

PD #:

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>									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Type</td> <td style="width:33%;">Activity</td> <td style="width:34%;">Number</td> </tr> <tr> <td>Review Group</td> <td></td> <td>Formerly</td> </tr> <tr> <td>Council/Board (Month, Year)</td> <td></td> <td>Date Received</td> </tr> </table>	Type	Activity	Number	Review Group		Formerly	Council/Board (Month, Year)		Date Received
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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 ( <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  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 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: _____
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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 _____
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