Department of Health and Human Services
Public Health Services

Grant Progress Report

Review Group	Type	Activity	Grant Number

Total Project Period
From: Through:

Requested Budget Period
From: Through:

1. TITLE OF PROJECT

2a. PROGRAM DIRECTOR / PRINCIPAL INVESTIGATOR (Name and address, street, city, state, zip code)

2b. E-MAIL ADDRESS

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

2d. MAJOR SUBDIVISION

2e. Tel: Fax:

3a. APPLICANT ORGANIZATION (Name and address, street, city, state, zip code)

The Rockefeller University
1230 York Avenue
New York, NY 10065-6399

3b. Tel: Fax:

3c. DUNS: 071037113 (UEI: LHGDNJMZ64Y1)

4. ENTITY IDENTIFICATION NUMBER
1131624158A1

6. HUMAN SUBJECTS ☐ No ☐ Yes

6a. Research Exempt	If Exempt ("Yes" in 6a): Exemption No.	If Not Exempt ("No" in 6a): IRB approval date
☐ No ☐ Yes		

6b. Federal Wide Assurance No.

6c. NIH-Defined Phase III Clinical Trial ☐ No ☐ Yes

5. NAME, TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

Collette L. Ryder, MBA, CRA
Director, Office of Sponsored Programs Administration

Tel: (212) 327-8054 Fax: N/A

E-MAIL:
OSPA@rockefeller.edu

7. VERTEBRATE ANIMALS ☐ No ☐ Yes

7a. If "Yes," IACUC approval Date

7b. Animal Welfare Assurance No.

10. PROJECT/PERFORMANCE SITE(S)

Organizational Name: The Rockefeller University

DUNS: 071037113 (UEI: LHGDNJMZ64Y1)

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT $	8b. TOTAL $

Street 1: 1230 York Avenue

Street 2:

9. INVENTIONS AND PATENTS ☐ No ☐ Yes

If "Yes," ☐ Previously Reported
☐ Not Previously Reported

City: New York	County:
State: NY	Province:
Country: US	Zip/Postal Code: 10065-6399

Congressional Districts: NY-012

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

Collette L. Ryder, MBA, CRA - Director, Office of Sponsored Programs Administration

TEL: (212) 327-8054	FAX: N/A	E-MAIL: OSPA@rockefeller.edu

12. Corrections to Page 1 Face Page

13. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. 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 11. *(In ink)*	DATE