Form Approved Through 02/28/2023 OMB No. 0925-0002

Department of Health and Human Services
Public Health Services

Grant Progress Report

Review Group	Type	Activity	Grant Number

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)
Vanderbilt University Medical Center
3319 West End Avenue, Suite 970
Nashville, TN 372036856

3b. Tel: 615-875-6070 Fax: 615-343-2447

3c. DUNS: 079917897

4. ENTITY IDENTIFICATION NUMBER
35-2528741

6. HUMAN SUBJECTS ☐ No ☐ Yes

6a. Research Exempt	If Exempt ("Yes" in 6a): Exemption No.	If Not Exempt ("No" in 6a): IRB approval date
☐ No ☐ Yes		

6b. Federal Wide Assurance No. FWA00005756

6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes

5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL
D. Clinton Brown, MBA, CRA
Vice President, Office of Sponsored Programs
3319 West End Avenue,
Nashville, TN 37203-6856
Tel: 615-875-6070 Fax: 615-343-2447
E-MAIL: sponsoredprograms@vumc.org

7. VERTEBRATE ANIMALS ☐ No ☐ Yes

7a. If "Yes," IACUC approval Date

7b. Animal Welfare Assurance No.

10. PROJECT/PERFORMANCE SITE(S)
Organizational Name: Vanderbilt University Medical Center
DUNS: 079917897

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT $ 8b. TOTAL $

Street 1:

Street 2:

9. INVENTIONS AND PATENTS ☐ No ☐ Yes

If "Yes, ☐ Previously Reported
☐ Not Previously Reported

City:	County:
State:	Province:
Country:	Zip/Postal Code:

Congressional Districts: TN-007

11. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 13)*
D. Clinton Brown, MBA, CRA - Vice President, Office of Sponsored Programs

TEL: 615-875-6070	FAX: 615-343-2447	E-MAIL: sponsoredprograms@vumc.org

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. *(In ink)*	DATE