Form Approved Through 10/31/2018 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.

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT $	8b. TOTAL $

9. INVENTIONS AND PATENTS ☐ No ☐ Yes

If "Yes," ☐ Previously Reported
☐ Not Previously Reported

10. PROJECT/PERFORMANCE SITE(S)

Organizational Name:

DUNS:

Street 1:

Street 2:

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	
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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:	

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.

☐ HHS Agreement dated: _____ ☐ No Facilities and Administrative Costs Requested.

☐ No HHS 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

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

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 Human Subjects and Clinical Trials Information

Note: the PHS Human Subjects and Clinical Trials Information form is not included in this combined form. See individual form here: http://grants.nih.gov/forms/human-subject-study-form.pdf

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:	
Number of Trainees from Disadvantaged Backgrounds:	

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