Department of Health and Human Services
Public Health Services

Grant Application

Do not exceed character length restrictions indicated.

LEAVE BLANK—FOR PHS USE ONLY.

Type	Activity	Number
Review Group		Formerly
Council/Board (Month, Year)		Date Received

1. TITLE OF PROJECT *(Do not exceed 81 characters, including spaces and punctuation.)*

2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION ☐ NO ☐ YES
(If "Yes," state number and title)
Number: Title:

3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR **New Investigator ☐ No ☐ Yes**

3a. NAME (Last, first, middle)

3b. DEGREE(S)

3h. eRA Commons User Name

3c. POSITION TITLE

3d. MAILING ADDRESS *(Street, city, state, zip code)*

3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

3f. MAJOR SUBDIVISION

3g. TELEPHONE AND FAX *(Area code, number and extension)*
TEL: FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS RESEARCH ☐ No ☐ Yes

4a. Research Exempt ☐ No ☐ Yes If "Yes," Exemption No.

4b. Federal-Wide Assurance No.

4c. Clinical Trial ☐ No ☐ Yes

4d. NIH-defined Phase III Clinical Trial ☐ No ☐ Yes

5. VERTEBRATE ANIMALS ☐ No ☐ Yes

5a. Animal Welfare Assurance No

6. DATES OF PROPOSED PERIOD OF SUPPORT *(month, day, year—MM/DD/YY)*		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
From	Through	7a. Direct Costs ($)	7b. Total Costs ($)	8a. Direct Costs ($)	8b. Total Costs ($)

9. APPLICANT ORGANIZATION
Name
Address

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 Cong. 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. 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. *(In ink. "Per" signature not acceptable.)*

DATE

Use only if preparing an application with Multiple PDs/PIs. See http://grants.nih.gov/grants/multi_pi/index.htm for details.

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

3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR		
3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
3c. POSITION TITLE	3d. MAILING ADDRESS *(Street, city, state, zip code)*	
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT		
3f. MAJOR SUBDIVISION		
3g. TELEPHONE AND FAX *(Area code, number and extension)* TEL: FAX:	E-MAIL ADDRESS:	

3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR		
3a. NAME (Last, first, middle)	3b. DEGREE(S)	3h. NIH Commons User Name
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3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR		
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3c. POSITION TITLE	3d. MAILING ADDRESS *(Street, city, state, zip code)*	
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT		
3f. MAJOR SUBDIVISION		
3g. TELEPHONE AND FAX *(Area code, number and extension)* TEL: FAX:	E-MAIL ADDRESS:	

3. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR		
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3c. POSITION TITLE	3d. MAILING ADDRESS *(Street, city, state, zip code)*	
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT		
3f. MAJOR SUBDIVISION		
3g. TELEPHONE AND FAX *(Area code, number and extension)* TEL: FAX:	E-MAIL ADDRESS:	

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

PROJECT SUMMARY (See instructions):

RELEVANCE (See instructions):

PROJECT/PERFORMANCE SITE(S) (if additional space is needed, use Project/Performance Site Format Page)

Project/Performance Site Primary 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:		

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

SCIENTIFIC/KEY PERSONNEL. See instructions. *Use continuation pages as needed* to provide the required information in the format shown below. Start with Program Director(s)/Principal Investigator(s). List all other key personnel in alphabetical order, last name first.

Name	eRA Commons User Name	Organization	Role on Project

OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project

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/. *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

The name of the program director/principal investigator must be provided at the top of each printed page and each continuation page.

RESEARCH GRANT

TABLE OF CONTENTS

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

DETAILED BUDGET FOR INITIAL BUDGET PERIOD
DIRECT COSTS ONLY

FROM | THROUGH

PERSONNEL *(Applicant organization only)*		Months Devoted to Project				DOLLAR AMOUNT REQUESTED *(omit cents)*		
NAME	ROLE ON PROJECT	Cal. Mnths	Acad. Mnths	Summer Mnths	INST.BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
	PD/PI							
SUBTOTALS →								

CONSULTANT COSTS		
EQUIPMENT *(Itemize)*		
SUPPLIES *(Itemize by category)*		
TRAVEL		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS *(Itemize by category)*		
OTHER EXPENSES *(Itemize by category)*		

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD *(Item 7a, Face Page)*		**$**
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD		**$**

BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD
DIRECT COSTS ONLY

BUDGET CATEGORY TOTALS		INITIAL BUDGET PERIOD *(from Form Page 4)*	ADDITIONAL YEARS OF SUPPORT REQUESTED			
			2nd	3rd	4th	5th
PERSONNEL: *Salary and fringe benefits. Applicant organization only.*						
CONSULTANT COSTS						
EQUIPMENT						
SUPPLIES						
TRAVEL						
PATIENT CARE COSTS	INPATIENT					
	OUTPATIENT					
ALTERATIONS AND RENOVATIONS						
OTHER EXPENSES						
CONSORTIUM/ CONTRACTUAL COSTS	DIRECT					
SUBTOTAL DIRECT COSTS *(Sum = Item 8a, Face Page)*						
CONSORTIUM/ CONTRACTUAL COSTS	F&A					
TOTAL DIRECT COSTS						

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD **$**

JUSTIFICATION. Follow the budget justification instructions exactly. Use continuation pages as needed.

RESOURCES

FACILITIES: Specify the facilities to be used for the conduct of the proposed research. Indicate the project/performance sites and describe capacities, pertinent capabilities, relative proximity, and extent of availability to the project. If research involving Select Agent(s) will occur at any performance site(s), the biocontainment resources available at each site should be described. Under "Other," identify support services such as machine shop, electronics shop, and specify the extent to which they will be available to the project. Use continuation pages if necessary.

