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

2b. E-MAIL ADDRESS

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

2e. Tel: Fax:

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

3b. Tel: Fax:

3c. DUNS:

4. ENTITY IDENTIFICATION NUMBER

5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

6. HUMAN SUBJECTS ☐ No ☐ Yes

6a. Research Exempt ☐ No ☐ Yes	If Exempt ("Yes" in 6a): Exemption No.	If Not Exempt ("No" in 6a): IRB approval date

Tel: Fax:

6b. Federal Wide Assurance No.

E-MAIL:

6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes

7. VERTEBRATE ANIMALS ☐ No ☐ Yes

10. PROJECT/PERFORMANCE SITE(S)

7a. If "Yes," IACUC approval Date

Organizational Name:

7b. Animal Welfare Assurance No.

DUNS:

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

Street 1:

8a. DIRECT $

Street 2:

8b. TOTAL $

City: County:

9. INVENTIONS AND PATENTS ☐ No ☐ Yes

State: Province:

If "Yes, ☐ Previously Reported ☐ Not Previously Reported

Country: Zip/Postal Code:

Congressional Districts:

11. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 13)*

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 11. *(In ink)*	DATE