**DO NOT SUBMIT UNLESS REQUESTED – PHS 398 OTHER SUPPORT**

Name of Individual:

Commons ID:

**PROJECTS/PROPOSALS**

ACTIVE

Title:

Major Goals:

Status of Support: Active

Project Number:

Name of PD/PI:

Source of Support:

Primary Place of Performance:

Project Start and End Date (MM/YYYY):

Total Award Amount (including Indirect Costs): $

Person Months (Calendar/Academic/Summer) per budget period:

| Year (YYYY) | Person Months (##.##) |
| --- | --- |
| 1.  |  |
| 2.  |  |
| 3.  |  |
| 4.  |  |
| 5.  |  |

PENDING

Title:

Major Goals:

Status of Support: Pending

Project Number:

Name of PD/PI:

Source of Support:

Primary Place of Performance:

Proposed Start and End Date (MM/YYYY):

Total Proposed Amount (including Indirect Costs): $

Person Months (Calendar/Academic/Summer) per budget period:

| Year (YYYY) | Person Months (##.##) |
| --- | --- |
| 1.  |  |
| 2.  |  |
| 3.  |  |
| 4.  |  |
| 5.  |  |

**IN-KIND**

Summary of In-Kind Contribution:

Status of Support (Active/Pending):

Start and End Date (MM/YYYY), if applicable:

Name of Individual, if applicable:

Effort (Person Months), if applicable:

Estimated Dollar Value of In-Kind Information: $

**OTHER RESOURCES/SUPPORT**

Summary of Activities/Resources:

Status of Support (Active/Pending):

Source of Support:

Start and End Date, if applicable:

Estimated Total Dollar Value: $

**OVERLAP**

Summary of any potential overlap with the projects, activities, positions, affiliations, resources, or other support in terms of science, budget, or individual’s committed effort, including resolution of overlap

**SIGNATURE**

I, PD/PI or other senior/key personnel, certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services 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.

Signature & Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_