



Boston University/Boston Medical Center  
Proposal Summary Form



BU-MED

BU-CRC

Boston Medical Center

Title of Project:

**Principal Investigator Information**

_____ Last Name	_____ First Name	_____ (MI)	_____ School (BU only)	_____ Dept./Division
_____ Section (BU-MED/BMC only)	_____ Unit/Dept. Number (BU only)	_____ Building & Room #	_____ Co-PI	
_____ PI Phone	_____ Fax Number	_____ E-Mail Address		
_____ Administrative Contact	_____ Contact Phone	_____ E-Mail Address		
Is this an NIH Multiple PI application? Yes No If yes, <u>all</u> PI/PDs must sign below.				_____ UID #

**Budget Information**

Effective Dates of Project (MM/DD/YYYY):	From: _____	To: _____	Proposed Year	From: _____	To: _____	Entire Project
Funds Requested:	Total Direct Costs _____	Total Indirect Costs _____	Total Costs _____	Total Direct Costs _____	Total Indirect Costs _____	Total Costs _____
F&A Rate _____%	Total Costs _____	Total Costs _____	Total Costs _____	Total Costs _____	Total Costs _____	Total Costs _____

**Cost Sharing for Proposed Year**

Direct _____	If Direct Cost Sharing, list account #(s): _____ _____ _____	Subawards: Yes No If Yes, how many? _____
Indirect _____		Sponsor Salary Cap Applies: Yes No
Total _____		Major Project ( <a href="#">see A21</a> ): Yes No
		Consultants: Yes No
		ARRA Funding: Yes No
		Modular Grant: Yes No

**Application Information**

_____ Funding Agency/Prime Sponsor	_____ Agency Deadline	_____ FOA/Solicitation Number
Application Type: Activity Type:	Prime Sponsor Type: Submission Method:	
If this a transfer, from where: _____ CTSI/GCRS Resources Needed (BU-MED/BMC only) Yes No		
Is this a Subcontract? Yes No If yes, from where? _____		
If this is an existing grant, please provide: _____ Agency Award # (if available) BU Source# OR BMC ACT#		

**PI/PD Assurance**

I certify that: (1) in conducting the proposed program, I am familiar with and will adhere to applicable Boston University/Boston Medical Center policies including, but not limited to, human and animal research, conflict of interest, misconduct in research, and patents and technology transfer (<http://www.bu.edu/research/compliance/>); (2) the information submitted within the application is true, complete, and accurate to the best of my (the PI's) knowledge; (3) any false, fictitious, or fraudulent statements or claims may subject me (as the PI) to criminal, civil, or administrative penalties; (4) I (as the PI) agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of the application; and (5) I will abide, as applicable, by the Federal clinical trials (ClinicalTrials.gov: <http://clinicaltrials.gov/>) and NIH Public Access (<http://publicaccess.nih.gov>) regulations.

_____ PI/PD	_____ Date	_____ PI/PD	_____ Date
_____ PI/PD	_____ Date	_____ PI/PD	_____ Date

**Approvals**

_____ Chief of Service (BMC only)	_____ Date	_____ Dean	_____ Date
_____ Department Chair	_____ Date	_____ OSP Director (BU-CRC only)	_____ Date
_____ Department Chair	_____ Date	_____ Institutional Official	_____ Date
_____ Dean	_____ Date	_____ Department/Staff Review	_____ Date

**Compliance Information**

Special Reviews:

	Yes	No	Project Approval** (Date or "Pending")	Protocol/Approval No. for Each Project
IRB	Yes	No	_____	_____
IACUC	Yes	No	_____	_____
IBC: Biohazards	Yes	No	_____	_____
IBC: rDNA	Yes	No	_____	_____
IBC: Select Agents	Yes	No	_____	_____
Radioisotopes	Yes	No	_____	_____
Human Embryonic Stem Cells	Yes	No	_____	_____
SCUBA/Snorkeling/Boats	Yes	No	_____	_____

**Mentor (if applicable)**

\_\_\_\_\_  
 Last Name                      First Name                      (MI)                      School (BU Only)                      Department/Division  
 \_\_\_\_\_  
 Phone                      Fax Number                      E-Mail Address

**Location of Project and Special Requirements**

Does your project require renovations to existing research space?                      Yes                      No  
 Does your project require new space?                      Yes                      No  
 Does your project require the services of the BU or BMC IT Department?                      Yes                      No  
 Do you plan to purchase capital equipment\* under this award?                      Yes                      No  
 \*defined as being equal to or greater than \$5000 in value and having a useful life of one year or more

**CRC Only:**

Location of Work on Project \_\_\_\_\_ On-Campus Effort \_\_\_\_\_ % Off-campus Effort \_\_\_\_\_%

**BU-MED/BMC only:**

Use drop-down menus in shaded cells below to select BU-MED/BMC site(s) where research will be performed. (Note: regarding industry-sponsored clinical research, all applications are submitted by OSP-MED including those in BMC space. If unsure whether research is on a BMC site, consult drop-down list by clicking in third shaded line below)

Select Building Location (click in the cells below)    Enter Building Letter    Enter Room Number    Enter Space Allocation %

**International Research**

Does this project have any of the following international components (check all that apply)

- A collaborator outside of US
- Travel outside of US by any BU participant (e.g. faculty, staff, students) in this project (paid or unpaid)
- Travel to the US by any collaborator involved with this study (paid or unpaid)
- Transport of any samples (e.g. tissue, blood, chemical) to or from US

Please provide contact information for the individual who is familiar with this project and who should be contacted by the Research Compliance Coordinator for further information.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Comments**