

Department of Health and Human Services Public Health Services <h3 style="margin: 0;">Grant Application</h3> <p style="font-size: small; margin: 0;"><i>Do not exceed character length restrictions indicated.</i></p>		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 56-characters, including spaces and punctuation.</i>)					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION NO YES (If "Yes," state number and title) Number: _____ Title: _____					
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR			New Investigator	No	Yes
3a. NAME (<i>Last, first, middle</i>)			3b. DEGREE(S)		
3c. POSITION TITLE			3d. MAILING ADDRESS (<i>Street, city, state, zip code</i>)		
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT			E-MAIL ADDRESS:		
3f. MAJOR SUBDIVISION					
3g. TELEPHONE AND FAX (<i>Area code, number and extension</i>) TEL: _____ FAX: _____					
4. HUMAN SUBJECTS RESEARCH		4a. Research Exempt No Yes If "Yes," Exemption No. _____		5. VERTEBRATE ANIMALS No Yes	
No Yes		4b. Human Subjects Assurance No.	4c. NIH-defined Phase III Clinical Trial No Yes	5a. If "Yes," IACUC approval Date	5b. Animal welfare assurance no
6. DATES OF PROPOSED PERIOD OF SUPPORT (<i>month, day, year—MM/DD/YY</i>) From _____ Through _____		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
		7a. Direct Costs (\$)	7b. Total Costs (\$)	8a. Direct Costs (\$)	8b. Total Costs (\$)
9. APPLICANT ORGANIZATION Name Address Institutional Profile File Number (if known)			10. TYPE OF ORGANIZATION Public: → Federal State Local Private: → Private Nonprofit For-profit: → General Small Business Woman-owned Socially and Economically Disadvantaged		
			11. ENTITY IDENTIFICATION NUMBER DUNS NO. Congressional 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. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.			SIGNATURE OF PI/PD NAMED IN 3a. <i>(In ink. "Per" signature not acceptable.)</i>		DATE
15. 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>		DATE