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| Form Approved Through 8/31/2015 OMB No. 0925-0001 |
| Department of Health and Human ServicesPublic Health ServicesGrant ApplicationDo 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.)*      |
| 2. CHECK BOXES IF APPLICABLE: [ ]  JUNIOR FACULTY [ ]  CANCER-RELATED PROPOSAL [ ]  NEUROSCIENCE-RELATED PROPOSAL  |
|  | You may check more than one box. |  |  |
| **3. PRINCIPAL INVESTIGATOR** |
| 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)* | E-MAIL ADDRESS:  |
| TEL: |       | FAX: |       |       |
| 4. HUMAN SUBJECTS RESEARCH | 4a. Research Exempt  | If “Yes,” Exemption No. |
|  [ ]  No [ ]  Yes | [ ]  No [ ]  Yes |       |
| 4b. Federal-Wide Assurance No.  | 4c. Clinical Trial | 4d. NIH-defined Phase III Clinical Trial |
|       | [ ]  No [ ]  Yes |  [ ]  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)* | 7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD | 8. DO NOT COMPLETE |
| From | Through | 7a. Direct Costs ($) | 7b. Do not complete | 8a. Do not complete | 8b. Do not complete |
|       |       |       |       |       |       |
| 9. APPLICANT ORGANIZATION | 10. DO NOT COMPLETE |
| Name |       | Public: **→** [ ]  Federal [ ]  State [ ]  Local |
| Address |       | Private: **→** [ ]  Private Nonprofit |
| For-profit: **→** [ ]  General [ ]  Small Business [ ]  Woman-owned [ ]  Socially and Economically Disadvantaged |
| 11. DO NOT COMPLETE      |
| DUNS NO. |       | Cong. District |       |
| 12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE | 13. DO NOT COMPLETE |
| Name |       | Name |       |
| Title |       | Title  |       |
| Address |       | Address |       |
| Tel: |       | FAX: |       | Tel: |       | FAX: |       |
| E-Mail: |       | 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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