Laboratory:

Clinical:

Animal:

Computer:

Office:

Other:

MAJOR EQUIPMENT: List the most important equipment items already available for this project, noting the location and pertinent capabilities of each.

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

CHECKLIST

TYPE OF APPLICATION *(Check all that apply.)*

☐ 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, renewal, or revision application.)

☐ RENEWAL of grant number: _____
(This application is to extend a funded grant beyond its current project period.)

☐ REVISION to grant number: _____
(This application is for additional funds to supplement a currently funded grant.)

☐ CHANGE of program director/principal investigator.

Name of former program director/principal investigator: _____

☐ CHANGE of Grantee Institution. Name of former institution: _____

☐ FOREIGN application ☐ Domestic Grant with foreign involvement List Country(ies) Involved:

INVENTIONS AND PATENTS *(Renewal appl. only)* ☐ No ☐ Yes

If "Yes," ☐ Previously reported ☐ Not previously reported

1. PROGRAM INCOME ***(See instructions.)***
All applications must indicate whether program income is anticipated during the period(s) for which grant support is request. 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 and listed in Part I, 4.1 under Item 14. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

3. FACILITIES AND ADMINSTRATIVE COSTS (F&A)/ INDIRECT COSTS. See specific instructions.

☐ DHHS Agreement dated: _____ ☐ No Facilities And Administrative Costs Requested.

☐ DHHS Agreement being negotiated with _____ Regional Office.

☐ No DHHS Agreement, but rate established with _____ Date _____

CALCULATION* *(The entire grant application, including the Checklist, will be reproduced and provided to peer reviewers as confidential information.)*

a. Initial budget period:	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
b. 02 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
c. 03 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
d. 04 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
e. 05 year	Amount of base $		x Rate applied	0.00%	% = F&A costs	$	
	Enter Rate above as a decimal (e.g., 0.25 for 25%, 0.495 for 49.5%)				TOTAL F&A Costs	$	

*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.):*

4. DISCLOSURE PERMISSION STATEMENT: If this application does not result in an award, is the Government permitted to disclose the title of your proposed project, and the name, address, telephone number and e-mail address of the official signing for the applicant organization, to organizations that may be interested in contacting you for further information (e.g., possible collaborations, investment)? ☐ Yes ☐ No

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

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

PERSONAL DATA ON PROGRAM DIRECTOR(S)/PRINCIPAL INVESTIGATOR(S)

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 program director(s)/principal investigator(s).

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. When multiple PDs/PIs are proposed, complete a form for each. **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 the 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/DD/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.

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	**Sex/Gender**		
	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.”

Program Director/Principal Investigator (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	Sex/Gender			
	Females	Males	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	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.

Type the name of the program director/principal investigator at the top of each printed page and each continuation page. (For type specifications, see PHS 398 Instructions.)

INSTITUTIONAL RESEARCH TRAINING INCLUDING RUTH L. KIRSCHSTEIN NATIONAL RESEARCH SERVICE AWARD TABLE OF CONTENTS (Substitute Page)

* Font and margin requirements must conform to limits provided in PHS 398 Specific Instructions.

Institutional Training Initial Budget Period Substitute Page

Program Director/Principal Investigator: (Last, first, middle)

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY (Institutional Training Substitute Page)	FROM	THROUGH
STIPENDS		**DOLLAR TOTAL**
PREDOCTORAL No. Requested:		
POSTDOCTORAL *(Itemize)* No. Requested:		
OTHER *(Specify)* No. Requested:		
TOTAL STIPENDS →		
TUITION and FEES *(Itemize)*		
TRAINEE TRAVEL *(Describe)*		
TRAINING-RELATED EXPENSES (including Health Insurance)		
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD *(Also enter on Face Page, Item 7)*		**$**

BUDGET FOR ENTIRE PROPOSED PERIOD OF SUPPORT DIRECT COSTS ONLY (Institutional Training Substitute Page)

BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD *(from Form Page 4)*		ADDITIONAL YEARS OF SUPPORT REQUESTED							
			2nd		3rd		4th		5th	
	No.		No.		No.		No.		No.	
PREDOCTORAL STIPENDS										
POSTDOCTORAL STIPENDS										
OTHER STIPENDS										
TOTAL STIPENDS										
TUITION AND FEES										
TRAINEE TRAVEL										
TRAINING-RELATED EXPENSES (including Health Insurance)										
TOTAL DIRECT COSTS										

TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD *(Item 8a, Face Page)* **$**

JUSTIFICATION. For all years, explain the basis for the budget categories requested. Follow the instructions for the Initial Budget Period and include anticipated postdoctoral levels.

DO NOT SUBMIT UNLESS REQUESTED
Renewal Applications Only
SENIOR/KEY PERSONNEL REPORT

All Senior/Key Personnel for the Current Budget Period

Name	Degree(s)	SSN (last 4 digits)	Role on Project (e.g. PI, Res. Assoc.)	Months Devoted to Project		
				Cal	Acad	Summer

Mailing address for application

Use this label or a facsimile

All applications and other deliveries to the Center for Scientific Review must come either via courier delivery or via the United States Postal Service (USPS.) Applications delivered by individuals to the Center for Scientific Review will not be accepted.

Applications sent via the USPS EXPRESS or REGULAR MAIL should be sent to the following address:

CENTER FOR SCIENTIFIC REVIEW
NATIONAL INSTITUTES OF HEALTH
6701 ROCKLEDGE DRIVE
ROOM 1040 – MSC 7710
BETHESDA, MD 20892-7710

NOTE: All applications sent via a courier delivery service (non-USPS) should use this address, but CHANGE THE ZIP CODE TO 20817

The telephone number is 301-435-0715. C.O.D. applications will *not* be accepted.

A special label for responding to RFAs is not required.