

COLLEGE OF ALLIED HEALTH
Research Seed Grant Program Application Form

1. Title of Proposal		2. Funding Amount Requested	
3. Principal Investigator			
Name/Credentials:			
Title/Position:			
Department:		Employment Date with CAH:	
Status:	Tenured	Tenure Track	Consecutive Term Temporary
Employment Status:	12 mo	10 mo	9 mo % Research Assignment:
Have you previously received funding from the CAH Research Seed Grant Program?			Yes No
Phone:	E-mail:	Fax:	
4. Co-Investigator(s)/Mentor(s)			
Name:		Title:	
Department:		University:	
Name:		Title:	
Department:		University:	
Name:		Title:	
Department:		University:	
5. Type of Research: Applied Basic Other (explain)			
6. Human Subjects:		Pending, date anticipated:	Date of Institutional Approval:
Yes No			
7. Vertebrate Animals:		Pending, date anticipated:	Date of Institutional Approval:
Yes No			
8. Biological Hazards: Yes No			
9. Radioisotopes: Yes No			
If yes, state name, address, and radioactive use number of the individual under whom radioisotopes will be purchased, stored, and used.			
Name:		Address:	
User mini-license no.:			
10. Principal Investigator Assurance:			
<p>I hereby accept responsibility for the scientific content of the project and for providing the materials required for annual contract performance evaluation. I give permission for the materials in this application to be reviewed by members of the CAH Review Panel and other College administrators as deemed necessary. I agree to maintain accurate records and to manage the administrative tasks</p>			

necessary to complete all planned work within the funding limitations.

I also certify that all statements and figures are accurate and agree to conform with all College and University policies in executing the project.

Signature of Principal Investigator

Date

11. Approval Signatures:

Department Chair

Date

For use by CAH Review Panel Only

Date Rec'd _____

Date of Final Review _____

Action:

- Accepted
- Approved but not funded
- Declined

Signature of Panel Chair