

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>		
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT				
3f. MAJOR SUBDIVISION				
3g. TELEPHONE AND FAX <i>(Area code, number and extension)</i>				
TEL:		E-MAIL ADDRESS:		
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 <i>(month, day, year—MM/DD/YY)</i>		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:		Tel:		FAX:
FAX:		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. <i>(In ink. "Per" signature not acceptable.)</i>		DATE

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

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	_____
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 four pages each)	_____
Other Biographical Sketches (Not to exceed four 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. Inclusion Enrollment Report (Renewal or Revision applications only)	_____
5. Bibliography and References Cited/Progress Report Publication List.....	_____
6. Protection of Human Subjects	_____
7. Inclusion of Women and Minorities	_____
8. Targeted/Planned Enrollment Table	_____
9. Inclusion of Children.....	_____
10. Vertebrate Animals.....	_____
11. Select Agent Research	_____
12. Multiple PD/PI Leadership Plan	_____
13. Consortium/Contractual Arrangements.....	_____
14. Letters of Support (e.g., Consultants)	_____
15. Resource Sharing Plan (s).....	_____
Appendix (Five 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.

**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.

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	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	Females	Males	Sex/Gender 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	Sex/Gender 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.

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

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.

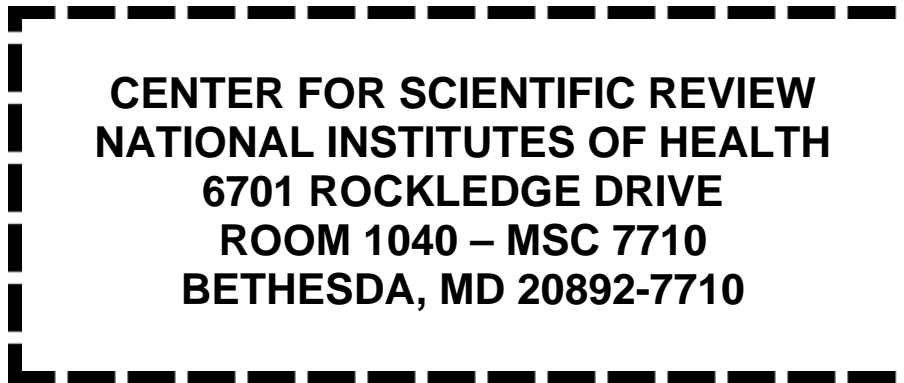
Commons ID	Name	Degree(s)	SSN (last 4 digits)	Role on Project (e.g. PD/PI, Res. Assoc.)	DoB (MM /YY)	Cal	Acad	Summer

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:



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.