

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>

Use only if preparing an application with Multiple PDs/Pis. See http://grants.nih.gov/grants/multi_pi/index.htm for details.

Contact Program Director/Principal Investigator (Last, First, Middle):		
3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR		
3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH 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:	
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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:	

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

PROJECT SUMMARY (See instructions):

RELEVANCE (See instructions):

PROJECT/PERFORMANCE SITE(S) (if additional space is needed, use Project/Performance Site Format Page)

Project/Performance Site Primary 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):

SENIOR/KEY PERSONNEL. See instructions. *Use continuation pages as needed* to provide the required information in the format shown below. Start with Program Director(s)/Principal Investigator(s). List all other senior/key personnel in alphabetical order, last name first.

Name	eRA Commons User Name	Organization	Role on Project
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OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project
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Human Embryonic Stem Cells No Yes

If the proposed project involves human embryonic stem cells, list below the registration number of the specific cell line(s) from the following list: <http://stemcells.nih.gov/research/registry/eligibilityCriteria.asp>. *Use continuation pages as needed.*

If a specific line cannot be referenced at this time, include a statement that one from the Registry will be used.

Cell Line

The name of the program director/principal investigator must be provided at the top of each printed page and each continuation page.

**RESEARCH GRANT
TABLE OF CONTENTS**

Page Numbers

Face Page	<u>1</u>
Description, Project/Performance Sites, Senior/Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells	<u>2</u>
Table of Contents	_____
Detailed Budget for Initial Budget Period	_____
Budget for Entire Proposed Period of Support	_____
Budgets Pertaining to Consortium/Contractual Arrangements	_____
Biographical Sketch – Program Director/Principal Investigator (<i>Not to exceed four pages each</i>).....	_____
Other Biographical Sketches (<i>Not to exceed four pages each – See instructions</i>).....	_____
Resources	_____
Checklist	_____
Research Plan	_____
1. Introduction to Resubmission Application, if applicable, or Introduction to Revision Application, if applicable *	_____
2. Specific Aims *	_____
3. Research Strategy *	_____
4. Inclusion Enrollment Report (Renewal or Revision applications only).....	_____
5. Bibliography and References Cited/Progress Report Publication List.....	_____
6. Protection of Human Subjects.....	_____
7. Inclusion of Women and Minorities.....	_____
8. Targeted/Planned Enrollment Table.....	_____
9. Inclusion of Children.....	_____
10. Vertebrate Animals.....	_____
11. Select Agent Research.....	_____
12. Multiple PD/PI Leadership Plan.....	_____
13. Consortium/Contractual Arrangements.....	_____
14. Letters of Support (e.g., Consultants).....	_____
15. Resource Sharing Plan (s).....	_____
Appendix (<i>Five identical CDs.</i>)	<input type="checkbox"/> Check if Appendix is Included

* Follow the page limits for these sections indicated in the application instructions, unless the Funding Opportunity Announcement specifies otherwise.

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

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY	FROM	THROUGH
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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	INST.BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
	PD/PI							
SUBTOTALS								

CONSULTANT COSTS	
EQUIPMENT (<i>Itemize</i>)	
SUPPLIES (<i>Itemize by category</i>)	
TRAVEL	
INPATIENT CARE COSTS	
OUTPATIENT CARE COSTS	
ALTERATIONS AND RENOVATIONS (<i>Itemize by category</i>)	
OTHER EXPENSES (<i>Itemize by category</i>)	

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (<i>Item 7a, Face Page</i>)		\$
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD		\$

**BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
DIRECT COSTS ONLY**

BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD <i>(from Form Page 4)</i>	2nd ADDITIONAL YEAR OF SUPPORT REQUESTED	3rd ADDITIONAL YEAR OF SUPPORT REQUESTED	4th ADDITIONAL YEAR OF SUPPORT REQUESTED	5th ADDITIONAL YEAR OF SUPPORT REQUESTED
PERSONNEL: <i>Salary and fringe benefits. Applicant organization only.</i>					
CONSULTANT COSTS					
EQUIPMENT					
SUPPLIES					
TRAVEL					
INPATIENT CARE COSTS					
OUTPATIENT CARE COSTS					
ALTERATIONS AND RENOVATIONS					
OTHER EXPENSES					
DIRECT CONSORTIUM/ CONTRACTUAL COSTS					
SUBTOTAL DIRECT COSTS <i>(Sum = Item 8a, Face Page)</i>					
F&A CONSORTIUM/ CONTRACTUAL COSTS					
TOTAL DIRECT COSTS					
TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD					\$

JUSTIFICATION. Follow the budget justification instructions exactly. Use continuation pages as needed.

