

**UNIVERSITY OF COLORADO DENVER ANSCHUTZ MEDICAL CAMPUS
APPROVAL OF APPLICATION FOR GRANT OR CONTRACT
(Routing Form)**

Routing Primary Contact First and Last Name

 Campus Box _____
 Contact Phone _____
 Contact Fax _____
 E-mail _____

Grants and Contracts
 No. _____
 Date: _____
 OGC ID: _____

FUNDING AGENCY: _____ DEADLINE: _____
 PRIMARY FUNDING SOURCE (If other than the funding agency listed above): _____ NEEDED BY: _____
 PRINCIPAL INVESTIGATOR(S): _____ RANK: _____ PHONE: _____
 SCHOOL: _____ DEPT/DIV: _____ ORG NO: _____
 FISCAL MGR NAME/POS NO: _____ FISCAL STAFF NAME/POS NO: _____

<p>1. PROJECT TITLE: 2a. PROPOSED PERIOD From _____ To _____ 2b. TOTAL PROJECT PERIOD From _____ To _____ 3. <input type="checkbox"/> New <input type="checkbox"/> Supplement <input type="checkbox"/> Revision <input type="checkbox"/> Continuation – Competing <input type="checkbox"/> Continuation – Non-Competing <input type="checkbox"/> Current Project No. _____ <input type="checkbox"/> Award No. _____ 4. <input type="checkbox"/> Research Program* <input type="checkbox"/> Fellowship/Traineeship <input type="checkbox"/> Facilities Request <input type="checkbox"/> Instructional Program <input type="checkbox"/> Career Development Award* <input type="checkbox"/> Service Program 5. FACILITIES: Is adequate space available to conduct the project? Yes <input type="checkbox"/> No <input type="checkbox"/> Where will the majority (50% or more) of UCD's work be performed (e.g., Biomedical Research Building (on-campus) or Anschutz Out-Patient Pavilion (off-campus))? Site/Location/Bldg. _____ Room #(s) _____ Location given is an <input type="checkbox"/> On-Campus Site <input type="checkbox"/> Off-Campus Site 6. LAB ANIMALS: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Protocol Number: _____ Approval/Re-approval Date: _____/_____/_____ 7. HUMAN SUBJECTS (HS): Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Protocol Number: _____ Approval/Re-approval Date: _____/_____/_____ 8a. RADIATION SAFETY: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Auth. Number: _____ Approval/Re-approval Date: _____/_____/_____ <input type="checkbox"/> Ionizing Radiation generating equipment <input type="checkbox"/> Other: _____ <input type="checkbox"/> Radioactive Materials 8b. BIOSAFETY: Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: Auth. Number: _____ Approval/Re-approval Date: _____/_____/_____ <input type="checkbox"/> Recombinant DNA <input type="checkbox"/> Infectious Agents <input type="checkbox"/> Select Agents <input type="checkbox"/> Other 9. COST SHARING: Does this proposal contribute any UCD resources (i.e. costs that will not be paid or reimbursed by the sponsor)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes: a. Is cost sharing required by this sponsor? Yes <input type="checkbox"/> No <input type="checkbox"/> b. Is cost sharing included in the proposal budget? Yes <input type="checkbox"/> No <input type="checkbox"/> c. Is cost sharing mentioned in the proposal narrative? Yes <input type="checkbox"/> No <input type="checkbox"/> 10. DISCLOSURE OF FINANCIAL INTERESTS* Do you have a current Conflict of Interest Disclosure on file with the UCD COI office? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, submit COI Disclosure to the COI Office as part of this routing process and check this box <input type="checkbox"/> indicating COI Disclosure is pending.</p> <p>PRINCIPAL INVESTIGATOR: My signature certifies that: 1) Acknowledge and accept responsibility for the technical content and quality of the proposed project; 2) I assure that the project and other professional activities are compatible; 3) I assure that no individuals on the project will have commitments in excess of 100% effort; 4) I accept responsibility for the proper technical and financial conduct of the project; 5) I assure that the information contained on this form and attached application/proposal is true, accurate and complete to the best of my knowledge; 6) I acknowledge and accept responsibility for compliance with award terms and conditions and university policies and procedures, particularly for the technical conduct of the work, submission of technical reports, regulatory compliance, and financial management if an award is made; 7) I assure that arrangements have been made to fund any cost sharing requirements if an award is made; 8) Any items requiring special consideration by the Dean, Chancellor's Office, Planning Office, etc. have been disclosed; 9) I assure that if a joint appointment with the Veterans Administration exists, a memorandum of understanding has been executed between the UCD and the VA, full disclosure has been made to the NIH or other sponsors as required, and my time and effort will not be double billed for the same effort; 10) I understand that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil or administrative penalties; 11) If an award is made, I am responsible for compliance with award terms and conditions and University policies and procedures, particularly for the technical conduct of the work, submission of technical reports, regulatory compliance, and financial management.</p> <p>Principal Investigator: _____ Date: _____</p>	<p>11. BUDGETARY ITEMS - If #7 (Human Subjects) is yes, answer the following: a. Will this project involve work with HS to be done at UCH, TCH, or any other non-UCD facilities? Yes <input type="checkbox"/> No <input type="checkbox"/> b. Are all research-related patient care costs included in the budget, including any applicable non-UCD facility charges incurred as direct costs? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, explain why under comments or on a separate page attached to this form.