

Department of Health and Human Services Public Health Services Grant Application <i>Do not exceed character length restrictions indicated.</i>		LEAVE BLANK—FOR PHS USE ONLY.		
		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: _____				
3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR				
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>