***A Disclosure of External Financial and Time Commitment Form is required to be on file with the Office of Research (OR) prior to submission for ALL “investigators” WHO WILL HAVE THE “AUTHORITY OR INDEPENDENT RESPONSIBILITY OVER THE DESIGN, CONDUCT OR REPORTING RESEARCH” and key personnel. If a form is not on file, please promptly contact the OR at 757-446-8480.* Please note – Principal Investigators (PIs) are responsible for providing this form to the Office of Research so that verification may be obtained that a conflict of interest form is on file for all key investigators prior to a proposal submission being sent to a sponsor. The completed OSP Approval Form should then be submitted by the PI to:** ***COI@evms.edu***

|  |  |
| --- | --- |
|  | ***DUE DATE TO SPONSOR***:        |
| EVMS’s Principal Investigator (s)/Project Director (s) & Phone #**eRA User ID** **If Multi-PI submission** **eRA User ID**  |     | Dept.& Contact |  |
| Co-Investigator/Co-Principal Investigator& Phone # |  | Dept.& Contact |  |
| Co-Investigator/Co-Principal Investigator& Phone # |  | Dept.& Contact |  |
| Co-Investigator/Co-Principal Investigator& Phone #***LIST THE NAMES OF ALL KEY PERSONNEL FOR THIS PROJECT*** | ***KEY PERSONNEL (Can be reported to the***  ***funding agency):***  | Dept.& Contact | *LIST ALL OTHER INDIVIDUALS DEEMED “INVESTIGATORS” (WHO WILL HAVE THE “****RESPONSIBILITY*** *OVER THE DESIGN, CONDUCT OR REPORTING RESEARCH ) BELOW:****INVESTIGATORS****:*   |
| **Project Title**:  |
| Sponsor/Funding Source:  |  |
| Sponsor Contact Info (Name/#) |  |
| ***Collaborating Institution/ Company/ Person, etc.*** ***Yes No*** ***PI and Key Personnel(s) Number and email and alt. contact*:** |  |
| Proposed Project Period |  | **To**  |  |
| Study Site: | [ ]  On Campus – (EVMS Property) |  [ ]  Off Campus – (Rent Expense budgeted) |
| Proposal type:  |  | [ ]  New  | [ ]  Competing Renewal  | [ ]  Non-Competing Renewal/Extension | [ ]  Transfer from       |
| Research category: |  | [ ]  Basic - 132 | [ ]  Clinical - 131 | [ ]  Teaching/Training – 149  | [ ]  Service - 151 |

 **Does your submission relate to one of the focal areas? Check all that apply:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | [ ]  | Cancer  | [ ]  | Diabetes/Obesity  | [ ]  | Geriatrics |  [ ]  | Education Innovation  |
|  | [ ]  | Cardiovascular | [ ]  | Virology/Infectious Disease | [ ]  | Women’s and Pediatric Health |   | Other |

|  |  |
| --- | --- |
| Budget request for first project year (or Current Year for Renewals) | Budget request for total project period |
| Total Direct Costs  |  |  | Total Direct Costs  |  |
| Total F & A Costs |  |    | Total F & A Costs |   |
| Subtotal**Clinical Study Only****Pass Through Costs** |   |  | Subtotal**Clinical Study Only****Pass Through Costs** |    |
| ***IRB Fee*** |        |   | ***IRB Fee*** |        |
| ***Advertising*** |        |  | *A****dvertising*** |        |
| ***Other \_\_\_\_\_\_\_\_\_\_*** |        |  | ***Other\_***\_\_\_\_\_\_\_\_\_\_\_ |        |
| Total Project Costs  | $ |  | **% F & A Costs** |  | **%** |  | Total Project Costs  | $ |
|  |  |  |
|  |  |  |
| Cost Share?**\*\*\*Requires Department Chair’s**  **Approval in order to ensure that cost**  **Share commitments are feasible.** | [ ]  No  | [ ]  Yes $ or %  | [ ]  Budget – Cost Match $ Included | **Amount of Cost Share****$** |
| Animal Research? | [ ]  No | [ ]  Yes[ ]  IACUC Approval date       | [ ]  IACUC Protocol #       | [ ]  IACUC pendingDate submitted       |
| Human Research? Such as use of specimens, data, or records | [ ]  No | [ ]  Yes[ ]  IRB Approval date       | [ ]  IRB Protocol #       | [ ]  IRB pendingDate submitted       |
| Radioisotopes or radiation-producing machines used?(e.g. fluoroscopy, x-ray) | [ ]  No | [ ]  Yes[ ]  User Authorization #       | Issued To       | [ ]  Authorization pendingDate submitted       |
| Recombinant DNA, biohazards/ infectious agents, or risk group 2 be Used? | [ ]  No | [ ]  Yes, Institutional Biosafety Committee (IBC) Approval #       | IBC Approval Date       | [ ]  Approval pending–Date submitted       |
| Does the Sponsor require ownership of inventions, ideas, or technologies that (may) result from this project?  | [ ]  No | [ ]  Yes, you must contact the Office of Technology Transfer for Inventions and Discoveries Policy information. | Contact OSP for assistance. |  |

