Department of Health and Human Services
Public Health Service

Ruth L. Kirschstein
National Research Service Award
Individual Fellowship Progress Report
Follow instructions carefully

Review Group	Type	Activity	Fellowship Number

Total Project Period
From: Through:

Requested Budget Period
From: Through:

1. TITLE OF RESEARCH TRAINING PROPOSAL

2a. FELLOW (Name and address, street, city, state, zip code)

2b. FELLOW'S E-MAIL ADDRESS

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

3a. NAME OF SPONSOR

3b. SPONSOR'S E-MAIL ADDRESS

4. SPONSORING INSTITUTION *(Name and address, street, city, state, zip code)*

University of Colorado Denver, Mail Stop F428, Anschutz Medical Campus, Bldg 500, Rm W1126, 13001 East 17th Place, Aurora, CO 80045-0508

6a. TITLE AND ADDRESS OF OFFICIAL IN SPONSORING INSTITUTION BUSINESS OFFICE

Director, Grants and Contracts, Mail Stop F428, Anschutz Medical Campus, Bldg 500, Rm W1126, 13001 E. 17th Pl, Aurora, CO 80045

5. ENTITY IDENTIFICATION NO. 1846000555A7

6b. E-MAIL ADDRESS: xenia@ucdenver.edu

7. HUMAN SUBJECTS ☐ NO ☐ YES

7a. Research Exempt ☐ NO ☐ YES

If Exempt ("Yes" in 7a): Exemption No.

If Not Exempt ("No" in 7a): IRB approval date

9. TRAINING SITE(S) *(Organizations and addresses)*

Organizational Name:

DUNS:

7b. Federalwide Assurance No. FWA00005070

Street 1:

7c. NIH Defined Phase III Clinical Trial ☐ NO ☐ YES

Street 2:

8. VERTEBRATE ANIMALS ☐ NO ☐ YES

City: County:

8a. If "Yes," IACUC approval date

8b. Animal welfare assurance no. A3269-01

State: Province:

Country: Zip/Postal Code:

10. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION *(Item 13)*

NAME Lora Mihelic, MBA, MA

TITLE Manager, PreAward, Grants and Contracts

TEL (303) 724-0090 FAX (303) 724-0814

E-MAIL xenia@ucdenver.edu

Congressional Districts:

11. FELLOW'S TELEPHONE INFORMATION

OFFICE

FAX

HOME

12. CORRECTIONS (Items 1 - 6)

13. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete, and accurate to the best of my knowledge, and I agree to comply with the Public Health Service terms and conditions if a grant is awarded as a result of this report. 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 10.
(In ink. "Per" signature not acceptable.)

DATE