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| Form Approved Through 02/28/2023 OMB No. 0925-0001 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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)* | | | | | | | | | | | | E-MAIL ADDRESS: | | | | | | | | | | | | | | | |
| TEL: |  | | | | | FAX: | |  | | | |  | | | | | | | | | | | | | | | |
| 4. HUMAN SUBJECTS RESEARCH | | | | | | | | | 4a. Research Exempt | | | If “Yes,” Exemption No. | | | | | | | | | | | | | | | |
| No  Yes | | | | | | | | | No  Yes | | |  | | | | | | | | | | | | | | | |
| 4b. Federal-Wide Assurance No. | | | | | | | | | 4c. Clinical Trial | | | | | | | | | 4d. NIH-defined Phase III Clinical Trial | | | | | | | | | |
|  | | | | | | | | | No  Yes | | | | | | | | | 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 | | | | | | | | | | | | 10. TYPE OF ORGANIZATION | | | | | | | | | | | | | | | |
| Name | | |  | | | | | | | | | Public: **→**  Federal  State  Local | | | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | 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 | | | | | | | | | | | | 13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION | | | | | | | | | | | | | | | |
| Name | | |  | | | | | | | | | Name | |  | | | | | | | | | | | | | |
| Title | | |  | | | | | | | | | Title | |  | | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | Address | |  | | | | | | | | | | | | | |
| Tel: |  | | | | | | FAX: | | |  | | Tel: |  | | | | | | | | | | FAX: | |  | | |
| E-Mail: | | |  | | | | | | | | | 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 |

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| **Use only if preparing an application with Multiple PDs/PIs. See** [**http://grants.nih.gov/grants/multi\_pi/index.htm**](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)* | | | | E-MAIL ADDRESS: | | | |
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| **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** | | | | | | | |
| 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)* | | | | E-MAIL ADDRESS: | | | |
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| **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)* | | | | E-MAIL ADDRESS: | | | |
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| 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: | | | | | |  | | | | | | | | |

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| Program Director/Principal Investigator (Last, First, Middle): | | | |  | | | | |
|  | | | | | | | | |
| SENIOR/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 senior/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:** <https://grants.nih.gov/stem_cells/registry/current.htm>. *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** | | | | | | | | |
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 Page 3 Form Page 2-continued

Number the following pages consecutively throughout   
 the application. Do not use suffixes such as 4a, 4b.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Program Director/Principal Investigator (Last, First, Middle): |  | | | | |
| 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 | | | | | |
|  | | | *Page Numbers* | | |
| Face Page | | |  | 1 |  |
| Description, Project/Performance Sites, Senior/Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells | | |  | 2 |  |
| Table of Contents | | |  |  |  |
| Detailed Budget for Initial Budget Period | | |  |  |  |
| Budget for Entire Proposed Period of Support | | |  |  |  |
| Budgets Pertaining to Consortium/Contractual Arrangements | | |  |  |  |
| Biographical Sketch – Program Director/Principal Investigator (*Not to exceed five pages each*) | | |  |  |  |
| Other Biographical Sketches (*Not to exceed five pages each –* *See instructions*) | | |  |  |  |
| Resources | | |  |  |  |
| Checklist | | |  |  |  |
|  | | |  | | |
| Research Plan | | |  |  |  |
|  | | |  | | |
| 1. Introduction to Resubmission Application, if applicable, or Introduction to Revision Application,  if applicable \* | | |  |  |  |
| 2. Specific Aims \* | | |  |  |  |
| 3. Research Strategy \* | | |  |  |  |
| 4. Bibliography and References Cited/Progress Report Publication List | | |  |  |  |
| 5. Vertebrate Animals | | |  |  |  |
| 6. Select Agent Research | | |  |  |  |
| 7. Multiple PD/PI Leadership Plan | | |  |  |  |
| 8. Consortium/Contractual Arrangements | | |  |  |  |
| 9. Letters of Support (e.g., Consultants) | | |  |  |  |
| 10. Resource Sharing Plan(s) | | |  |  |  |
| 11. Authentication of Key Biological and/or Chemical Resources | | |  |  |  |
| 12. PHS Human Subjects and Clinical Trials Information | | |  |  |  |
|  | | |  | | |
| Appendix *(Two identical CDs.)* | |  | | Check if  Appendix is  Included | |
| \* Follow the page limits for these sections indicated in the application instructions, unless the Funding Opportunity Announcement specifies otherwise. | | | | | |

