



Office of Research Services Proposal Checklist and Routing Sheet

ORS USE ONLY: Date:

Time In:

Month/Year:

ORS Log No.:

ORS File No.:

Purpose:

- ☐ Research ☐ Training
☐ Public Service ☐ Clinical Trial (CTA)
☐ Fellowship ☐ Material Transfer
☐ Confidential Disclosure Agreement (MTA)
☐ Agreement (CDA) ☐ Other (specify):

Type:

- ☐ Grant
☐ Contract
☐ Consortium

Status:

- ☐ New
☐ Non-Competing Continuation (Progress Report)
☐ Competing Continuation (Renewal)
☐ Revised/Amended (Resubmission)
☐ Competing Supplemental (Revision)
No-Cost Extension

- ☐ Transfer
☐ Amendment
☐ Subcontract
☐ JIT
☐ Final Report
☐ Carryover Request
☐ Other (specify):

Principal Investigator (Contact PI): LAST NAME	FIRST NAME	P/S No.	Electronic: Yes <input type="checkbox"/> No <input type="checkbox"/>
Additional Principal Investigator (if Multi-PI application): LAST NAME	FIRST NAME	Electronic by ORS: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Contact PI's Dept. of Primary Appointment/Section/School:	Tel.:	Email:	Alternate # (cell, pager, etc.)
Additional PI's Dept. of Primary Appointment/Section/School:	Tel.:	Email:	Alternate # (cell, pager, etc.)
Administrative Contact:	Contact Phone:	Fax:	Email:
Sponsor (if MTA, list material Provider or Recipient):		Due Date to Sponsor:	
If LSUHSC-NO is sub, who is Prime Applicant (if applicable)?		Due Date to Prime Applicant (if applicable):	
Funding Opportunity Announcement # (if applicable):		Grant Award # (if applicable):	
Title of Project (if MTA, describe Material):	Award Mechanism (R01, R21, K12, etc.):	Keyword:	

Clinical Trial Performance Site:

Signature Approval of Clinical Trial Performance Site:

If Clinical Trial, will personal, professional, or consulting services be purchased? Yes ☐ No ☐ N/A ☐ (if yes, contact your school's contracts management office)

If Clinical Trial, will technical/operational services be purchased? Yes ☐ No ☐ N/A ☐ (if yes, contact supply chain management)

Budget Information:	Dates		Direct \$	Indirect \$	Total \$
First budget year covered by this application:	From:	To:			
Total period covered by this application:	From:	To:			

Please check the following before submission:

☐ 42% Fringe Benefits on Personnel

☐ Other Fringe Benefit rate applied (see: <http://www.lsuhscc.edu/no/administration/accounting/cost/fade/default.aspx>)

☐ 46% MTDC* F&A (Indirect Costs) on Research Projects – On Campus

☐ 45% Other Sponsored Projects

☐ 26% Off Campus rate

☐ 25% Clinical Trial Agreements IRB Fee Applied: ☐ Yes ☐ No ☐ N/A

☐ F&A (Indirect Costs) of less than 25% or Not Allowed (Attach copy of guidelines so stating)

Exemption of approved University Indirect Cost Rate

Rate Accepted by Sponsored Projects:

Signature

*MTDC: Exclude Subcontracts over \$25,000 (the first \$25,000 is included in the calculation), capital equipment expenditures in excess of \$5,000, alterations & renovations, patient care costs, rental costs of off-site facilities, student stipends & tuition payments. **Fringe benefits & patient incentives are included in this calculation.**

Committee Approvals: (Copies of approval forms must be attached.)

	Approval Date	Approval #	Status*	*Status Definitions:
RADIATION SAFETY				(A) Pending
IRB				(B) Submitted to Committee
IACUC				(C) Not Applicable
BIOSAFETY (aka "IBC")				

Publications: Have articles resulting from DHHS funding been entered into NLM database? ☐ Yes ☐ No ☐ N/A

Space & Facilities: *Approved: _____ Date: _____ Associate Vice Chancellor, Property & Facilities Management	Are PATENT RIGHTS addressed in this proposal? <input type="checkbox"/> Yes <input type="checkbox"/> No
1. Do you have adequate space available for this project? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the material/information being sent the subject of an
2. Are alterations or renovations required? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, requires institutional approval.)*	<input checked="" type="checkbox"/> INVENTION DISCLOSURE submitted to the Office of
3. Are utilities available for requested equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Technology Management (OTM)? Yes No
4. Are all facilities required presently available? <input type="checkbox"/> Yes <input type="checkbox"/> No	Approval: _____ Date _____
	Director, OTM

U.S. Department of Health and Human Services

Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief, that:

- (1.) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
- (2.) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, and officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
- (3.) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Sections 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

Certification Regarding Significant Financial Interest Disclosure

As described in Chancellor's Memorandum #35, each Investigator is required to disclose any significant financial interest of the Investigator that would reasonably appear to be directly and significantly affected by the research or educational activities funded, or proposed for funding.

Regardless of the above minimum requirement, a faculty or staff member, in his or her own best interest, may choose to disclose any other financial or related interest that could present an actual conflict of interest or be perceived to present conflict of interest. Disclosure is a key factor in protecting one's reputation and career from potentially embarrassing or harmful allegations of misconduct.

Each person who has significant financial interests requiring disclosure must complete a CM35 Significant Financial Interests Disclosure Form, attach all required supporting documentation, including a copy of any relevant PM-11 disclosure, and place the materials in a sealed envelope addressed to the Office of Research Services and clearly marked "CONFIDENTIAL Significant Financial Interests Disclosure", and identified with the name of the person making the disclosure, the name of the sponsor, and the project name.

NIH Assurances

As Principal Investigator and/or Fellow on this NIH Application I assure the following:

- (1.) To the best of my knowledge the information submitted within the application is true, complete, and accurate;
- (2.) I understand that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties;
- (3.) That as PI, 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 the application
- (4.) That LSUHSC-NO will provide appropriate training, adequate facilities, and supervision if a fellowship is awarded as a result of the application; and
- (5.) That I, the Fellow, have read the Ruth L. Kirschstein National Research Service Award Payback Assurance and will abide by the assurance if an award is made, and that the award will not support residency training.

Do Not Write Below this Line

PI Certifications and Assurances:	
1. This work will be accomplished in a <i>Drug Free Environment</i> .	Signature of Principal Investigator Date
2. I have read the Certification Regarding Lobbying & the Certification Regarding Significant Financial Interest Disclosure on this page & I will comply with the requirements. In addition, with my signature on this page, I agree to the NIH Assurances listed.	Signature of Fellow (if applicable) Date
3. All information provided in this LSUHSC-NO ORS Checklist and in the pre-award materials provided is correct.	Signature of Business Manager Date Phone #: Email:
	Signature of Department Head Date