Form approved
OMB No. 0920-0261
Expiration Date: 01/31/2004

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION

TRAINING GRANT APPLICATION
(Non-Competing Continuation)

REVIEW GROUP	TYPE	ACTIVITY	GRANT NUMBER (Insert on all pages)

TOTAL PROJECT PERIOD
From: Through:

REQUESTED BUDGET PERIOD
From: Through:

1. TITLE

2a. PROGRAM DIRECTOR *(Name, address, street, city, state, zip code)*

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

2b. DEPARTMENT, SERVICE, LABORATORY OR EQUIVALENT

4. ENTITY IDENTIFICATION NUMBER

2c. MAJOR SUBDIVISION

5. TITLE AND ADDRESS OF OFFICIAL IN BUSINESS OFFICE OF APPLICANT ORGANIZATION

6. HUMAN SUBJECTS AND VERTEBRATE ANIMALS

Do you plan to conduct or support research activities during the budget period under the ERC Pilot Project Research Training Program? ☐ Yes ☐ No

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

TELEPHONE INFORMATION

	Area Code	Telephone No. and Extension
9a. PROGRAM DIRECTOR (Item 2a) **PHONE:** **FAX:** **EMAIL:**		
9b. NAME OF BUSINESS OFFICIAL (Item 5)		
9c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item12)*		

8. DIRECT COST REQUESTED FOR BUDGET PERIOD

10. DO NOT USE THIS SPACE

11. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application. (U.S. Code, Title 18, Section 1001).	**SIGNATURE OF PERSON NAMED IN 2a** *(In ink. "Per" signature not acceptable)*	**DATE**
12. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and I accept the obligation to comply with the Public Health Service 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(U.S. Code, Title 18,Section1001).	**SIGNATURE OF PERSON NAMED IN 9c** *(In ink. "Per" signature not acceptable)*	**DATE**

SUMMARY OF TRAINING PROPOSAL

BRIEFLY DESCRIBE THE TRAINING PROGRAM USING THE FOLLOWING HEADINGS ***(Do not exceed this page.)***

A. Purpose and Program Characteristics
B. Trainees
C. Training Facilities

Program Director _____

DETAILED BUDGET FOR REQUESTED 12 MONTH BUDGET PERIOD

FROM | THROUGH

A. TRAINING RELATED EXPENSES				DOLLAR AMOUNT REQUESTED *(Omit cents)*		
1. PERSONNEL (Do not list trainees)		EFFORT		SALARY	FRINGE BENEFITS	TOTALS
NAME	POSITION TITLE	TOTAL FTE	REQUESTED FTE			
SUBTOTALS ---->						
2. CONSULTANT COSTS *(Itemize)*						
3. EQUIPMENT *(Itemize)*						
4. SUPPLIES *(Itemize by category)*						
5. STAFF TRAVEL *(Itemize)*						
6. OTHER EXPENSES *(Itemize by category)*						
7. CONSORTIUM/CONTRACTUAL COSTS *(Itemize)*						
SUBTOTAL (Section A) --------->						
B. TRAINEE EXPENSES						
1. TRAINEE COSTS	PREDOCTORAL STIPENDS *(Itemize)* No. Requested:					
	POSTDOCTORAL STIPENDS *(Itemize)* No. Requested:					
	OTHER STIPENDS *(Itemize)* No. Requested:					
	TOTAL STIPENDS --------->					
	TUITION AND FEES *(Itemize)*					
	TOTAL TRAINEE COSTS -------->					
2. TRAINEE TRAVEL *(Describe)*						
SUBTOTAL *(Section B)* --------->						
C. TOTAL DIRECT COST *(Add subtotals of Sections A and B)* --------->						
D. INDIRECT COST --------->						
E. TOTAL COST						

DETAILED BUDGET FOR REQUESTED BUDGET PERIOD *(Continued)*	GRANT NUMBER

D. INDIRECT COST REQUESTED ***(See instructions)***

□ No □ Yes If "Yes," at _____ % rate.

E. Supplemental information and budget justification. Provide supplemental information for budget and justification for budget items on page 2. ***(See instructions)***

PROGRESS REPORT SUMMARY	GRANT NUMBER	
PROGRAM DIRECTOR	**PERIOD COVERED BY THIS REPORT**	
	FROM	**THROUGH**
NAME OF ORGANIZATION		
TITLE *(Repeat title shown in item 1 on first page)*		

(SEE INSTRUCTIONS)

BIOGRAPHICAL SKETCH

Give the following information for all personnel contributing to the training program, beginning with the Program Director. Photocopy this page for each person. Do not exceed two pages on any individual.

Name	Title	Birthdate *(Mo. Day, Yr.)*

EDUCATION *(Begin with baccalaureate or other initial professional education and include postdoctoral training)*

INSTITUTION AND LOCATION	DEGREE	YEAR CONFERRED	FIELD OF STUDY

RESEARCH AND/OR PROFESSIONAL EXPERIENCE: Concluding with present position, list in chronological order previous employment, experience, and honors. Include present membership on any Federal Government public advisory committee. List in chronological order, the titles and complete references to all publications during the past three years and to representative earlier publications pertinent to this application. DO NOT EXCEED TWO PAGES.

Program Director _____

CHECKLIST

This is the required last page of the application
(Check the appropriate boxes and provide the information requested)

TYPE OF APPLICATION

☐ **NON-COMPETING CONTINUATION**

☐ **CHANGE of Program Director.**
Name of former Program Director: _____

1. ASSURANCES / CERTIFICATIONS

The following assurances/certifications are made and verified by the signature of the Official Signing for Applicant Organization on the Face Page of the application. Descriptions of individual assurances/certifications begin on page 3 of the Instructions. If unable to certify compliance where applicable, provide an explanation and place it after this page. Human Subjects; Vertebrate Animals; Debarment and Suspension; Drug-Free Workplace (applicable to new [Type 1] or revised [Type 1] applications only); Lobbying; Delinquent Federal Debt; Research Misconduct; Civil Rights (Form HHS 441 or HHS 690); Handicapped Individuals (Form HHS 641 or HHS 690); Sex Discrimination (Form HHS 639-A or HHS 690); Age Discrimination (Form HHS 680 or HHS 690).

2. PROGRAM INCOME *(See Instructions)*

All applications must indicate whether program income is anticipated during the period(s) for which grant support is requested. If program income is anticipated, use the format below to reflect the amount and source(s).

Budget Period	Anticipated Amount	Source(s)

INDIRECT COST REQUESTED *(See instructions)*

☐ **No** ☐ **Yes** **If "Yes," at** _____ **% rate.**

CONTENTS OF PACKAGE *(Check the appropriate boxes to insure that all requested information is included in the package mailed to CDC.)*

	Page No.	
☐	1, 1A	**Face Page, Summary of Training Proposal**
☐	2	**Detailed Budget for Requested Budget Period**
☐	3	**Budget Justification**
☐	4	**Progress Report**
☐	5	**Biographical Sketch(es)**
☐	_____	**Checklist**
☐	_____	**Appendices**