

Department of Health and Human Services Public Health Services Grant Application <i>Do not exceed character length restrictions indicated.</i>		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 81 characters, including spaces and punctuation.)</i>					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION NO YES <i>(If "Yes," state number and title)</i> Number: _____ Title: _____					
3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR					
3a. NAME (Last, first, middle)			3b. DEGREE(S)		3h. eRA Commons User Name
3c. POSITION TITLE			3d. MAILING ADDRESS <i>(Street, city, state, zip code)</i> E-MAIL ADDRESS:		
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT					
3f. MAJOR SUBDIVISION					
3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i> TEL: _____ FAX: _____					
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 <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			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. <i>(In ink. "Per" signature not acceptable.)</i>		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 <i>(Street, city, state, zip code)</i>	
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3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i> TEL: FAX:		

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
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OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project
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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):

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY	FROM	THROUGH
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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

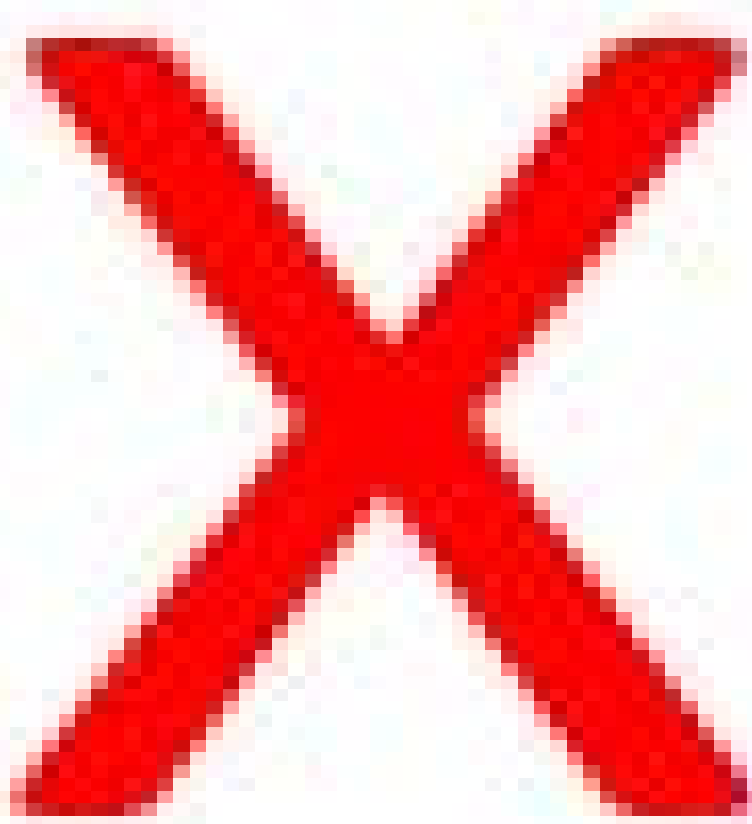
NAME	ROLE ON PROJECT	Cal. Mnths	Acad. Mnths	Summer Mnths	INST.BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
	PD/PI							
SUBTOTALS →								

CONSULTANT COSTS	
EQUIPMENT (<i>Itemize</i>)	
SUPPLIES (<i>Itemize by category</i>)	
TRAVEL	
INPATIENT CARE COSTS	
OUTPATIENT CARE COSTS	
ALTERATIONS AND RENOVATIONS (<i>Itemize by category</i>)	
OTHER EXPENSES (<i>Itemize by category</i>)	

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (<i>Item 7a, Face Page</i>)		\$
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 <i>(from Form Page 4)</i>	2nd ADDITIONAL YEAR OF SUPPORT REQUESTED	3rd ADDITIONAL YEAR OF SUPPORT REQUESTED	4th ADDITIONAL YEAR OF SUPPORT REQUESTED	5th ADDITIONAL YEAR OF SUPPORT REQUESTED
PERSONNEL: <i>Salary and fringe benefits. Applicant organization only.</i>					
CONSULTANT COSTS					
EQUIPMENT					
SUPPLIES					
TRAVEL					
INPATIENT CARE COSTS					
OUTPATIENT CARE COSTS					
ALTERATIONS AND RENOVATIONS					
OTHER EXPENSES					
DIRECT CONSORTIUM/ CONTRACTUAL COSTS					
SUBTOTAL DIRECT COSTS <i>(Sum = Item 8a, Face Page)</i>					
F&A CONSORTIUM/ CONTRACTUAL COSTS					
TOTAL DIRECT COSTS					



TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD \$

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

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

RESOURCES

Follow the 398 application instructions in Part I, 4.7 Resources.

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.

HHS Agreement dated: _____ No Facilities And Administrative Costs Requested.

HHS Agreement being negotiated with _____ Regional Office.

No HHS 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 _____	% = F&A costs _____	\$ _____
b. 02 year	Amount of base \$ _____	x Rate applied _____	% = F&A costs _____	\$ _____
c. 03 year	Amount of base \$ _____	x Rate applied _____	% = F&A costs _____	\$ _____
d. 04 year	Amount of base \$ _____	x Rate applied _____	% = F&A costs _____	\$ _____
e. 05 year	Amount of base \$ _____	x Rate applied _____	% = F&A costs _____	\$ _____
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.):*