

Department of Health and Human Services Public Health Services <h2 style="text-align: center;">Grant Progress Report</h2>	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
---	---

6. HUMAN SUBJECTS No Yes 6a. Research Exempt <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:15%;"></td> <td style="width:15%; text-align: center;">No</td> <td style="width:15%; text-align: center;">Yes</td> <td style="width:15%; border-left: 1px solid black; border-right: 1px solid black; text-align: center;">If Exempt ("Yes" in 6a): Exemption No.</td> <td style="width:15%; border-left: 1px solid black; border-right: 1px solid black; text-align: center;">If Not Exempt ("No" in 6a): IRB approval date</td> </tr> </table> 6b. Federal Wide Assurance No. 6c. NIH-Defined Phase III Clinical Trial No Yes		No	Yes	If Exempt ("Yes" in 6a): Exemption No.	If Not Exempt ("No" in 6a): IRB approval date	5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL Tel: _____ Fax: _____ E-MAIL:
	No	Yes	If Exempt ("Yes" in 6a): Exemption No.	If Not Exempt ("No" in 6a): IRB approval date		

7. VERTEBRATE ANIMALS No Yes 7a. If "Yes," IACUC approval Date 7b. Animal Welfare Assurance No.	10. PROJECT/PERFORMANCE SITE(S) Organizational Name: DUNS:
---	--

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD 8a. DIRECT \$ 8b. TOTAL \$	Street 1: Street 2:
--	----------------------------

9. INVENTIONS AND PATENTS No Yes If "Yes, Previously Reported Not Previously Reported	City: _____ County: _____ State: _____ Province: _____ 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
--	---	------

Contact Program Director/Principal Investigator:

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. TELEPHONE AND FAX (Area code, number and extension)

TEL:

FAX:

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. TELEPHONE AND FAX (Area code, number and extension)

TEL:

FAX:

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. TELEPHONE AND FAX (Area code, number and extension)

TEL:

FAX:

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. TELEPHONE AND FAX (Area code, number and extension)

TEL:

FAX:

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

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

List PERSONNEL (*Applicant organization only*)
 Use Cal, Acad, or Summer to Enter Months Devoted to Project
 Enter Dollar Amounts Requested (*omit cents*) for Salary Requested and Fringe Benefits

NAME	ROLE ON PROJECT	Cal. Mnths	Acad. Mnths	Summer Mnths	SALARY REQUESTED	FRINGE BENEFITS	TOTALS
	PD/PI						
SUBTOTALS →							

CONSULTANT COSTS

EQUIPMENT (*Itemize*)

SUPPLIES (*Itemize by category*)

TRAVEL

INPATIENT CARE COSTS

OUTPATIENT CARE COSTS

ALTERATIONS AND RENOVATIONS (*Itemize by category*)

OTHER EXPENSES (*Itemize by category*)

SUBTOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD \$

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
------------------------------	--------------	--

CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
------------------------------	-------------------------------------	--

TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD (*Item 8a, Face Page*) \$

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

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.

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

PROGRESS REPORT SUMMARY	GRANT NUMBER	
	PERIOD COVERED BY THIS REPORT	
PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR	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 PD/PI Leadership Plan	No Change Since Previous Submission	Change
E. Human Embryonic Stem Cell Line(s) Used	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.

Program Director/Principal Investigator (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 policies, assurances and/or certifications listed in the application instructions when applicable. Descriptions of individual assurances/certifications are provided in Part III of the PHS 398, and listed in Part I, 4.1 under Item 14. If unable to certify compliance, where applicable, provide an explanation and place it after the Progress Report (Form Page 5).

3. FACILITIES AND ADMINISTRATIVE (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*

Entire proposed budget period: Amount of base \$ _____ x Rate applied _____ % = 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.):

ALL PERSONNEL REPORT

GRANT NUMBER

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

Always list the PD/PI(s). In addition, list all other personnel who participated in the project during the current budget period for at least one person month or more, regardless of the source of compensation (a person month equals approximately 160 hours or 8.3% of annualized effort). Use the following abbreviated categories for describing Role on Project:

- PD/PI
- Co-Investigator
- Faculty
- Postdoctoral (scholar, fellow, or other postdoctoral position)
- Technician
- Staff Scientist (doctoral level)
- Statistician
- Graduate Student (research assistant)
- Non-student Research Assistant
- Undergraduate Student
- High School Student
- Consultant
- Other (please specify)

If personnel are supported by a Reentry or Diversity Supplement please indicate such after the Role on Project, using the following abbreviations: RS - Reentry Supplement; DS - Diversity Supplement.

Use Cal (calendar), Acad, or Summer to enter months devoted to project.

Commons ID	Name	Degree(s)	SSN (last 4 digits)	Role on Project	DoB (MM /YY)	Cal	Acad	Summer

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

NEXT BUDGET PERIOD <i>(Follow instructions carefully)</i>	FROM	THROUGH	GRANT NUMBER
ITEMIZE DIRECT COSTS REQUESTED FOR NEXT BUDGET PERIOD			DOLLAR AMOUNT REQUESTED (omit cents)
PREDOCTORAL STIPENDS <i>(List trainee names)</i>			
TOTAL STIPENDS			
TUITION and FEES (including Health Insurance when applicable – see new Instructions) <i>(Itemize)</i> <i>(List each category separately)</i>			
TRAINEE TRAVEL <i>(Describe)</i>			
TRAINING-RELATED EXPENSES (including Health Insurance when applicable – see new Instructions)			
TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD <i>(Also enter on Page 1, Item 8a)</i>			

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	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			
More Than One Race			
Racial Categories: Total of All Subjects *			

* The "Ethnic Category: Total of All Subjects" must be equal to the "Racial Categories: Total of All Subjects."

Program Director/Principal Investigator (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	Females	Males	Sex/Gender 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	Sex/Gender 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.

Trainee Diversity Report

This report format should NOT be used for data collection from trainees.

Training Grant Title: _____

Total Number of Appointed: _____

Grant Number: _____

PART A. TOTAL TRAINEE APPOINTMENTS REPORT: Number of Trainees Appointed 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 Trainees*				*
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 Trainees*				*
PART B. HISPANIC TRAINEE APPOINTMENTS REPORT: Number of Hispanics or Latinos Appointed				
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**				**
PART C. TRAINEES WITH DISABILITIES OR FROM DISADVANTAGED BACKGROUNDS				
Number of Trainees with Disabilities:				
Number of Trainees from Disadvantaged Backgrounds:				

(*) (**) These totals must agree.

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

Use only if additional space is needed to list additional project/performance sites.

Additional Project/Performance Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

Additional Project/Performance Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

Additional Project/Performance Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

Additional Project/Performance Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

Additional Project/Performance Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

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

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors in the order listed on Form Page 2.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME		POSITION TITLE	
eRA COMMONS USER NAME (credential, e.g., agency login)			
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	MM/YY	FIELD OF STUDY

Please refer to the application instructions in order to complete sections A, B, C, and D of the Biographical Sketch.

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

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

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

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