Public reporting burden for this collection of information is estimated to 15 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0002). Do not send progress reports to this address.

Form Approved Through 08/31/2015 OMB No. 0925-0002

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
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 6b. Federal Wide Assurance No. 6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes	5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL Tel: Fax: E-MAIL:
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	**$**
CONSORTIUM/CONTRACTUAL COSTS — DIRECT COSTS	
CONSORTIUM/CONTRACTUAL COSTS — FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD *(Item 8a, Face Page)*	**$**

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.

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.

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 ADMINSTRATIVE (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.):*

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

ALL PERSONNEL REPORT

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

GRANT NUMBER

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 *(Follow instructions carefully)*	**FROM**	**THROUGH**	**GRANT NUMBER**

ITEMIZE DIRECT COSTS REQUESTED FOR NEXT BUDGET PERIOD	DOLLAR AMOUNT REQUESTED (omit cents)
PREDOCTORAL STIPENDS *(List trainee names)* No. Requested:	$
POSTDOCTORAL STIPENDS *(Itemize) (List trainee names and levels)* No. Requested:	$
OTHER STIPENDS *(Specify)*	$
TOTAL STIPENDS	$
TUITION and FEES (including Health Insurance when applicable – see new Instructions) *(Itemize)* *(List each category separately)*	$
TRAINEE TRAVEL *(Describe)*	$
TRAINING-RELATED EXPENSES (including Health Insurance when applicable – see new Instructions)	$
TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD *(Also enter on Page 1, Item 8a)*	$

PHS Inclusion Enrollment Report

OMB Number: 0925-0001 and 0925-0002

This report format should not be used for collecting data from study participants

*Study Title:

*Delayed onset sudy? ☐ Yes ☐ No

If study is not delayed onset, the following selections are required:

Enrollment Type ☐ Planned ☐ Cumulative (Actual)

Using an Existing Dataset or Resource ☐ Yes ☐ No

Participants Location ☐ Domestic ☐ Foreign

Clinical Trial ☐Yes ☐No NIH-Defined Phase III Clinical Trial? ☐ Yes ☐ No Trial Phase? -- Select Phase--

Phase 0
Phase 1
Phase 1/2
Phase 2
Phase 2/3
Phase 3
Phase 4

Comments:

Racial Categories	Ethnic Categories: Not Hispanic or Latino			Hispanic or Latino			Unknown/Not Reported Ethnicity			Total
	Female	Male	Unknown/ Not Reported	Female	Male	Unknown/ Not Reported	Female	Male	Unknown/ Not Reported	
American Indian or Alaska Native	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	0	0	0	0	0	0	0
Native Hawaiian or Other Pacific Islander	0	0	0	0	0	0	0	0	0	0
Black or African American	0	0	0	0	0	0	0	0	0	0
White	0	0	0	0	0	0	0	0	0	0
More than One Race	0	0	0	0	0	0	0	0	0	0
Unknown or Not Reported	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0

DELETE REPORT NEXT REPORT

To ensure proper performance, please save frequently

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

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	**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 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**	**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**				**

PART C. TRAINEES WITH DISABILITIES OR FROM DISADVANTAGED BACKGROUNDS	
Number of Trainees with Disabilities (as described in the Americans with Disabilities Act):	
Number of Trainees from Disadvantaged Backgrounds (applies only to undergraduate and high school students:	

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