



Application for Health Effects Institute Research Agreement

All Agreements Use the Cost Reimbursement Format

Number (Leave Blank)

1. TITLE OF APPLICATION (limit title to this space)

2. RESPONSE TO RFA OR RFPA NUMBER AND TITLE

3. TYPE OF ORGANIZATION (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Private Non-Profit | <input type="checkbox"/> Private Profit | <input type="checkbox"/> Minority Owned |
| <input type="checkbox"/> Educational | | <input type="checkbox"/> Small Business |
| <input type="checkbox"/> Public (<input type="checkbox"/> Federal, <input type="checkbox"/> State, <input type="checkbox"/> Local) | | <input type="checkbox"/> Woman Owned |

4. PRINCIPAL INVESTIGATOR

4A. NAME (LAST, FIRST, MIDDLE)

4B. MAILING ADDRESS (Organization, Street, City, State, Zip Code)

Signature and Date

4C. TELEPHONE NUMBER (Area Code, Extension)

4D. FAX NUMBER (Area Code)

4E. EMAIL

4F. POSITION TITLE

5. TOTAL COST REQUESTED FIRST 12-MONTH PERIOD
(Enter from Page F-4a)

6. HUMAN SUBJECTS OR DERIVED MATERIALS INVOLVED?

YES _____ NO _____

7. TOTAL COST REQUESTED ENTIRE PROJECT PERIOD
(Enter from Page F-5a1) / Number of Years

_____/_____
Years

8. APPLICANT INSTITUTION AND CONGRESSIONAL DISTRICT

9. NAME, TITLE, ADDRESS, EMAIL & TELEPHONE NUMBER OF INDIVIDUAL(S) AUTHORIZED TO NEGOTIATE AGREEMENT

Signature and Date

10. NAME, TITLE, ADDRESS, EMAIL & TELEPHONE NUMBER OF INDIVIDUAL(S) AUTHORIZED TO EXECUTE AGREEMENT (if different than above)

Signature and Date