|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CCTST Pilot Grant Program **Processes and Methods Pilot Grant Application** | | | | | | | | | | | |
| 1. TITLE OF PROJECT *(Do not exceed 56 characters, including spaces and punctuation.)* | | | | | | | | | | | |
| 1a. Type of application:  Basic Research  Clinical Research  Methodology Research  Ethics Research | | | | | | | | | | | |
| **2. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR** | | | | | | **New CCTST Investigator  No  Yes** | | | | | |
| 2a. NAME *(Last, first, middle)* | | | | | | 2b. DEGREE(S) |  | | | | |
|  |  | | |  |  |
| 2c. POSITION TITLE | | | | | | 2d. MAILING ADDRESS *(Street, city, state, zip code)* | | | | | |
| 2e. DIVISION | | | | | |  | | | | | |
| 2f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | | | | |
| 2g. TELEPHONE AND FAX *(Area code, number and extension)* | | | | | | E-MAIL ADDRESS: | | | | | |
| TEL: | | FAX: | | | |  | | | | | |
| **3. OTHER INVESTIGATOR  CO-PI  CO-I** | | | | | | **New CCTST Investigator  No  Yes** | | | | | |
| 3a. NAME *(Last, first, middle)* | | | | | | 3b. DEGREE(S) |  | | | | |
|  |  | | |  |  |
| 3c. POSITION TITLE | | | | | | 3d. MAILING ADDRESS *(Street, city, state, zip code)* | | | | | |
| 3e. DIVISION | | | | | |  | | | | | |
| 3f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT | | | | | |
| 3g. TELEPHONE AND FAX *(Area code, number and extension)* | | | | | | E-MAIL ADDRESS: | | | | | |
| TEL: | | | | FAX: | |  | | | | | |
| 4. Human Subjects Research  No  Yes | | | | 4a. Research Exempt  No  Yes  If “Yes,” Exemption No. | | 4b. Human Subjects Assurance No.  4c. NIH-Defined Phase I Clinical Trial  No  Yes | | | 5. Human Subjects Protection Certification:  No  Yes  5a. Certification Date: | | |
| 6. Vertebrate Animals  No  Yes  6a. If “Yes,” IACUC Approval Date    6b. Animal Welfare Assurance No. | | | | 7. IBC Protocol  No  Yes  7a. If “Yes,” Approval Date:    7b. Approval Number: | | 8. Radiation  No  Yes  8a. If “Yes,” Approval Date | | |  | | |
| 9. DATES OF PROPOSED PERIOD OF  SUPPORT *(month, day, year—MM/DD/YY)* | | | | | | 1. COSTS REQUESTED   Direct Costs ($) | | | 11a. Name of Business Manager: | | |
| From | Through | | | | |  | | | 11b. Business Manager’s email address: | | |
|  |  | | | | |  | | |
| 12. The undersigned reviewed this application for a CCTST research award and are familiar with the policies, terms, and conditions of UC and/or CCHMC concerning research support and accept the obligation to comply with all such policies, terms, and conditions. | | | | | | | | | | | |
| Primary Applicant: | | | | | | Division Chair of Primary Applicant: | | | | | |
| Signature of Primary Applicant | | | | | Date: | Signature of Division Chair of Primary Applicant | | | | | Date: |
| Affiliate applicant: | | | | | | Division Chair of Affiliate Applicant: | | | | | |
| Signature of Affiliate Applicant | | | | | Date: | Signature of Division Chair of Affiliate Applicant: | | | | | Date: |
| OFFICE USE ONLY: | | | Received by: | | | | | Date Received: | | | |

OMB No. 0925-0001 and 0925-0002 (Rev. 12/2020 Approved Through 02/28/2023)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.  
Follow this format for each person. **DO NOT EXCEED FIVE PAGES.**

NAME:

eRA COMMONS USER NAME (credential, e.g., agency login):

POSITION TITLE:

EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)

| INSTITUTION AND LOCATION | DEGREE  (if applicable) | Completion Date  MM/YYYY | FIELD OF STUDY |
| --- | --- | --- | --- |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**A. Personal Statement**

**B. Positions, Scientific Appointments, and Honors**

**C. Contributions to Science**

|  |  |
| --- | --- |
|  | **Center for Clinical & Translational Science & Training**  240 Albert Sabin Way  Location S, 2nd Floor, Suite 500, ML 11028  Cincinnati, OH 45229  Email: cctst@uc.edu | Web: cctst.org |

**Center for Clinical and Translational Science and Training**

**Processes and Methods Step 1 Checklist**

|  |  |
| --- | --- |
| **Please check each box to certify that you have included each item in your proposal** |  |
| 1. Face page |  |
| 2. PI, Co-PI, and Co-I biosketches |  |
| 3. This checklist |  |
| 4. Cite any prior CCTST funding, resulting grant submissions and outcomes. State, if you have not received any prior CCTST funding |  |
| 5. Background and scientific merit of the research |  |
| 6. Hypotheses or Study Aims |  |
| 7. Brief discussion of what procedures and strategies will be used to conduct the study and test the hypotheses |  |
| 8. Clear, itemized, one or two sentence description of how the funds will be spent ($5,000 maximum) |  |
| 9. How this award might position you to apply for additional extramural support in a related area |  |
| 10. Attestations |  |