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| Form Approved Through 02/28/2023 OMB No. 0925-0002 OMB No. 0925-0001  |
| Department of Health and Human ServicesPublic Health Services | Review Group      | Type      | Activity      | Grant Number      |
| Grant Progress Report | 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 | 5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL |
| 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.       | Tel:       | Fax:       |
| 6c. NIH-Defined Phase III Clinical Trial [ ]  No [ ]  Yes | E-MAIL:       |
| 7. VERTEBRATE ANIMALS [ ]  No [ ]  Yes | 10. PROJECT/PERFORMANCE SITE(S) |
| 7a. If “Yes,” IACUC approval Date       | Organizational Name:       |
| 7b. Animal Welfare Assurance No.       | DUNS:       |
| 8. COSTS REQUESTED FOR NEXT BUDGET PERIOD | Street 1:       |
| 8a. DIRECT $      | 8b. TOTAL $      | Street 2:       |
| 9. INVENTIONS AND PATENTS [ ]  No [ ]  Yes  If “Yes, [ ]  Previously Reported [ ]  Not Previously Reported | 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      |

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