

Department of Health and Human Services Public Health Services  <b>Grant Application</b>  <i>Do not exceed character length restrictions indicated.</i>		<b>LEAVE BLANK—FOR PHS USE ONLY.</b>			
		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 <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(If "Yes," state number and title)</i> Number: _____ Title: _____					
<b>3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR</b>					
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: _____ FAX: _____					
E-MAIL ADDRESS:					
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes		If "Yes," Exemption No. _____	
4b. Federal-Wide Assurance No.		4c. Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes		4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes	
5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes			5a. Animal Welfare Assurance No. _____		
6. DATES OF PROPOSED PERIOD OF SUPPORT <i>(month, day, year—MM/DD/YY)</i> From _____ Through _____		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
		7a. Direct Costs (\$)		7b. Total Costs (\$)	
		8a. Direct Costs (\$)		8b. Total Costs (\$)	
9. APPLICANT ORGANIZATION Name _____ Address _____			10. TYPE OF ORGANIZATION		
			Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local  Private: → <input type="checkbox"/> Private Nonprofit  For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business <input type="checkbox"/> Woman-owned <input type="checkbox"/> 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. <i>(In ink. "Per" signature not acceptable.)</i>		DATE