | | | | | | | | | | | | | | | | | |
| Department of Health and Human Services  Public Health Service | | | | | | | | | | | | | Review Group | | | Type | | Activity | | | | Fellowship Number | | |
| Ruth L. Kirschstein National Research Service Award Individual Fellowship Progress Report *Follow instructions carefully* | | | | | | | | | | | | | Total Project Period | | | | | | | | | | | |
| From: | |  | | | | Through: | | | |  | |
| Requested Budget Period | | | | | | | | | | | |
| From: | |  | | | | Through: | | | |  | |
| 1. TITLE OF RESEARCH TRAINING PROPOSAL | | | | | | | | | | | | | | | | | | | | | | | | |
| 2a. FELLOW (Name and address, street, city, state, zip code) | | | | | | | | | | | 2b. FELLOW’S E-MAIL ADDRESS | | | | | | | | | | | | | |
| 2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | | | | | | | | | | | | |
| 2d. MAJOR SUBDIVISION | | | | | | | | | | | | | |
| 3a. NAME OF SPONSOR | | | | | | | | | | | 3b. SPONSOR’S E-MAIL ADDRESS | | | | | | | | | | | | | |
| 4. SPONSORING INSTITUTION *(Name and address, street, city, state, zip code)* | | | | | | | | | | | 6a. TITLE AND ADDRESS OF OFFICIAL IN SPONSORING INSTITUTION BUSINESS OFFICE | | | | | | | | | | | | | |
| 5. ENTITY IDENTIFICATION NO. | | | | | |  | | | | | 6b. E-MAIL ADDRESS: | | | | | |  | | | | | | | |
| 7. HUMAN SUBJECTS  NO  YES | | | | | | | | | | | 9. TRAINING SITE(S) *(Organizations and addresses)* | | | | | | | | | | | | | |
| 7a. Research Exempt  NO  YES | | | | If Exempt ("Yes" in 7a): Exemption No. | | | | | | | Organizational Name: | | | | | | | | | | | | | |
| If Not Exempt ("No" in 7a): IRB approval date | | | | | | | DUNS: | | | | | | | | | | | | | |
| 7b. Federalwide Assurance No. | | | | |  | | | | | | Street 1: | | | | | | | | | | | | | |
| 7c. NIH Defined Phase III Clinical Trial | | | | | | | | | NO  YES | | Street 2: | | | | | | | | | | | | | |
| 8. VERTEBRATE ANIMALS  NO  YES | | | | | | | | | | | City: | | | | | | | | | County: | | | | |
| 8a. If “Yes,” IACUC approval date | | | | | | 8b. Animal welfare assurance no. | | | | | State: | | | | | | | | | Province: | | | | |
| Country: | | | | | | | | | Zip/Postal Code: | | | | |
| 10. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT  ORGANIZATION *(Item 13)* | | | | | | | | | | | Congressional Districts: | | | | | | | | | | | | | |
| NAME | | |  | | | | | | | | 11. FELLOW’S TELEPHONE INFORMATION | | | | | | | | | | | | | |
| TITLE | | |  | | | | | | | | OFFICE | | |  | | | | | | | | | | |
| TEL | | |  | | | | | FAX | |  | FAX | | |  | | | | | | | | | | |
| E-MAIL | | |  | | | | | | | | HOME | | |  | | | | | | | | | | |
| 12. CORRECTIONS (Items 1 - 6) | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and I agree to comply with the Public Health Service terms and conditions if a grant is awarded as a result of this report. 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 10.  *(In ink. “Per” signature not acceptable.)* | | | | | | | | | | | | | | | | | | | | | | DATE | | |

PHS 416-9 (Rev. 10/08) Form Page 1