

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. 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:			E-MAIL ADDRESS:		
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 <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			10. TYPE OF ORGANIZATION		
Name			Public: → Federal State Local		
Address			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			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION		
Name			Name		
Title			Title		
Address			Address		
Tel:			Tel:		FAX:
FAX:			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. <i>(In ink. "Per" signature not acceptable.)</i>		DATE