1. PROJECT TITLE:

2. PROPOSED PERIOD From ________ To ________

3. TOTAL PROJECT PERIOD From ________ To ________

4. Research Program ☐ Fellowship/Traineeship ☐ Facilities Request

5. FACILITIES: Is adequate space available to conduct the project? ☐ Yes ☒ No

6. LAB ANIMALS: ☐ Yes ☐ No If yes: Protocol Number: ____________________ Approval/Re-approval Date: __________ / __________

7. HUMAN SUBJECTS (HS): ☐ Yes ☐ No If yes: Protocol Number: ____________________ Approval/Re-approval Date: __________ / __________

8a. RADIATION SAFETY: ☐ Yes ☒ No If yes: Auth. Number: ____________________ Approval/Re-approval Date: __________ / __________ ☐ ionizing Radiation generating equipment ☐ Other: ____________________

8b. BIOSAFETY: ☐ Yes ☒ No If yes: Auth. Number: ____________________ Approval/Re-approval Date: __________ / __________ ☐ Recombinant DNA ☐ Infectious Agents ☐ Select Agents ☐ Other: ____________________

9. COST SHARING: Does this proposal contribute any UCD resources (i.e. costs that will not be paid or reimbursed by the sponsor)? ☐ Yes ☐ No If yes: a. Is cost sharing required by this sponsor? ☐ Yes ☐ No b. Is cost sharing included in the proposal budget? ☐ Yes ☐ No c. Is cost sharing mentioned in the proposal narrative? ☐ Yes ☐ No

10. DISCLOSURE OF FINANCIAL INTERESTS: The PI is responsible for ensuring that all individuals performing work under the proposed project have a current Conflict of Interest Disclosure on file with the UCD COI office. ☐ Agreed ☐ Not Agreed

11. BUDGETARY ITEMS - If #7 (Human Subjects) is yes, answer the following:
   a. Will this project involve work with HS to be done at UCH, TCH, or any other non-UCD facilities? ☐ Yes ☐ No
   b. Are all research-related patient care costs included in the budget, including any applicable non-UCD facility charges incurred as direct costs? ☐ Yes ☐ No

12. CLINICAL TRIAL-Answer the following questions if the project is a clinical trial:
   a. Project sponsor is: ☐ US Govt. agency ☐ agency of U.S. state, county, or municipality; ☐ foreign government; ☐ private company
   b. Project hypothesis developed by the PI? ☐ Yes ☐ No
   c. Protocol designed by university personnel? ☐ Yes ☐ No
   d. Who initiated the project? ☐ Sponsor ☐ PI
   e. Is Universtiy the only entity conducting this research for sponsor? ☐ Yes ☐ No

13. SUMMARY OF PROPOSED BUDGET

   DIRECT COSTS

   - Salaries and Wages $____________
   - Fringe Benefits $____________
   - Consultant Costs $____________
   - Equipment (over $5,000) $____________
   - Supplies $____________
   - Travel $____________
   - Hospital Patient Care Costs $____________
   - Subrecipient(s): How many? $____________
   - Trainee Costs $____________
     - Stipends $____________
     - Tuition and Fees $____________
     - Other Expenses $____________
   - Center for Laboratory Animal Care (at SOM) $____________
   - IRB Review of Industry Sponsored Protocols $____________
   - Rent $____________
   - Tuition Remission & Related Fringe Benefits $____________
   - TOTAL DIRECT COSTS $____________

   FACILITIES AND ADMINISTRATIVE COSTS (F&A)

   % F&A $____________
   Costs Subject to F&A $____________
   TOTAL DIRECT AND F&A COSTS $____________

   APPROVALS (To be obtained by PI/Administrator)

   Department Chair or Director Date
   Dean Date
   Grants and Contracts Date

   Principal Investigator: ____________________ Date: __________

   UNIVERSTY OF COLORADO DENVER
   APPROVAL OF APPLICATION FOR GRANT OR CONTRACT
   (Routing Form)

   DEPARTMENT OR SUBPROGRAM: ____________________
   RANK: ____________________
   PHONE: ____________________
   DEPT/DIV: ____________________
   ORG NO: ____________________
   Grants and Contracts Date
   Routing Primary Contact First and Last Name ____________________
   Contact Phone ____________________
   Contact Fax ____________________
   Contact E-mail ____________________
   FUNDING AGENCY: ____________________
   DEADLINE: ____________________
   PRIMARY FUNDING SOURCE: ____________________
   RANK: ____________________
   FISCAL MGR NAME/POS NO: ____________________
   FISCAL STAFF NAME/POS NO: ____________________

   Form FP4-SA, Revised 4/11