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

RESOURCES

Follow the 398 application instructions in Part I, 4.7 Resources.

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

CHECKLIST

TYPE OF APPLICATION (Check all that apply.)

NEW application. (This application is being submitted to the PHS for the first time.)

RESUBMISSION of application number: _____

(This application replaces a prior unfunded version of a new, renewal, or revision application.)

RENEWAL of grant number: _____

(This application is to extend a funded grant beyond its current project period.)

REVISION to grant number: _____

(This application is for additional funds to supplement a currently funded grant.)

CHANGE of program director/principal investigator.

Name of former program director/principal investigator: _____

CHANGE of Grantee Institution. Name of former institution: _____

FOREIGN application

Domestic Grant with foreign involvement

List Country(ies)
Involved: _____

INVENTIONS AND PATENTS (Renewal appl. only)

No

Yes

If "Yes," Previously reported

Not previously reported

1. PROGRAM INCOME (See instructions.)

All applications must indicate whether program income is anticipated during the period(s) for which grant support is request. 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 and listed in Part I, 4.1 under Item 14. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

3. FACILITIES AND ADMINSTRATIVE COSTS (F&A)/ INDIRECT COSTS. See specific instructions.

DHHS Agreement dated: _____

No Facilities And Administrative Costs Requested.

DHHS Agreement being negotiated with _____

Regional Office.

No DHHS Agreement, but rate established with _____

Date _____

CALCULATION* (The entire grant application, including the Checklist, will be reproduced and provided to peer reviewers as confidential information.)

a. Initial budget period: Amount of base \$ _____ x Rate applied _____ % = F&A costs \$ _____

b. 02 year Amount of base \$ _____ x Rate applied _____ % = F&A costs \$ _____

c. 03 year	Amount of base \$	_____	x Rate applied	_____	% = F&A costs	\$	_____
d. 04 year	Amount of base \$	_____	x Rate applied	_____	% = F&A costs	\$	_____
e. 05 year	Amount of base \$	_____	x Rate applied	_____	% = F&A costs	\$	_____
						TOTAL F&A Costs	\$

*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.)*:

4. DISCLOSURE PERMISSION STATEMENT: If this application does not result in an award, is the Government permitted to disclose the title of your proposed project, and the name, address, telephone number and e-mail address of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information (e.g., possible collaborations, investment)? Yes No

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."

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.

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

DO NOT SUBMIT UNLESS REQUESTED
Renewal Applications Only
ALL PERSONNEL REPORT

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 Cal, Acad, or Summer to Enter Months Devoted to Project.

Commons ID	Name	Degree(s)	SSN (last 4 digits)	Role on Project (e.g. PD/PI, Res. Assoc.)	DoB (MM /YY)	Cal	Acad	Summer

Mailing address for application

Use this label or a facsimile

All applications and other deliveries to the Center for Scientific Review must come either via courier delivery or via the United States Postal Service (USPS.) Applications delivered by individuals to the Center for Scientific Review will not be accepted.

Applications sent via the USPS EXPRESS or REGULAR MAIL should be sent to the following address:

**CENTER FOR SCIENTIFIC REVIEW
NATIONAL INSTITUTES OF HEALTH
6701 ROCKLEDGE DRIVE
ROOM 1040 – MSC 7710
BETHESDA, MD 20892-7710**

NOTE: All applications sent via a courier delivery service (non-USPS) should use this address, but CHANGE THE ZIP CODE TO 20817

The telephone number is 301-435-0715. C.O.D. applications will *not* be accepted.

A special label for responding to RFAs is not required.

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):