

Department of Health and Human Services Public Health Services	Review Group	Type	Activity	Grant Number
Grant Progress Report	Total Project Period			
	From:		Through:	
	Requested Budget Period			
	From:		Through:	

1. TITLE OF PROJECT

2a. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR (Name and address, street, city, state, zip code)	2b. E-MAIL ADDRESS
	2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT
	2d. MAJOR SUBDIVISION
	2e. Tel: Fax:

3a. APPLICANT ORGANIZATION (Name and address, street, city, state, zip code)	3b. Tel: Fax:
	3c. DUNS:
	4. ENTITY IDENTIFICATION NUMBER

6. HUMAN SUBJECTS No Yes 6a. Research Exempt <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> <tr> <td>No</td> <td>Yes</td> <td colspan="2">If Exempt ("Yes" in 6a): Exemption No.</td> <td colspan="2">If Not Exempt ("No" in 6a): IRB approval date</td> <td colspan="4"></td> </tr> </table>											No	Yes	If Exempt ("Yes" in 6a): Exemption No.		If Not Exempt ("No" in 6a): IRB approval date						5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL Tel: Fax: E-MAIL:
No	Yes	If Exempt ("Yes" in 6a): Exemption No.		If Not Exempt ("No" in 6a): IRB approval date																	
6b. Federal Wide Assurance No. 6c. NIH-Defined Phase III Clinical Trial No Yes																					

7. VERTEBRATE ANIMALS No Yes 7a. If "Yes," IACUC approval Date 7b. Animal Welfare Assurance No.	10. PROJECT/PERFORMANCE SITE(S) Organizational Name: DUNS:
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8. COSTS REQUESTED FOR NEXT BUDGET PERIOD 8a. DIRECT \$ 8b. TOTAL \$	Street 1: Street 2:
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9. INVENTIONS AND PATENTS No Yes If "Yes," Previously Reported Not Previously Reported	City: County: State: Province: Country: Zip/Postal Code: Congressional Districts:
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11. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION (Item 13)

TEL:	FAX:	E-MAIL:
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12. Corrections to Page 1 Face Page

13. 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 11. <i>(In ink)</i>	DATE
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