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| Program Director/Principal Investigator (Last, First, Middle): |  | | |
|  | | | |
| DETAILED BUDGET FOR INITIAL BUDGET PERIODDIRECT COSTS ONLY | | FROM | THROUGH |
|  |  |

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 |  |  |  | |  |  |  | |  |
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| SUBTOTALS | | | | | | |  |  | |  |
| CONSULTANT COSTS | | | | | | | | | |  |
| EQUIPMENT *(Itemize)* | | | | | | | | | |  |
| SUPPLIES *(Itemize by category)* | | | | | | | | | |  |
| TRAVEL | | | | | | | | | |  |
| INPATIENT CARE COSTS | | | | | | | | | |  |
| OUTPATIENT CARE COSTS | | | | | | | | | |  |
| 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 | | | | | | | | | $ |  |

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| Program Director/Principal Investigator (Last, First, Middle): | | |  | | | | | |
|  | | | | | | | | |
| BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD DIRECT COSTS ONLY | | | | | | | | |
| BUDGET CATEGORY TOTALS | INITIAL BUDGET PERIOD *(from Form Page 4)* | 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: *Salary and fringe benefits. Applicant organization only*. |  |  | |  |  | |  | |
| CONSULTANT COSTS |  |  | |  |  | |  | |
| EQUIPMENT |  |  | |  |  | |  | |
| SUPPLIES |  |  | |  |  | |  | |
| TRAVEL |  |  | |  |  | |  | |
| INPATIENT CARE COSTS |  |  | |  |  | |  | |
| OUTPATIENT CARE  COSTS |  |  | |  |  | |  | |
| ALTERATIONS AND RENOVATIONS |  |  | |  |  | |  | |
| OTHER EXPENSES |  |  | |  |  | |  | |
| DIRECT CONSORTIUM/ CONTRACTUAL COSTS |  |  | |  |  | |  | |
| SUBTOTAL DIRECT COSTS  *(Sum = Item 8a, Face Page)* |  |  | |  |  | |  | |
| 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. | | | | | | | | |

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| Program Director/Principal Investigator (Last, First, Middle): |  |
|  | |
| RESOURCES | |
| Follow the 398 application instructions in Part I, 4.7 Resources. | |
|  | |

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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Program Director/Principal Investigator (Last, First, Middle): | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
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| 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) | | | | | | | | | | |
|  | | | |  | | | | | | | | | | | | | |  | | | | | | | | | | |
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| **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 the [NIH Grants Policy Statement, Section 4: Public Policy Requirements, Objectives and Other Appropriation Mandates](https://grants.nih.gov/grants/policy/nihgps/HTML5/section_4/4_public_policy_requirements__objectives_and_other_appropriation_mandates.htm?tocpath=4%20Public%20Policy%20Requirements%2C%20Objectives%20and%20Other%20Appropriation%20Mandates%7C_____0). 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.):* | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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PHS Human Subjects and Clinical Trials Information

Note: The PHS Human Subjects and Clinical Trials Information form is not included in this combined form. See individual form here: <https://grants.nih.gov/grants/forms/human-subjects-clinical-trials-information.pdf>.

**\*\*** The PHS Human Subjects and Clinical Trials Information fillable form can be opened in Internet Explorer. However, you may download it from any browser.\*\*

0925-0001 (Rev. 03/2020) Page     **PHS** **Human Subjects and Clinical Trial Information**

# DO NOT SUBMIT UNLESS REQUESTED

Renewal Applications Only

# ALL PERSONNEL REPORT

Always list the PD/PI(s). In addition, list all other personnel who participated in the project during the current budget period for at least one person month or more, regardless of the source of compensation (a person month equals approximately 160 hours or 8.3% of annualized effort). Use Cal, Acad, or Summer to Enter Months Devoted to Project.

| Commons ID | Name | Degree(s) | SSN (last 4 digits) | Role on Project (e.g. PD/PI, Res. Assoc.) | DoB (MM /YY) | Cal | Acad | Summer |
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***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.**