Form Approved Through 9/30/2007 OMB No. 0925-0001

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

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

2b. E-MAIL ADDRESS

4. ENTITY IDENTIFICATION NUMBER

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

5. TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

2d. MAJOR SUBDIVISION

E-MAIL:

6. HUMAN SUBJECTS
No
Yes

6a. Research Exempt
No Yes

6b. Human Subjects Assurance No.

If Exempt ("Yes" in 6a):
Exemption No.

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

If Not Exempt ("No" in 6a):
IRB approval date

Full IRB **or**
Expedited Review

7. VERTEBRATE ANIMALS
No
Yes

7a. If "Yes," IACUC approval Date

7b. Animal Welfare Assurance No.

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT $

8b. TOTAL $

9. INVENTIONS AND PATENTS
No Yes If "Yes," Previously Reported
Not Previously Reported

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

11a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR *(Item 2a)*
TEL
FAX

11b. ADMINISTRATIVE OFFICIAL NAME *(Item 5)*
TEL
FAX

11c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 14)*
NAME
TITLE
TEL FAX
E-MAIL

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 11c. *(In ink. "Per" signature not acceptable.)*

DATE