



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