</p> <p>12. CLINICAL TRIAL-Answer the following questions if the project is a clinical trial: a. Project sponsor is: <input type="checkbox"/> US Govt. agency <input type="checkbox"/> agency of U.S. state, country or municipality; <input type="checkbox"/> foreign government; <input type="checkbox"/> private company b. Project hypothesis developed by the PI? <input type="checkbox"/> Yes <input type="checkbox"/> No c. Protocol designed by university personnel? <input type="checkbox"/> Yes <input type="checkbox"/> No d. Who initiated the project? <input type="checkbox"/> Sponsor <input type="checkbox"/> PI e. Is University the only entity conducting this research for sponsor? <input type="checkbox"/> Yes <input type="checkbox"/> No f. Stage of drug development for trial: <input type="checkbox"/> Preclinical testing <input type="checkbox"/> Phase I <input type="checkbox"/> Phase II <input type="checkbox"/> Phase III <input type="checkbox"/> Phase IV <input type="checkbox"/> New Drug App. has been filed <input type="checkbox"/> Device <input type="checkbox"/> Other</p> <p>13. SUMMARY OF PROPOSED BUDGET</p> <p>DIRECT COSTS</p> <table style="width:100%; border-collapse: collapse;"> <tr><td>Personnel</td><td></td></tr> <tr><td>- Salaries and Wages</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- Fringe Benefits</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Consultant Costs</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Equipment (over \$5,000)</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Supplies</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Travel</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Hospital Patient Care Costs</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Subrecipient(s): How many? _____</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Trainee Costs</td><td></td></tr> <tr><td>- Stipends</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- Tuition and Fees</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>Other Expenses</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- Center for Laboratory Animal Care (at SOM)</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- IRB Review of Industry Sponsored Protocols</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- Rent</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>- Tuition Remission & Related Fringe Benefits</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>TOTAL DIRECT COSTS</td><td style="text-align: right;">\$ _____</td></tr> <tr><td colspan="2">FACILITIES AND ADMINISTRATIVE COSTS (F&A)</td></tr> <tr><td>% F&A _____ %</td><td></td></tr> <tr><td>Costs Subject to F&A \$ _____</td><td style="text-align: right;">\$ _____</td></tr> <tr><td>TOTAL DIRECT AND F&A COSTS</td><td style="text-align: right;">\$ _____</td></tr> </table> <p>APPROVALS (To be obtained by PI/Administrator)</p> <table style="width:100%; border-collapse: collapse;"> <tr><td style="width:80%; border-bottom: 1px solid black;">Department Chair or Director</td><td style="width:20%; border-bottom: 1px solid black;">Date</td></tr> <tr><td style="border-bottom: 1px solid black;">Dean</td><td style="border-bottom: 1px solid black;">Date</td></tr> <tr><td style="border-bottom: 1px solid black;">Grants and Contracts</td><td style="border-bottom: 1px solid black;">Date</td></tr> <tr><td style="border-bottom: 1px solid black;"> </td><td style="border-bottom: 1px solid black;">Date</td></tr> </table>	Personnel		- Salaries and Wages	\$ _____	- Fringe Benefits	\$ _____	Consultant Costs	\$ _____	Equipment (over \$5,000)	\$ _____	Supplies	\$ _____	Travel	\$ _____	Hospital Patient Care Costs	\$ _____	Subrecipient(s): How many? _____	\$ _____	Trainee Costs		- Stipends	\$ _____	- Tuition and Fees	\$ _____	Other Expenses	\$ _____	- Center for Laboratory Animal Care (at SOM)	\$ _____	- IRB Review of Industry Sponsored Protocols	\$ _____	- Rent	\$ _____	- Tuition Remission & Related Fringe Benefits	\$ _____	TOTAL DIRECT COSTS	\$ _____	FACILITIES AND ADMINISTRATIVE COSTS (F&A)		% F&A _____ %		Costs Subject to F&A \$ _____	\$ _____	TOTAL DIRECT AND F&A COSTS	\$ _____	Department Chair or Director	Date	Dean	Date	Grants and Contracts	Date		Date
Personnel																																																					
- Salaries and Wages	\$ _____																																																				
- Fringe Benefits	\$ _____																																																				
Consultant Costs	\$ _____																																																				
Equipment (over \$5,000)	\$ _____																																																				
Supplies	\$ _____																																																				
Travel	\$ _____																																																				
Hospital Patient Care Costs	\$ _____																																																				
Subrecipient(s): How many? _____	\$ _____																																																				
Trainee Costs																																																					
- Stipends	\$ _____																																																				
- Tuition and Fees	\$ _____																																																				
Other Expenses	\$ _____																																																				
- Center for Laboratory Animal Care (at SOM)	\$ _____																																																				
- IRB Review of Industry Sponsored Protocols	\$ _____																																																				
- Rent	\$ _____																																																				
- Tuition Remission & Related Fringe Benefits	\$ _____																																																				
TOTAL DIRECT COSTS	\$ _____																																																				
FACILITIES AND ADMINISTRATIVE COSTS (F&A)																																																					
% F&A _____ %																																																					
Costs Subject to F&A \$ _____	\$ _____																																																				
TOTAL DIRECT AND F&A COSTS	\$ _____																																																				
Department Chair or Director	Date																																																				
Dean	Date																																																				
Grants and Contracts	Date																																																				
	Date																																																				