

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 <input type="checkbox"/> NO <input type="checkbox"/> 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: _____ FAX: _____					
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

ABSTRACT

Please provide a succinct and accurate description of the proposed work in 30 lines of text or fewer. Should be informative to other persons working in the same or related fields and understandable to a scientifically literate reader. Include: the project's broad, long-term objectives and specific aims, and a description of the research design and methods. Do not include: proprietary or confidential information, or descriptions of past accomplishments.