Department of Health and Human Services
Public Health Services

Grant Application

Do not exceed character length restrictions indicated.

LEAVE BLANK—FOR PHS USE ONLY.

Type	Activity	Number
Review Group		Formerly
Council/Board (Month, Year)		Date Received

1. TITLE OF PROJECT *(Do not exceed 81 characters, including spaces and punctuation.)*

SAMPLE

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 **New Investigator** ☐ **No** ☐ **Yes**

3a. NAME (Last, first, middle)

3b. DEGREE(S)

3h. eRA Commons User Name

3c. POSITION TITLE

3d. MAILING ADDRESS *(Street, city, state, zip code)*

3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

3f. MAJOR SUBDIVISION

3g. TELEPHONE AND FAX *(Area code, number and extension)*
TEL: FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS RESEARCH ☐ No ☐ Yes

4a. Research Exempt ☐ No ☐ Yes If "Yes," Exemption No.

4b. Federal-Wide Assurance No.

4c. Clinical Trial ☐ No ☐ Yes

4d. NIH-defined Phase III Clinical Trial ☐ No ☐ Yes

5. VERTEBRATE ANIMALS ☐ No ☐ Yes

5a. Animal Welfare Assurance No

6. DATES OF PROPOSED PERIOD OF SUPPORT *(month, day, year—MM/DD/YY)*
From Through

7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD
7a. Direct Costs ($) 7b. Total Costs ($)

8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT
8a. Direct Costs ($) 8b. Total Costs ($)

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.
(In ink. "Per" signature not acceptable.)

DATE

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