

Department of Health and Human Services Public Health Service Ruth L. Kirschstein National Research Service Award Individual Fellowship Application <i>Follow instructions carefully.</i> <i>Do not exceed character length restrictions indicated.</i>		LEAVE BLANK—For PHS use only.		
		Type	Activity	Number
		Review Group		Formerly
		Meeting Dates		Date Received
1. TITLE OF RESEARCH TRAINING PROPOSAL (Do not exceed 81 characters, including spaces and punctuation.)				
2. LEVEL OF FELLOWSHIP	3. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT <i>(If "Yes," state number and title)</i>			NO YES
	Number:	Title:		
4a. NAME OF APPLICANT (Last, First, Middle)		4b. ERA COMMONS USER NAME		4c. HIGHEST DEGREE(S)
4d. PRESENT MAILING ADDRESS (Street, City, State, Zip Code)		4e. PERMANENT MAILING ADDRESS (Street, City, State, Zip Code)		
		4f. E-MAIL ADDRESS:		
TELEPHONES AND FAX (Area code, number and extension)				
4g. OFFICE		4h. HOME	4i. PERMANENT	4j. FAX NUMBER
4k. U.S. CITIZEN OR U.S. NONCITIZEN NATIONAL		PERMANENT RESIDENT OF U.S. PENDING		
PERMANENT RESIDENT OF U.S.		NON-U.S. CITIZEN WITH TEMPORARY U.S. VISA		
5. TRAINING UNDER PROPOSED AWARD (See Fields of Training)			6. PRIOR AND/OR CURRENT NRSA SUPPORT <i>(Individual or Institutional)</i>	
Discipline No.:	Subcategory Name:		NO YES <i>(If "Yes," refer to item 22, Form Page 5)</i>	
7a. DATES OF PROPOSED AWARD		7b. PROPOSED AWARD DURATION		8. DEGREE SOUGHT DURING PROPOSED AWARD
From (MM/DD/YY):	Through (MM/DD/YY):	<i>(in months)</i>		Degree:
				Expected Completion Date:
9. HUMAN SUBJECTS RESEARCH No Yes Indefinite		9b. Federalwide Assurance No.		10. VERTEBRATE ANIMALS No Yes
		9c. Clinical Trial No Yes	9d. NIH-defined Phase III Clinical Trial No Yes	10a. Animal Welfare Assurance No.
9a. Research Exempt No Yes If "Yes," Exemption No.				
11. SPONSORING INSTITUTION Name Address			13. OFFICIAL SIGNING FOR SPONSORING INSTITUTION Name Title Address	
12a. ENTITY IDENTIFICATION NO.		12b. DUNS NO.		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 I agree to comply with the terms and conditions of award if an award is issued 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

Kirschstein–NRSA Individual Fellowship Application <i>(To be completed by applicant – follow PHS 416-1 instructions)</i>		NAME OF APPLICANT <i>(Last, first, middle initial)</i>
SPONSOR and Co Sponsor Information		
15. NAME OF SPONSOR	16. NAME OF Co-SPONSOR <i>(When applicable)</i>	
15a. NAME AND DEGREE(S)	16a. NAME AND DEGREE(S)	
15b. ERA COMMONS USER NAME	16b. ERA COMMONS USER NAME	
15c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT	16c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT	
15d. MAJOR SUBDIVISION	16d. MAJOR SUBDIVISION	
15e. Address:	16e. Address:	
Telephone:	Telephone:	
Fax:	Fax:	
E-Mail:	E-Mail:	
RESEARCH PROPOSAL		
17. DESCRIPTION: See instructions. State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project (i.e., relevance to the mission of the agency). Describe concisely the research design and methods for achieving these goals. Describe the rationale and techniques you will use to pursue these goals. In addition , in two or three sentences, describe in plain, lay language the relevance of this research to public health . If the application is funded, this description, as is, will become public information. Therefore, do not include proprietary/confidential information. DO NOT EXCEED THE SPACE PROVIDED.		

