

Department of Health and Human Services Public Health Services <h2 style="margin: 0;">Grant Application</h2> <p style="margin: 0;"><i>Do not exceed character length restrictions indicated.</i></p>		<b>LEAVE BLANK—FOR PHS USE ONLY.</b> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Type</td> <td style="width: 33%;">Activity</td> <td style="width: 34%;">Number</td> </tr> <tr> <td>Review Group</td> <td></td> <td>Formerly</td> </tr> <tr> <td>Council/Board (Month, Year)</td> <td></td> <td>Date Received</td> </tr> </table>		Type	Activity	Number	Review Group		Formerly	Council/Board (Month, Year)		Date Received
Type	Activity	Number										
Review Group		Formerly										
Council/Board (Month, Year)		Date Received										
1. TITLE OF PROJECT <i>(Do not exceed 81 characters, including spaces and punctuation.)</i>												
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:										
<b>3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR</b>												
3a. NAME (Last, first, middle)		3b. DEGREE(S)	3h. eRA Commons User Name									
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>		E-MAIL ADDRESS:										
TEL:		FAX:										
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		4a. Research Exempt If "Yes," Exemption No. <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 <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 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. _____ 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. <i>(In ink. "Per" signature not acceptable.)</i>	DATE									