# \*\*\*\* Research Resources\*\*\*\*

# *Will this project utilize one or more of the listed Centers below? Yes or No*

# *If no, proceed to the assurances and approvals section.*

# *If yes, Please check all that apply below.*

# *By checking the box(es) below, I acknowledge that I have consulted with and provided the required information to the appropriate Center Director(s).* \*\*\*Proposed changes are incorporated as a tracking mechanism for EVMS Strategic Plan\*\*\*

|  |  |  |  |
| --- | --- | --- | --- |
|

|  |  |
| --- | --- |
| [ ]  No  | [ ]  Yes  |

 | ***Cancer Center***  |
|

|  |  |
| --- | --- |
| [ ]  No  | [ ]  Yes  |

 | **M. Foscue Brock Institute for Community and Global Health** |
|

|  |  |
| --- | --- |
| [ ]  No  | [ ]  Yes  |

 | **Research Infrastructure Service Enterprise (RISE)** |
|

|  |  |
| --- | --- |
| [ ]  No  | [ ]  Yes  |

 | ***Biorepository***  |

# ASSURANCES AND APPROVALS

I certify that this proposal complies with all Institutional and departmental requirements and that I will have secured or have requested the approval of all appropriate compliance committees prior to final acceptance of the award and initiation of the project. I further certify that I will withdraw this proposal if approval needed for any pending items is not received from the appropriate committees.

In the event that my grant/contract is funded, I understand that prior to the release of an account number; my application must also be reviewed and approved for chemical and physical safety concerns by the Chemical and Environmental Safety Committee and the Radiation Safety and Environmental Health and Safety (RS&EHS) office. Their approval does not imply that every safety aspect is addressed in the grant; safety in the laboratory is, as always, the responsibility of the principal investigator. I also understand that my application must be reviewed and approved by all other appropriate committees prior to the initiation of the project.

I further certify that I accept my responsibilities as Principal Investigator in accordance with EVMS Office of Sponsored Programs Principal Investigator Policy 13.20, which includes, but not limited to: assuming responsibility for the day-to-day management of the project; adhering to sponsor policies and compliance regulations; ensuring that project expenditures are made in accordance with sponsor requirements; and, maintaining an accurate record of project expenses including a monthly review of financial reports.

**PI/PD Investigator**: Date

**PI/PD Signature:**  Date

**PI/PD Department Chairman: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. I certify that I have reviewed this proposal for merit.**

**2. I certify that taking this proposal into account, the PI is not accounting for more than 100% of his/her effort.**

**3. If EVMS Health Services employees are included in this project, I certify that the department is maintaining its**

 **clinical responsibility.**

**Co-I/Co-PI - *Please submit to your department chair for approval and signature if you are in a different department than the PI/PD***

***I acknowledge my participation in this project as proposed.***

**Co-Investigator**: \_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-Investigator**: Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-Investigator**: Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-I/Co-PI Department Chairman:**

1. I certify that I have reviewed this proposal for merit.

2. I certify that taking this proposal into account, the PI is not accounting for more than 100% of his/her effort.

3. If **EVMS Health Services** employees are included in this project, I certify that the department is maintaining its clinical responsibility.

**Co-I/Co-PI Department Chairman:** \_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-I/Co-PI Department Chairman:** \_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Co-I/Co-PI Department Chairman:** \_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vice Dean for Research**:

I certify that the above named Principal Investigator is in compliance with all relevant institutional requirements (e.g. appropriate committee approvals, etc.) or that the appropriate steps have been taken to assure compliance.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Milton L. Brown, MD, PhD, FNAI