Kirschstein–NRSA Individual Fellowship Application*(To be completed by applicant – follow PHS 416-1 instructions)*NAME OF APPLICANT *(Last, first, middle initial)*

18. GOALS FOR KIRSCHSTEIN–NRSA FELLOWSHIP TRAINING AND CAREER

19. ACTIVITIES PLANNED UNDER THIS AWARD: Approximate percentage of proposed award time in activities identified below. *(See instructions.)*

Year	Research	Course Work	Teaching	Clinical
First				
Second				
Third				
PREDOCTORAL FELLOWSHIPS ONLY				
Fourth				
Fifth				
MD/PhD FELLOWSHIPS ONLY				
Sixth				

Briefly explain activities other than research and relate them to the proposed research training.

20. TRAINING SITE(S) Is the Primary Training Site the same as the Sponsoring Institution? Yes No

If No, provide detailed information below for the Primary Training Site Location

Organizational Name:

DUNS:

Street 1:

Street 2:

City:

County:

State:

Province:

Country:

Zip/Postal Code:

Project/Performance Site Congressional Districts:

21. 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

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:			

	Page Numbers
Section I — Applicant/Fellow	
<i>(Number pages consecutively at the bottom throughout the application. Do not use suffixes such as 6a, 6b.)</i>	
Face Page	1
Sponsor’s Contact Information, Description (Form Page 2)	2
Training & Career Goals, Activities Planned Under This Award, Training Site(s), Human Embryonic Stem Cells (Form Page 3)	_____
Table of Contents (Form Page 4)	_____
Biographical Sketch – Applicant/Fellow <i>(Not to exceed four pages)</i>	_____
Previous Research Experience (Form Page 5)	_____
Research Training Plan	
1. Introduction to Resubmission Application <i>(not to exceed 1 page)</i>	_____
2. Specific Aims	_____
3. Background/Significance	_____
4. Preliminary Studies/Progress Report	_____
5. Research Design and Methods	_____
6. Inclusion Enrollment Report <i>(for Renewal applications only)</i>	_____
7. Progress Report Publication List <i>(for Renewal applications only)</i>	_____
8. Human Subjects <i>(Required if Item 9 on the Face Page is marked “Yes”)</i>	_____
9. Clinical Trial	_____
10. Agency-Defined Phase III Clinical Trial	_____
11. Protection of Human Subjects <i>(Required if Item 9 on the Face Page is marked “Yes”)</i>	_____
12. Inclusion of Women and Minorities <i>(Required if Item 9 on the Face Page is marked “Yes” and is Clinical Research)</i>	_____
13. Targeted/Planned Enrollment Table <i>(for new and continuing clinical research studies)</i>	_____
14. Inclusion of Children <i>(Required if Item 9 on the Face Page is marked “Yes”)</i>	_____
15. Vertebrate Animals <i>(Required if Item 10 on the Face Page is marked “Yes”)</i>	_____
16. Select Agent Research	_____
17. Bibliography and References Cited (formerly "Literature Cited")	_____
18. Resource Sharing	_____
19. Respective Contributions	_____
20. Selection of Sponsor and Institution	_____
21. Responsible Conduct of Research	_____

Section II — Sponsor’s/Co-Sponsor’s Information

Biographical Sketch--Sponsor	_____
Research Support Available	_____
Previous Fellows/Trainees	_____
Training Plan, Environment, Research Facilities	_____
Number of Fellows/Trainees to be Supervised	_____
Applicant’s Qualifications and Potential	_____
Checklist (Completed by Fellow/Applicant & Sponsoring Institution)	_____

Section III — Letters of Reference (Minimum of 3)

(See instructions for submission of references.)

List full name, institution, and department of individuals submitting reference letters.

Other Items *(list)*:

Personal Data Page for Fellowship Applicants

Appendix

Appendix *(Five identical CDs)*

Check if
Appendix is
Included

Kirschstein-NRSA Individual Fellowship Application
Previous Research Experience

(To be completed by applicant – follow PHS 416-1 instructions.)

NAME OF APPLICANT (Last, first, middle initial)

22. PRIOR AND CURRENT KIRSCHSTEIN-NRSA SUPPORT. List type (individual and/or institutional), level (predoctoral or postdoctoral), dates, and grant or award numbers.

23. APPLICATION(S) FOR CONCURRENT SUPPORT

NO YES Using format below, list all support (training, research, supplies, travel, etc.) applied for that would run concurrently with the period covered by this application. Include the type, dates, source, and amount.

Type:	Dates:
Source:	Amount:
Type:	Dates:
Source:	Amount:
Type:	Dates:
Source:	Amount:

24a. TITLE(S) OF THESIS/DISSERTATION(S) (Predoctoral and Senior Fellowships omit this section.)

