DEPARTMENT OF HEALTH AND HUMAN SERVICES RFP/CONTRACT NUMBER PUBLIC HEALTH SERVICE NATIONAL INSTITUTES OF HEALTH PROPOSAL SUMMARY AND DATA RECORD PROJECT TITLE LEGAL NAME AND ADDRESS OF OFFEROR PLACE OF PERFORMANCE (Full address including ZIP) ☐ COST REIMBURSEMENT ☐ FIXED PRICE ☐ COST-PLUS-FIXED-FEE $\ \square \ \mathsf{OTHER}$ ESTIMATED TIME REQUIRED TO COMPLETE PROJECT ESTIMATED DIRECT COSTS IN PROPOSED YEAR (From budget) PROPOSED STARTING DATE DOES THIS PROPOSAL INCLUDE A SUBCONTRACT \square YES \square NO (If yes, please furnish name and location of organization, description of services, basis for selection, responsible person employed by subcontractor and cost information.) NAME AND TITLE OF PRINCIPAL INVESTIGATOR SOCIAL SECURITY NO. EST. HOURS WEEKLY AREA CODE/TEL. NO. NAME AND TITLE OF CO-INVESTIGATORS (Use attachment if necessary). SOCIAL SECURITY NO. EST. HOURS WEEKLY AREA CODE/TEL. NO. NAME AND TITLE OF INDIVIDUAL(S) AUTHORIZED TO NEGOTIATE CONTRACTS AREA CODE/TELEPHONE NUMBER NAME AND TITLE OF INDIVIDUAL(S) AUTHORIZED TO EXECUTE CONTRACTS AREA CODE/TELEPHONE NUMBER DOES THIS PROPOSAL INVOLVE EXPERIMENTS WITH HUMAN SUBJECTS □ YES □ NO DATE APPROVED □ PENDING Institution's General Assurance re Human Subjects DATE APPROVED □ PENDING Institution's Review Board's Approval of this Proposal

OFFEROR'S ACKNOWLEDGEMENT OF AMENDMENTS TO THE RFP (Use attachment if necessary)

ERRATA NUMBER

DATE

ERRATA NUMBER

NUMBER OF EMPLOYEES CURRENTLY EMPLOYED

DOLLAR VOLUME OF BUSINESS PER ANNUM

THIS OFFER EXPIRES ____ DAYS FROM THE DATE OF THIS OFFER (120 days if not specified)

□ YES □ NO

☐ YES ☐ NO

SIGNATURE OF PRINCIPAL INVESTIGATOR SIGNATURE OF BUSINESS REPRESENTATIVE TYPED NAME AND TITLE TYPED NAME AND TITLE EMPLOYER IDENTIFICATION NUMBER DATE OF OFFER

An example of the informed consent for this study is enclosed

A Clinical Protocol is enclosed