|  |  |  |  |
| --- | --- | --- | --- |
| Women's Health Research at Yale Pilot Project Program  Application Face Page | | | |
| **PROJECT TITLE** *(60 characters maximum, including spaces and punctuation)* | | | |
|  | | | |
| PRINCIPAL INVESTIGATOR | | | |
| Name | | Degree(s) | |
| Position Title | | Mailing Address *(street, city, state, zip code)* | |
| Department/Section | |
| Telephone and Fax *(area code, number and extension)*  Tel: Fax: | | E-mail address | |
| HUMAN SUBJECTS RESEARCH  No If “Yes,” HIC/IRB No:  Yes Approval Date: | | CLINICAL TRIAL  No  ­Yes | |
| VERTEBRATE ANIMALS  No If “Yes,” IACUC No:  Yes Approval Date: | | DATES OF PROPOSED PERIOD OF SUPPORT *(mm/dd/yy)*  From:  Through: | |
| **FUNDS REQUESTED** *(direct costs only)* | | **AWARD CATEGORY** *(Please only select one)*  ***1. Pilot Project Program Award:***  Up to $35,000 (over a 1-year period) OR  Up to $35,000 (over a 2-year period)  ***2. The Wendy U. & Thomas C. Naratil Pioneer Award:***  Up to $50,000 (over a 1-year period) OR  Up to $50,000 (over a 2-year period)  ***3. Award for data-driven community place-based research designed to advance the health of women as a pathway to economic and social mobility:***  Up to $35,000 (over a 1-year period) OR  Up to $35,000 (over a 2-year period) | |
| Year 1:  $ | Year 2:  $ |
| TOTAL FOR PERIOD OF SUPPORT *(direct costs only)*  $ | |
| **PRINCIPAL INVESTIGATOR ASSURANCE:** I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with the Women's Health Research at Yale policies if a grant is awarded as a result of this application. | | **SIGNATURE OF PRINCIPAL INVESTIGATOR** | DATE |
| **DEPARTMENT CHAIR/BUSINESS MANAGER ASSURANCE:**   I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Women's Health Research at Yale policie*s* if a grant is awarded as a result of this application. | | **SIGNATURE OF DEPARTMENT CHAIR** | DATE |
| Please print name: | |
| **SIGNATURE OF BUSINESS MANAGER** | DATE |
| Please print name: | |
| **ONLY FOR YALE AFFILIATED HOSPITALS**: If the applicant is not a Yale University employee, Yale University policies apply and signature of authorized institutional official is required. I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Women's Health Research at Yale policies if a grant is awarded as a result of this application. | | **SIGNATURE OF AUTHORIZED INSTITUTIONAL OFFICIAL** | DATE |
| Please print name: | |

# Women's Health Research at Yale Pilot Project Program Application

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• Specific Aims

• Background and Significance

• Preliminary Data

• Design and Methods

• External Funding

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## – ## Biographical Sketch – Principal Investigator

*(Not to exceed five pages)*

## – ## Other Biographical Sketches for Key Personnel

*(Not to exceed five pages for each)*

## – ## Letters from Collaborators

*Women's Health Research at Yale is dedicated to funding outstanding projects that advance women's health research across medical and psychosocial disciplines. The center strives to strengthen existing research in women's health, and to develop new cutting-edge areas of investigation that will result in direct practical benefit for women.*

**ABSTRACT:** Provide an abstract describing the project in the space provided.

**WORK LOCATION**

|  |  |  |
| --- | --- | --- |
| FACILITY | BUILDING | ROOM |
|  |  |  |
|  |  |  |

**KEY PERSONNEL** (Include PI, co-investigators, collaborators, etc. If necessary, use one additional sheet and label 4a)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME | ORGANIZATION/DEPARTMENT | % EFFORT | CALENDAR MONTHS | ROLE ON PROJECT |
|  |  |  |  |  |
|  |  |  |  |  |
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**AREAS OF EXPERTISE REQUIRED BY REVIEWERS** (be specific, e.g., gerontology, ultrasound technology, psychiatric epidemiology)