24b. NAME OF DISSERTATION ADVISOR OR CHIEF OF SERVICE
(If reference report not included, explain why not.)

TITLE, DEPARTMENT, AND INSTITUTION

25. DOCTORAL DISSERTATION AND OTHER RESEARCH EXPERIENCE

(See Instructions -- particularly Predoctoral and Senior Fellowships should follow special instructions for this section. Use continuation pages. Do not exceed two pages.)

Kirschstein–NRSA Individual Fellowship Application Checklist

NAME OF APPLICANT *(Last, first, middle initial)*

To be completed by Applicant

A. TYPE OF APPLICATION

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 or renewal application.)

RENEWAL of award number _____

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

CHANGE of Sponsoring Institution Name of former Institution: _____

B. ASSURANCES/CERTIFICATIONS

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. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

C. KIRSCHSTEIN–NRSA SENIOR FELLOWSHIP APPLICANTS ONLY

1. PRESENT INSTITUTIONAL BASE SALARY

Amount Academic Period/number of months

2. STIPEND/SALARY DURING FIRST YEAR OF PROPOSED FELLOWSHIP

a. Stipend requested from PHS

Amount Number of months

b. Supplementation from other sources

Amount Number of months Type *(sabbatical leave, salary, etc.)* Source

D. TUITION and FEES

Predoctoral applicants should list estimated combined costs of tuition and fees. Postdoctoral applicants should list the estimated costs for the tuition and fees for courses planned that support the research training experience. For postdoctoral applicants, those courses should be described under Section D. Research Design and Methods of the Research Training Plan. Health insurance for predoctoral and postdoctoral fellowships is now paid as part of the institutional allowance. Senior Fellowship applicants should omit this section.

None Requested

Funds Requested:

Year – 01	Year – 02	Year – 03	Year – 04	Year – 05	Year – 06 (when applicable)

Personal Data on Kirschstein–NRSA Individual Fellowship Applicant

Clip this form to the signed original of the application after the checklist. Do not duplicate.

NAME OF APPLICANT (Last, first, middle initial)

The Public Health Service has a continuing commitment to monitor the operation of its review and award processes to detect—and deal appropriately with—any instances of real or apparent inequities with respect to age, sex, race, or ethnicity of the proposed applicant.

To provide the PHS with the information it needs for this important task, complete the form below and attach it to the signed original of the application after the Checklist. **Do not attach copies of this form to the duplicated copies of the application.**

Upon receipt of the application by the PHS, this form will be separated from the application. This form will **not** be duplicated, and it will **not** be a part of the review process. Data will be confidential, and will be maintained in Privacy Act record system 09-25-0036, “Grants: IMPAC (Grant/Contract Information).” The PHS requests the last four digits of the Social Security Number for accurate identification, referral, and review of applications and for management of PHS grant programs. Although provision of this portion of the Social Security Number is voluntary, providing this information may improve both the accuracy and speed of processing the application. Please be aware that no individual will be denied any right, benefit, or privilege provided by law because of refusal to disclose this section of the Social Security Number. The PHS requests the last four digits of the Social Security Number under Sections 301(a) and 487 of the PHS Acts as amended (42 U.S.C. 241a and U.S.C. 288). All analyses conducted on the date of birth, gender, race and/or ethnic origin data will report aggregate statistical findings only and will not identify individuals. If you decline to provide this information, it will in no way affect consideration of your application. Your cooperation will be appreciated.

DATE OF BIRTH (MM/YY)	SEX/GENDER
SOCIAL SECURITY NUMBER (last 4 digits only) XXX-XX-	Female Male

ETHNICITY

1. Do you consider yourself to be Hispanic or Latino? (See definition below.) Select one.

Hispanic or Latino. A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, “Spanish origin,” can be used in addition to “Hispanic or Latino.”

Hispanic or Latino

Not Hispanic or Latino

RACE

2. What race do you consider yourself to be? Select one or more of the following.

American Indian or Alaska Native. A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment.

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. (Note: Individuals from the Philippine Islands have been recorded as Pacific Islanders in previous data collection strategies.)

Black or African American. A person having origins in any of the black racial groups of Africa. Terms such as “Haitian” or “Negro” can be used in addition to “Black” or African American.”

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Check here if you do not wish to provide some or all of the above information.

