

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. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR		New Investigator	No	Yes	
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		5. VERTEBRATE ANIMALS No Yes			
No Yes		4b. Human Subjects Assurance No.		5a. If "Yes," IACUC approval Date	
		4c. Clinical Trial No Yes	4d. NIH-defined Phase III Clinical Trial No Yes		
4a. Research Exempt No Yes		5b. Animal welfare assurance no.			
If "Yes," Exemption 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:		FAX:		Tel:	
E-Mail:				FAX:	
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