

Department of Health and Human Services Public Health Services Grant Application <i>Do not exceed character length restrictions indicated.</i>		LEAVE BLANK—FOR PHS USE ONLY.			
		Type	Activity	Number	
		Review Group		Formerly	
		Council/Board (Month, Year)		Date Received	
1. TITLE OF PROJECT (<i>Do not exceed 81 characters, including spaces and punctuation.</i>)					
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>If "Yes," state number and title</i>) Number: _____ Title: _____					
3. PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR					
3a. NAME (Last, first, middle)		3b. DEGREE(S)		3h. eRA Commons User Name	
3c. POSITION TITLE		3d. MAILING ADDRESS (<i>Street, city, state, zip code</i>) E-MAIL ADDRESS:			
3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT					
3f. MAJOR SUBDIVISION					
3g. TELEPHONE AND FAX (<i>Area code, number and extension</i>) TEL: _____ FAX: _____					
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input type="checkbox"/> Yes		4a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes		If "Yes," Exemption No. _____	
4b. Federal-Wide Assurance No.		4c. Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes		4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes	
5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input type="checkbox"/> Yes			5a. Animal Welfare Assurance No. _____		
6. DATES OF PROPOSED PERIOD OF SUPPORT (<i>month, day, year—MM/DD/YY</i>) From _____ Through _____		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
		7a. Direct Costs (\$)		7b. Total Costs (\$)	
		8a. Direct Costs (\$)		8b. Total Costs (\$)	
9. APPLICANT ORGANIZATION Name Vanderbilt University Medical Center Address Office of Sponsored Programs 3319 West End Avenue, Suite 970 Nashville, TN 37203			10. TYPE OF ORGANIZATION Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local Private: → <input type="checkbox"/> Private Nonprofit For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business <input type="checkbox"/> Woman-owned <input type="checkbox"/> Socially and Economically Disadvantaged		
			11. ENTITY IDENTIFICATION NUMBER 1-352528741-A1 DUNS NO. 079917897 Cong. District TN-007		
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name D. Clinton Brown, MBA, CRA Title Associate Vice President, Office of Sponsored Programs Address 3319 West End Avenue, Suite 970 Nashville, TN 37203 Tel: 615-875-6070 FAX: 615-343-2447 E-Mail: sponsoredprograms@vumc.org			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name D. Clinton Brown, MBA, CRA Title Vice President, Office of Sponsored Programs Address 3319 West End Avenue, Suite 970 Nashville, TN 37203 Tel: 615-875-6070 FAX: 615-343-2447 E-Mail: sponsoredprograms@vumc.org		
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. (<i>In ink. "Per" signature not acceptable.</i>)		DATE