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| Form Approved Through 02/28/2023 OMB No. 0925-0002 OMB No. 0925-0001 | | | | | | | | | | | | | | | | |
| Department of Health and Human Services  Public 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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