Department of Health and Human Services
Public Health Services

Grant Progress Report

Review Group	Type	Activity	Grant Number

Total Project Period
From: Through:

Requested Budget Period:
From: Through:

1. TITLE OF PROJECT

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR
(Name and address, street, city, state, zip code)

3. APPLICANT ORGANIZATION
(Name and address, street, city, state, zip code)

University of Hawaii
Office of Research Services
2530 Dole Street, Sakamaki D200
Honolulu, HI 96822

2b. E-MAIL ADDRESS

4. ENTITY IDENTIFICATION NUMBER
99-6000354

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

5. TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

Yaa-Yin Fong
Director of Research Services
2530 Dole Street, Sakamaki D200
Honolulu, HI 96822

E-MAIL: hanaokak@hawaii.edu

6. HUMAN SUBJECTS
☐ No ☐ Yes
6a. Research Exempt ☐ No ☐ Yes
6b. Human Subjects Assurance No.

If Exempt ("Yes" in 6a):
Exemption No.

6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes

If Not Exempt ("No" in 6a):
IRB approval date
☐ Full IRB **or**
☐ Expedited Review

7. VERTEBRATE ANIMALS
☐ No
☐ Yes
7a. If "Yes," IACUC approval Date
7b. Animal Welfare Assurance No.

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD
8a. DIRECT $
8b. TOTAL $

9. INVENTIONS AND PATENTS
☐ No ☐ Yes If "Yes," ☐ Previously Reported ☐ Not Previously Reported

10. PERFORMANCE SITE(S) *(Organizations and addresses)*

11a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR *(Item 2a)*
TEL
FAX

11b. ADMINISTRATIVE OFFICIAL NAME *(Item 5)*
Yaa-Yin Fong
TEL (808) 956-7800
FAX (808) 956-9081

11c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 14)*
NAME
TITLE Administrative Officer
TEL
FAX (808) 956-9081
E-MAIL

12. Corrections to Page 1 Face Page

13. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I 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 this application.	SIGNATURE OF PI/PD NAMED IN 2a. *(In ink. "Per" signature not acceptable.)*	DATE
14. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I 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 OF OFFICIAL NAMED IN 11c. *(In ink. "Per" signature not acceptable.)*	DATE