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)*
TEL: FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS RESEARCH No Yes	4a. Research Exempt If "Yes," Exemption No. No Yes	
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 *(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
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. *(In ink. "Per" signature not acceptable.)*	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 *(Street, city, state, zip code)*	
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3g. TELEPHONE AND FAX *(Area code, number and extension)* TEL: FAX:	E-MAIL ADDRESS:	

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

OTHER SIGNIFICANT CONTRIBUTORS

Name	Organization	Role on Project

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

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

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 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. Protection of Human Subjects .... ____
6. Data Safety Monitoring Plan .... ____
7. Inclusion of Women and Minorities .... ____
8. PHS Inclusion Enrollment Report .... ____
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) .... ____
16. Authentication of Key Biological and/or Chemical Resources .... ____

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.

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

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT 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							
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)*		**$**
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD		**$**

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.