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|  | | | | | | | | | | | | | | |
| **DETAILED BUDGET FOR INITIAL BUDGET PERIOD**  DIRECT COSTS ONLY | | | | | | | FROM | | | | THROUGH | | | |
|  | | | |  | | | |
| List PERSONNEL (Applicant organization only)  Use Cal, Acad, or Summer to Enter Months Devoted to Project. **Use NIH Salary Cap and University Funds Fringe Benefits**  Enter Dollar Amounts Requested (*omit cents*) for Salary Requested and University Funds Fringe Benefits | | | | | | | | | | | | | | |
| NAME | ROLE ON PROJECT | Cal.  Mnths | Acad.  Mnths | | INST.BASE SALARY | | | SALARY REQUESTED | FRINGE BENEFITS | | | | TOTAL | | |
|  | PD/PI |  |  | |  | | |  |  | | | |  | | |
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| SUBTOTALS | | | | | |  | | | |  | |  | | |
| CONSULTANT COSTS | | | | | | | | | | | |  | | |
| EQUIPMENT *(Itemize)* | | | | | | | | | | | |  | | |
| SUPPLIES (Itemize by category) | | | | | | | | | | | |  | | |
| INPATIENT CARE COSTS | | | | | | | | | | | |  | | |
| OUTPATIENT CARE COSTS | | | | | | | | | | | |  | | |
| OTHER EXPENSES (Itemize by category) | | | | | | | | | | | |  | | |
|  | | | | DIRECT COSTS | | | | | | | |  | | |
| SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD | | | | | | | | | | | | $ | |  | | |
|  | | | | FACILITIES AND ADMINISTRATIVE COSTS | | | | | | | |  | | |
| TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD | | | | | | | | | | | | $ | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | |
| BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD DIRECT COSTS ONLY | | | | | | |
| **BUDGET CATEGORY** TOTALS | INITIAL BUDGET PERIOD *(from Form Page 4)* | 2nd ADDITIONAL YEAR OF SUPPORT REQUESTED | 3rd ADDITIONAL YEAR OF SUPPORT REQUESTED | 4th ADDITIONAL YEAR OF SUPPORT REQUESTED | 5th ADDITIONAL YEAR OF SUPPORT REQUESTED | |
| PERSONNEL: Salary and fringe benefits (**University Funds). NIH Salary Cap** |  |  |  |  |  | |
| CONSULTANT COSTS |  |  |  |  |  | |
| EQUIPMENT |  |  |  |  |  | |
| SUPPLIES |  |  |  |  |  | |
| INPATIENT CARE COSTS |  |  |  |  |  | |
| OUTPATIENT CARE COSTS |  |  |  |  |  | |
| OTHER EXPENSES |  |  |  |  |  | |
| SUBTOTAL DIRECT COSTS  (Sum = Item 8a, Face Page) |  |  |  |  |  | |
| TOTAL DIRECT COSTS |  |  |  |  |  | |
| TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD | | | | | $ |  |
| **BUDGET JUSTIFICATION.** Follow the budget justification instructions exactly. Use continuation page (**Form Page 7**) as needed.  Include Key Personnel, Consultant Costs, Equipment, Supplies, and Other Expenses. | | | | | | |

**BUDGET JUSTIFICATION** (continued)

**PRACTICAL BENEFIT FOR WOMEN’S HEALTH** *(not to exceed one page)*

**RESEARCH PLAN** (not to exceed 6 pages)

Please include Specific Aims, Background and Significance, Preliminary Data, Design and Methods, and External Funding.

**Literature Cited** (not to exceed 2 pages)

**PLEASE ATTACH:**

1. Biographical Sketch – Principal Investigator

* Use the NIH Biosketch format (<https://grants.nih.gov/grants/forms/biosketch.htm>),
* also submit the NIH updated format for Other Support (<https://grants.nih.gov/grants/forms/othersupport.htm>).

1. Other Biographical Sketches for Key Personnel

* Use the NIH Biosketch format (<https://grants.nih.gov/grants/forms/biosketch.htm>),
* also submit the NIH updated Format for Other Support (<https://grants.nih.gov/grants/forms/othersupport.htm>).

1. Letters from Collaborators

**And update the table of contents on Page 3 with corresponding page numbers.**