



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) _____		Lead Unit Number (BU only) _____		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 Direct Costs _____		Total Indirect Costs _____	
F&A Rate _____%	Total Indirect Costs _____		Total Indirect Costs _____		Total Costs _____	
Total Costs _____		Total Costs _____		Total Costs _____		

**Cost Sharing for Proposed Year**

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

**Application Information**

Funding Agency/Prime Sponsor _____	Agency Deadline _____	Solicitation Number _____
Application Type: _____	Prime Sponsor Type: _____	
Activity Type: _____	Submission Method: _____	
If this a transfer, from where: _____	CTSI Resources Needed: 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 SAP# _____ OR BMC ACT# _____

**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 %

**Mentor (if applicable)**

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

**International Research**

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

Yes	No	A collaborator outside of US
Yes	No	Travel outside of US by any BU participant (e.g. faculty, staff, students) in this project (paid or unpaid)
Yes	No	Travel to the US by any collaborator involved with this study (paid or unpaid)
Yes	No	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 Export Control Director for further information.

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

**Compliance Information**

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

Financial Interest Disclosure Yes (required)

The PI must ensure that **all** those responsible for the design, conduct, or reporting of the proposed program have completed the financial interest disclosure forms and training as dictated at <http://www.bu.edu/orc/coi/forms/>.

**Final disclosure for this project was submitted:** \_\_\_\_\_  
Date

**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/>) as well as sponsor requirements and applicable Federal regulations; (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

**Comments**