

**APPLICATION FOR FEDERAL ASSISTANCE
 SF 424 (R&R)**

3. DATE RECEIVED BY STATE	State Application Identifier

1. * TYPE OF SUBMISSION

Pre-application Application Changed/Corrected Application

4. a. Federal Identifier

b. Agency Routing Identifier

2. DATE SUBMITTED

01/22/2010

Applicant Identifier

Assigned by OIC

5. APPLICANT INFORMATION

* **Organizational DUNS:** 057588857

* **Legal Name:** University of Louisville Research Foundation, Inc.

Department: Industry Contracts **Division:** Clinical Research

* **Street1:** MedCenter One

Street2: 501 E. Broadway, Suite 200

* **City:** Louisville **County / Parish:** Jefferson

* **State:** KY: Kentucky **Province:**

* **Country:** USA: UNITED STATES *** ZIP / Postal Code:** 40202-1798

Person to be contacted on matters involving this application

Prefix: Mrs. *** First Name:** Vaquita **Middle Name:** Doss

* **Last Name:** Bunton **Suffix:** JD

* **Phone Number:** 502-852-8359 **Fax Number:** 502-852-2590

Email: indcontr@louisville.edu

6. * EMPLOYER IDENTIFICATION (EIN) or (TIN): 1611029626A1

7. * TYPE OF APPLICANT: M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)

Other (Specify):

Small Business Organization Type Women Owned Socially and Economically Disadvantaged

8. * TYPE OF APPLICATION:

New Resubmission Renewal Continuation Revision

If Revision, mark appropriate box(es):

A. Increase Award B. Decrease Award C. Increase Duration D. Decrease Duration

E. Other (specify):

* Is this application being submitted to other agencies? Yes No What other Agencies?

9. * NAME OF FEDERAL AGENCY:

National Institutes of Health

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:

TITLE:

11. * DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:

List Title of Project Here

12. PROPOSED PROJECT:

* **Start Date** 07/01/2010 *** Ending Date** 06/30/2014

*** 13. CONGRESSIONAL DISTRICT OF APPLICANT**

KY-003

14. PROJECT DIRECTOR/PRINCIPAL INVESTIGATOR CONTACT INFORMATION

Prefix: *** First Name:** Name of PI **Middle Name:**

* **Last Name:** Last Name of PI **Suffix:**

Position/Title: Assistant Professor

* **Organization Name:** University of Louisville Research Foundation, Inc.

Department: Name of PI's dept **Division:** PI's division

* **Street1:** MedCenter One

Street2: 501 E. Broadway, Suite 200

* **City:** Louisville **County / Parish:** Jefferson

* **State:** KY: Kentucky **Province:**

* **Country:** USA: UNITED STATES *** ZIP / Postal Code:** 40202-1798

* **Phone Number:** 502-852- **Fax Number:** 502-852-

* **Email:** PIemail@louisville.edu

<p>15. ESTIMATED PROJECT FUNDING</p> <p>a. Total Federal Funds Requested <input style="width:100px;" type="text" value="0.00"/></p> <p>b. Total Non-Federal Funds <input style="width:100px;" type="text" value="0.00"/></p> <p>c. Total Federal & Non-Federal Funds <input style="width:100px;" type="text" value="0.00"/></p> <p>d. Estimated Program Income <input style="width:100px;" type="text" value="0.00"/></p>	<p>16. * IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?</p> <p>a. YES <input type="checkbox"/> THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE: <input style="width:100px;" type="text"/></p> <p>b. NO <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372; OR <input type="checkbox"/> PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW</p>
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17. By signing this application, I certify (1) to the statements contained in the list of certifications* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances * and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

* I agree

* The list of certifications and assurances, or an Internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

18. SFLLL or other Explanatory Documentation

Add Attachment
Delete Attachment
View Attachment

19. Authorized Representative

Prefix: * First Name: Middle Name:

* Last Name: Suffix:

* Position/Title:

* Organization:

Department: Division:

* Street1:

Street2:

* City: County / Parish:

* State: Province:

* Country: * ZIP / Postal Code:

* Phone Number: Fax Number:

* Email:

*** Signature of Authorized Representative**

Completed on submission to Grants.gov

*** Date Signed**

Completed on submission to Grants.gov

20. Pre-application

Add Attachment
Delete Attachment
View Attachment