

Application for Certification of Qualified Investments Eligible for Credits and Grants Under the Qualifying Therapeutic Discovery Project Program

▶ See separate instructions for required attachments.

Part I Applicant Information Check if this is an amended application

1 Name of applicant	2 Taxpayer identification number (TIN)
3 Number and street	Room/suite
4 City, town, or post office, state, and ZIP code	
5 Telephone number	
6 URL address for applicant's website	
7 Is the applicant a member of an affiliated group filing consolidated returns? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," complete lines 8 through 12.	
8 This corporation has been a member of this group: a <input type="checkbox"/> For the entire year b <input type="checkbox"/> From / / 20 until / / 20 .	
9 Name of the common parent of the affiliated group	10 Employer identification number (EIN)
11 Number and street	Room/suite
12 City, town, or post office, state, and ZIP code	
13 Contact person. Attach a properly completed Form 2848, Power of Attorney and Declaration of Representative, if necessary. See instructions.	
a Name of contact person	
b Number and street	Room/suite
c City, town, or post office, state, and ZIP code	
d Telephone number	e Fax number
14a Name of the project	
b Description of the project (see instructions)	

Part II Certification and Grant Election Information (see instructions)

15 Enter the number of employees in all businesses of the applicant on the date this application is submitted. See instructions ▶ _____
If more than 250, do not continue with this application.

16 Are the applicant and any other entities considered to be a single employer under section 52(a) or (b) or section 414(m) or (o)? See instructions ▶ Yes No
If "Yes":
• Attach a statement listing the name, address, and employer identification number (EIN) for each of the other entities; and
• Applicant certifies it has 250 or fewer employees, taking into account the employees of these other entities, on the date this application is submitted.

17 Is the applicant electing for this application for certification to be an application for a grant for a tax year beginning in:
a 2009? Yes No If "Yes" for either **a** or **b**, complete lines 18 and 19.
b 2010? Yes No If "No" to both **a** and **b**, skip to line 20.

18 Enter the applicant's Data Universal Numbering System (D-U-N-S) number. See instructions. ▶ _____

19 Check the applicable box that describes the applicant. If any of the following describes the applicant, the applicant is not eligible for a grant.
 Federal, state, or local government or any political subdivision, agency, or instrumentality thereof.
 Organization described in section 501(c) and exempt from tax under section 501(a).
 Entity referred to in section 54(j)(4).
 Partnership or other pass-through entity with a government or any political subdivision, agency, or instrumentality thereof, section 501(c) organization, or section 54(j)(4) entity as a direct or indirect partner (or other direct or indirect holder of an equity or profits interest). **Note:** Do not check this box if such entity owns only an indirect interest in the applicant through a C corporation.

Part II Certification and Grant Election Information *(continued)*

20 Will this project create and sustain (directly or indirectly) high-quality, high-paying jobs in the United States? Yes No

21 Enter the number of full-time and part-time employees in the United States whose work is directly billed to the project and the average salaries of the employees in each category. See instructions.

Employees	Number of employees	Average salaries of the employees
a Full-time		
b Part-time		

22a Enter the number of contractors in the United States paid for work on the project _____

b Enter the average monthly hours of the contractors entered on line 22a _____

c Enter the average monthly compensation of the contractors entered on line 22a. _____

23 Will this project advance United States competitiveness in the fields of life, biological, and medical sciences? Yes No

24 As of the date this application is submitted, is the project active, terminated, or suspended? Check one.
 Active Terminated Suspended

25 If the project is terminated or suspended for any of the failures below, check all boxes that apply.
 The project failed a clinical trial.
 The project failed a pre-clinical research milestone.
 The project failed to secure FDA licensure.
 If the applicant checked any of the boxes above, do not continue with this application.

26 Will the project produce a new or significantly improved technology, or a new application of or significant improvement to existing technology, as compared to commercial technologies currently in service? . . . Yes No

27 Is the project expected to lead to the construction or use of a contract production facility in the United States in the next 5 years? Yes No

Part III Qualified Investment (see instructions)

	(a) As of September 30, 2010 (tax year 2009 only) (see instructions)	(b) Tax year 2009	(c) Tax year 2010	
28 Qualified investment derived from employee wages.				
29 Qualified investment derived from supplies and lab costs.				
30 Qualified investment derived from depreciable property.				
31 Qualified investment derived from third-party contractors.				
32 Qualified investment derived from other costs.				
33 Amount in line 30 attributable to qualified progress expenditures.				
34 Total. Add lines 28 through 32 in each column.				
35 Qualified investment for which certification is requested. Add line 34 columns (b) and (c).				
36 This application is for certification of qualified investment, related to a qualifying therapeutic discovery project, for (check only one): <input type="checkbox"/> Tax year beginning in 2009 only. Enter the ending date of the tax year ▶ / / <input type="checkbox"/> Tax year beginning in 2010 only. Enter the ending date of the tax year ▶ / / <input type="checkbox"/> Tax years beginning in 2009 and 2010. Enter the ending date of the tax year for 2009 ▶ / / and for 2010 ▶ / /				

Sign Here Keep a copy of this form for your records.

Under penalties of perjury, I declare that I have examined this submission, including the accompanying documents, and, to the best of my knowledge and belief, all of the facts contained herein are true, correct, and complete. Declaration of preparer (other than taxpayer) is based on all information of which preparer has any knowledge.

Signature of Applicant

Date

Title

Preparer's Use Only

Preparer's signature ▶ _____ Date _____ Check if self-employed Preparer's SSN or PTIN _____

Firm's name (or yours if self-employed), address, and ZIP code ▶ _____ EIN _____

Phone no. _____