

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: FAX:			
4. HUMAN SUBJECTS RESEARCH No Yes		5. VERTEBRATE ANIMALS No Yes	
4b. Human Subjects Assurance No.		5a. If "Yes," IACUC approval Date	5b. Animal welfare assurance no.
4c. Clinical Trial No Yes	4d. NIH-defined Phase III Clinical Trial No Yes		
4a. Research Exempt No Yes		If "Yes," Exemption 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	
		7a. Direct Costs (\$)	7b. Total Costs (\$)
		8a. Direct Costs (\$)	8b. Total Costs (\$)
8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT			
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. (<i>In ink. "Per" signature not acceptable.</i>)	DATE