Name of Applicant (Last, first, middle): _____

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			
Racial Categories: Total of All Subjects *			

* The "Ethnic Category: Total of All Subjects" must be equal to the "Racial Categories: Total of All Subjects."

Name of Applicant (Last, first, middle): _____

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.

Applicant's Instructions for Submission of References

This notice explains the submission of references for Ruth L. Kirschstein National Research Service Award Individual Fellowship applicants. Applications will not be reviewed unless at least three (3) references are received with the application. Applicants are responsible for complete applications reaching the PHS on schedule.

Submission Process

Forward reference forms to referees with sufficient lead time so that the completed forms will be part of the application package. Fill out upper right corner before forwarding to referee. Referees should be provided with postage-paid return envelopes addressed to you with the following words in the front bottom left corner —DO NOT OPEN—PHS USE ONLY. Attach unopened references to the front of the original application and submit the entire package by the submission deadline.

Note to Respondent

The applicant is applying for a competitive Ruth L. Kirschstein National Research Service Award Individual Fellowship from the Public Health Service (PHS) for research training in health-related areas. Your assessment of the applicant's potential for a research career is requested. The references will be used by PHS committees of consultants in assessing applicants.

At least three references must be submitted with the application or the application will be returned. ***Please complete this form and return it to the applicant in sufficient time for the applicant to meet the deadline date.***

Complete the form in English. The form should be typed if possible. If any part of the form is handwritten, use a black pen. The color blue does not reproduce. If the space provided is inadequate, use an 8-1/2 x 11" sheet of paper and put the applicant's name in the upper right corner.

Although the Privacy Act of 1974 allows NSRA applicants to have access to personal information contained in their records, we have asked the applicant to provide you with a self-addressed envelope with — ***DO NOT OPEN—PHS USE ONLY*** — in the front bottom left corner. Applicants are asked not to open the references in order to protect the confidentiality of the process. Thank you for your assistance.

PHS estimates that it will take 45 minutes to complete this form. This includes time for reviewing the instructions, gathering needed information, and completing the form. 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. If you have comments regarding this burden estimate or any other aspects of the collection of information, including suggestions for reducing this burden, send comments to NIH Project Clearance Office, 6705 Rockledge Drive MSC 7974, Bethesda, MD 20892-7974, Attention: PRA (0925-0002). ***DO NOT RETURN THE COMPLETED FORM TO THIS ADDRESS.***

Department of Health and Human Services
Public Health Service

(Applicant completes this block.)

NAME OF APPLICANT *(Last, first, middle initial)*

Reference

**Ruth L. Kirschstein National Research Service Award
Individual Fellowship**

PROPOSED SPONSORING INSTITUTION

Compare the applicant with other individuals of similar training and experience with whom you have been associated. Use the following numerical scores, from 1 (best) to 5 (poorest). Mark every block; insert "X" if insufficient knowledge to rate and "NA" if not applicable.

- 1 Comparable to the best individual in a current class or research laboratory (upper 5%)
- 2 Upper 6 to 20%
- 3 Upper 21 to 40%
- 4 Middle 41 to 60%
- 5 Lower 40%

Use black ink.

- | | |
|--|---|
| <input type="checkbox"/> Research Ability and Potential | <input type="checkbox"/> Originality |
| <input type="checkbox"/> Written and Verbal Communications | <input type="checkbox"/> Accuracy |
| <input type="checkbox"/> Perseverance in Pursuing Goals | <input type="checkbox"/> Scientific Background |
| <input type="checkbox"/> Self-Reliance and Independence | <input type="checkbox"/> Familiarity with Research Literature |
| <input type="checkbox"/> Clinical Proficiency, if relevant | <input type="checkbox"/> Ability to Organize Scientific Data |
| <input type="checkbox"/> Laboratory Skills and Techniques, if relevant | |

Describe your association with the applicant. Comment on the above items, including other areas as appropriate, identifying the strengths and weaknesses that should be considered in evaluating the applicant's potential for a research career. *(Use continuation pages as necessary.)*

DATES ASSOCIATED WITH APPLICANT

CAPACITY AT THAT TIME *(Teacher, dissertation advisor, supervisor, or other) (Use continuation pages as necessary.)*

RESPONDENT *(Name, title, department, and institution)*

TELEPHONE NUMBER

SIGNATURE

DATE