OMB Number: 4040-0001
Expiration Date: 06/30/2011

APPLICATION FOR FEDERAL ASSISTANCE
SF 424 (R&R)

3. DATE RECEIVED BY STATE | **State Application Identifier**

1. * TYPE OF SUBMISSION
☐ Pre-application ☒ Application ☐ Changed/Corrected Application

4. a. Federal Identifier

b. Agency Routing Identifier

2. DATE SUBMITTED: 06/05/2010
Applicant Identifier:

5. APPLICANT INFORMATION
*** Organizational DUNS:** 002593692

* Legal Name: Arkansas Children's Hospital Research Institute
Department:
Division:
* Street1: 13 Children's Way
Street2:
* City: Little Rock
County / Parish: Pulaski
* State: AR: Arkansas
Province:
* Country: USA: UNITED STATES
* ZIP / Postal Code: 72202-3591

Complete Fields 5, 6, and 7 with the provided ACHRI information. You must use the "+4" ZIP code. Use the USPS' ZIP Code Lookup tool (http://zip4.usps.com/zip4/welcome.jsp) to find a ZIP+4.

Person to be contacted on matters involving this application
Prefix: Mr.
* First Name: Lee
Middle Name:
* Last Name: Smith
Suffix:
* Phone Number: 501-364-3581
Fax Number: 501-364-2705
Email: SmithLee@uams.edu

6. * EMPLOYER IDENTIFICATION *(EIN) or (TIN):* 710694931

7. * TYPE OF APPLICANT: M: Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education)
Other (Specify):
Small Business Organization Type ☐ Women Owned ☐ Socially and Economically Disadvantaged

8. * TYPE OF APPLICATION:
☒ New ☐ Resubmission
☐ Renewal ☐ Continuation ☐ Revision

If Revision, mark appropriate box(es).
☐ A. Increase Award ☐ B. Decrease Award ☐ C. Increase Duration ☐ D. Decrease Duration
☐ E. Other (specify):

* Is this application being submitted to other agencies? Yes ☐ No ☒ What other Agencies?

9. * NAME OF FEDERAL AGENCY:
National Institutes of Health

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER:
TITLE:

NIH will complete CFDA numbers; leave blank.

11. * DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:
Insert Descriptive Project Title

The project title should be descriptive and no longer than 81 characters (including spaces and punctuation). It is suggested that Field 11 matches the title on the main page of the application.

12. PROPOSED PROJECT:
* Start Date: 12/01/2010
* Ending Date: 11/30/2015

*** 13. CONGRESSIONAL DISTRICT** AR-002

14. PROJECT DIRECTOR/PRINCIPAL INVESTIGATOR CONTACT INFORMATION
Prefix: Dr.
* First Name: Jane
Middle Name: Q.
* Last Name: Doe
Suffix: M.D.
Position/Title:
* Organization Name: Arkansas Children's Hospital Research Institute
Department: Department of Pediatrics
Division: College of Medicine
* Street1: 13 Children's Way
Street2:
* City: Little Rock
County / Parish: Pulaski
* State: AR: Arkansas
Provi
* Country: USA: UNITED STATES
* ZIP / Postal Code: 72202-3591
* Phone Number: 501-555-1234
Fax Number: 501-555-5678
* Email: DoeJaneQ@uams.edu

The PI's address in Field 15 must match the PI employment section in NIH Commons. ACHRI's street address has changed to "13 Children's Way". Update this address in NIH Commons if necessary. A ZIP+4 must be used with any address throughout the application.

15. ESTIMATED PROJECT FUNDING

a. Total Federal Funds Requested	1,000,000.00
b. Total Non-Federal Funds	0.00
c. Total Federal & Non-Federal Funds	1,000,000.00
d. Estimated Program Income	0.00

Enter the amounts from your complete budget in Field 15.

16. * IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES ☐ THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON:

DATE:

b. NO ☒ PROGRAM IS NOT COVERED BY E.O. 12372; OR

☐ PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. By signing this application, I certify (1) to the statements contained in the list of certifications* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances * and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 18, Section 1001)

☒ *** I agree**

*** *The list of certifications and assurances, or an Internet site where you may obtain this list, is contained in the announcement or agency specific instructions.***

18. SFLLL or other Explanatory Documentation

Add Attachment | Delete Attachment | View Attachment

19. Authorized Representative

Prefix: Mr. * First Name: Lee Middle Name:

* Last Name: Smith Suffix:

* Position/Title: Research Administrator

* Organization: Arkansas Children's Hospital Research Institute

Department: Division:

* Street1: 13 Children's Way

Street2:

* City: Little Rock County / Parish: Pulaski

* State: AR: Arkansas Province:

* Country: USA: UNITED STATES * ZIP / Postal Code: 72202-3591

* Phone Number: 501-364-3581 Fax Number: 501-364-2705

* Email: SmithLee@uams.edu

Enter the provided Authorized Representative information in Field 19.

* Signature of Authorized Representative	* Date Signed
Completed on submission to Grants.gov	Completed on submission to Grants.gov

20. Pre-application

Add Attachment | Delete Attachment | View Attachment

Asterisks denote required fields. These fields will first appear with yellow highlighting before you enter information. Many fields are optional, but some may be required by NIH. Review the application instructions to ensure you have completed all necessary fields.

Review the *Grants.gov Application Guide SFS424 (R&R)* before you enter information and refer to it as you have questions. You can download the proper grant application guide from the grant application listing at Grants.gov.

If you still have a question, contact Lee Smith, Research Administrator, at 364-3581 or SmithLee@uams.edu.