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| Form Approved Through 02/28/2023 OMB No. 0925-0001 | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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.)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION  NO  YES  *(If “Yes,” state number and title)* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number: | | P20GM103447 | | | Title: | | **OK-INBRE Collaborative Grant** | | | | | | | | | | | | | | | | | | | | |
| **3. PROGRAM DIRECTOR/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. COSTS REQUESTED FOR PROPOSED  PERIOD OF SUPPORT | | | | | | | |
| From | | | | Through | | | | | | | 7a. Direct Costs ($) | 7b. Total Costs ($) | | | | | | | | 8a. Direct Costs ($) | | | | 8b. Total Costs ($) | | | |
| 05/01/2024 | | | | 04/30/2025 | | | | | | |  |  | | | | | | | |  | | | |  | | | |
| 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: |  | | | | | | 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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| Program Director/Principal Investigator (Last, First, Middle): | | | | | | | | |  | | | | | |
|  | | | | | | | | | | | | | | |
| PROJECT SUMMARY (See NIH instructions): | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| RELEVANCE (See NIH instructions): | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |
| PROJECT/PERFORMANCE SITE(S) (if additional space is needed, use Project/Performance Site Format Page) | | | | | | | | | | | | | | |
| **Project/Performance Site Primary Location** | | | | | | | | | | | | | | |
| Organizational Name: | | | |  | | | | | | | | | | |
| DUNS: | |  | | | | | | | | | | | | |
| Street 1: | |  | | | | | | | | Street 2: |  | | | |
| City: |  | | | | | | | County: | |  | | | State: |  |
| Province: | | |  | | Country: | |  | | | | | Zip/Postal Code: | |  |
| Project/Performance Site Congressional Districts: | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | |
| **Additional Project/Performance Site Location** | | | | | | | | | | | | | | |
| Organizational Name: | | | |  | | | | | | | | | | |
| DUNS: | |  | | | | | | | | | | | | |
| Street 1: | |  | | | | | | | | Street 2: |  | | | |
| City: |  | | | | | | | County: | |  | | | State: |  |
| Province: | | |  | | Country: | |  | | | | | Zip/Postal Code: | |  |
| Project/Performance Site Congressional Districts: | | | | | |  | | | | | | | | |