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| --- |
| **2024 Mario Family Foundation Award Grant Application** |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. TITLE OF PROJECT *(Do not exceed 81 characters, including spaces and punctuation.)* | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **3. APPLICANT** | | | | | | | | |  | | | | | | | | | | | | | |
| 3a. NAME (Last, first, middle) | | | | | | | | | 3b. DEGREE(S) | | | | | | | |  | | | | | |
|  | | | | | | | | |  | | |  | |  | | |  | | | | | |
| 3c. FELLOW YEAR (PG) | | | | | | | | | 3f. E-MAIL ADDRESS OF APPLICANT: | | | | | | | | | | | | | |
| 3e. DIVISION | | | | | | | | |
| 4. HUMAN SUBJECTS  RESEARCH  No  Yes | | | | | | 4b. Human Subjects IRB No. | | | 4c. Clinical Trial  No  Yes | | | | | | | 4d. NIH-defined Phase III  Clinical Trial  No  Yes | | | | | | |
| 5. DATES OF PROPOSED PERIOD OF  SUPPORT *(month, day, year—MM/DD/YYYY)* | | | | | | | | 6. COSTS REQUESTED FOR BUDGET PERIOD | | | | | | |  | | | | | | | |
| From | | | | Through | | | | 6a. Direct Costs ($) | 6b. Total Costs ($) | | | | | |  | | | |  | | | |
| 07/01/2024 | | | | 6/30/2025 | | | | 35,000 | 35,000 | | | | | |  | | | |  | | | |
| 7. DIVISION NAME & CHIEF | | | | | | | | |  | | | | | | | | | | | | | |
| Division | |  | | | | | | |  | | | | | | | | | | | | | |
| Chief Name: | |  | | | | | | |  | | | | | | | | | | | | | |
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| 8. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE | | | | | | | | |  | | | | | | | | | | | | | |
| Name | | |  | | | | | |  | |  | | | | | | | | | | | |
| Title | | |  | | | | | |  | |  | | | | | | | | | | | |
| Address | | |  | | | | | |  | |  | | | | | | | | | | | |
| Tel: |  | | | | FAX: | |  | |  |  | | | | | | | | : | |  | | |
| E-Mail: | | |  | | | | | |  | |  | | | | | | | | | | | |
| 9. MENTOR | | | | | | | | | SIGNATURE OF APPLICANT | | | | | | | | | | | | | DATE |
|  | | | | | | | | | SIGNATURE OF DIVISION CHIEF | | | | | | | | | | | | | DATE |

Face Page **Form Page 1**

|  |  |  |  |  |
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| |  |  | | --- | --- | | APPLICANT (Last, First, Middle): |  | | | |
| **2024 Mario Family Foundation Award** Grant Application | | |
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|  | *Page Numbers* | |
| Face Page (*Form Page 1*) ……………………………………………………………………………………… |  | 1 |
| Table of Contents (*This page*) ……………………………………………………………………………. |  | 2 |
| Detailed Budget for Budget Period (*Form Page 3)* |  | 3 |
| Abstract (*no more than 30 lines*)………………………………..……………………………..…………….. |  | 4 |
| Biographical Sketch—Applicant *(Not to exceed five pages)* |  |  |
| Biographical Sketch— Mentor/Sponsor (*Not to exceed five pages)* |  |  |
| Resources (*should follow standard NIH guidelines*) |  |  |
| Research Plan: (Note: Sections A-C *not to exceed three pages)* |  |  |
| A. Specific Aims |  |  |
| B. Background and Significance |  |  |
| C. Research Design and Methods...........................……………………………*……………………………………………………….* |  |  |
| D. References |  |  |
| D. Human Subjects (not to exceed 1 page) |  |  |
| E. Letter of Support from Mentor |  |  |
| F. Letter from Division Chief or Program Director ...…………………………………………………………………………………. |  |  |
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|  | | |
| **Font Requirement: Requires the use of Arial or Helvetica and a font size of 11 points or larger. (A Symbol font may be used to insert Greek letters or special characters). Font size of 10 points may be used for figure legends.** | | |

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| APPLICANT (Last, First, Middle): | | | | | |  | | | | | | | |
|  | | | | | | | | | | | | | |
| DETAILED BUDGET FOR INITIAL BUDGET PERIODDIRECT COSTS ONLY | | | | | | | | | FROM | | THROUGH | | |
|  | |  | | |
| PERSONNEL *(Applicant organization only)* | | | |  | % | |  | DOLLAR AMOUNT REQUESTED *(omit cents)* | | | | | |
| NAME | | ROLE ON PROJECT | | TYPE APPT. *(months)* | EFFORT ON PROJ. | | INST. BASE SALARY | SALARY REQUESTED | | FRINGE BENEFITS | | | TOTAL |
|  | | Principal Investigator | |  |  | |  |  | |  | | |  |
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| SUBTOTALS | | | | | | | |  | |  | | |  |
|  | | | | | | | | | | | | |  |
| EQUIPMENT *(Itemize)* | | | | | | | | | | | | |  |
| SUPPLIES *(Itemize by category)* | | | | | | | | | | | | |  |
| PATIENT CARE COSTS | INPATIENT | |  | | | | | | | | | |  |
| OUTPATIENT | |  | | | | | | | | | |  |
|  | | | | | | | | | | | | |  |
| OTHER EXPENSES *(Itemize by category)* | | | | | | | | | | | | |  |
| TOTAL DIRECT COSTS FOR BUDGET PERIOD | | | | | | | | | | | | $ | 35,000 |
|  | | | | | | | | | | | |  | |