Form Approved Through 2/28/01
OMB No. 0925-0001

Department of Health and Human Services
Public Health Service

# Application for Continuation Grant

| Review Group | Type | Activity | Grant Number |
|---|---|---|---|
| | | | |

Total Project Period
From: Through:

Requested Budget Period
From: Through:

1. TITLE OF PROJECT

2. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR *(Name and address, street, city, state, zip code)*

2b. E-MAIL ADDRESS

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

3. ORGANIZATIONAL CODE

4. APPLICANT ORGANIZATION *(Name and address, street, city, state, zip code)*

5. ENTITY IDENTIFICATION NUMBER

6. TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

E-MAIL ADDRESS

7. HUMAN SUBJECTS
☐ No
☐ Yes

7a. If "Yes," Exemption no. **or**
IRB approval date
☐ Full IRB **or**
☐ Expedited Review

7b. Assurance of compliance no.

8. VERTEBRATE ANIMALS
☐ No
☐ Yes

8a. If "Yes," IACUC approval date

8b. Animal welfare assurance no.

9. COSTS REQUESTED FOR NEXT BUDGET PERIOD
9a. DIRECT $ 9b. TOTAL $

10. INVENTIONS AND PATENTS *(See instructions)*
☐ No ☐ Yes If "Yes," ☐ Previously reported ☐ Not previously reported

11. PERFORMANCE SITE(S) *(Organizations and addresses)*

12a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR *(Item 2a)* | AREA CODE | TELEPHONE NO. AND FAX NO.

12b. NAME OF ADMINISTRATIVE OFFICIAL *(Item 6)*

12c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 15)*

E-MAIL ADDRESS

13. *Do not use this space.*

| | | |
|---|---|---|
| 14. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application. | SIGNATURE OF PI / PD NAMED IN 2a *(In ink. "Per" signature not acceptable.)* | DATE |
| 15. 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 Service 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 12c *(In ink. "Per" signature not acceptable.)* | DATE |