

Certificate of Proposal (COP)

The University of Texas Health Science Center at San Antonio

Office of Sponsored Programs (OSP)

210-567-2340 / grants@uthscsa.edu

This form is required by OSP with all externally sponsored proposals and agreements.

Instructions and definitions of terms can be found online at <http://research.uthscsa.edu/osp/forms/copinstructions.doc>.

Project Title: _____

Sponsor: _____ Due Date: _____

Prime Sponsor (if flow-through): _____ Deadline Type: _____ Postmark _____ Receipt _____

FOA or RFP # or title: _____

Activity Type: Research Clinical Study Training Services Testing Other: _____

Project Status: New Resubmission Competitive Renewal Non-Competing Grant Progress Report Supplement

If renewal or continuation: Grant #: _____ Current HSC PGID #: _____

Investigator(s) Information

INVESTIGATOR(S) CERTIFICATION: My signature below certifies that (1) I am not delinquent on any federal debt; (2) I am not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from current transactions by any federal department or agency; (3) I have not and will not lobby any federal agency on behalf of this award; (4) The information submitted within the application is true, complete, and accurate to the best of my knowledge; (5) I understand that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties; (6) I agree to accept responsibility for the scientific conduct of the project; and (7) I will be responsible for meeting the requirements of the award, including, but not limited to providing the proper stewardship of sponsored funds, submitting all required technical progress reports on a timely basis, properly disclosing all inventions to the Office of Technology Commercialization, and adhering to all federal compliance requirements.

| | |
|---|---|
| Principal Investigator/Project Director: _____ | Employee ID #: _____ |
| Department: _____ | School _____ |
| Phone #: _____ | Annual Committed Effort on Project: _____ % |
| Center/Institute Affiliation(s): | VA Appointment with compensation: |
| Barshop Biggs Mays Cancer Ctr | |
| Strong Star GCCRI IIMS RII | |
| | _____ (signature) |

| | |
|--|---|
| Participating Investigator: _____ | Employee ID #: _____ |
| Department: _____ | School _____ |
| Phone #: _____ | Annual Committed Effort on Project: _____ % |
| Center/Institute Affiliation(s): | VA Appointment with compensation: |
| Barshop Biggs Mays Cancer Ctr | |
| Strong Star GCCRI IIMS RII | |
| | _____ (signature) |

| | |
|--|---|
| Participating Investigator: _____ | Employee ID #: _____ |
| Department: _____ | School _____ |
| Phone #: _____ | Annual Committed Effort on Project: _____ % |
| Center/Institute Affiliation(s): | VA Appointment with compensation: |
| Barshop Biggs Mays Cancer Ctr | |
| Strong Star GCCRI IIMS RII | |
| | _____ (signature) |

(If additional participating investigators are involved, attach additional sheets as necessary – continuation page available at http://research.uthscsa.edu/osp/forms/cop_cont.pdf)

Proposed Project Dates (mm/dd/yyyy): _____ Budget Requested: _____
Initial Period: _____ to _____ Direct \$ _____ F&A \$ _____ Total \$ _____
Entire Period: _____ to _____ Direct \$ _____ F&A \$ _____ Total \$ _____

FOR CLINICAL TRIALS ONLY: number of patients anticipated for enrollment: _____

Contact for proposal questions/pickup: _____
name phone number

Location of Project: _____ on campus _____ off campus, identify: _____
(room and/or building)

F&A (Indirect Cost) Rate Applied: _____ %

Project Key Words (at least one required):

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

Will project involve the use of:

| | | | | | |
|--|-----|------------------------|-------------------|---------|----------|
| Vertebrate animals or animal tissues/fluids? | Yes | No | If yes, IACUC is: | Pending | Approved |
| IACUC Approval Date: _____ | | IACUC Protocol # _____ | | | |

| | | | | | | |
|--------------------------|-----|----------------------|-----------------|---------|----------|--------|
| Human subjects? | Yes | No | If yes, IRB is: | Pending | Approved | Exempt |
| IRB Approval Date: _____ | | IRB Protocol # _____ | | | | |

| | | | | | |
|-----------------------|-------------------|----------------------|---------------|-------------------------|--|
| Check all that apply: | | | | | |
| recombinant DNA | infectious agents | chemical carcinogens | radioisotopes | select agents or toxins | |
| List: _____ | | | | | |

Check all applicable Institutional Core Facilities that were used to develop proposal data and/or will be used to complete the project:

| | | |
|---|-----------------------|--|
| Bioanalytics & Single-Cell (BASiC) | Biomolecular NMR | Center for Macromolecular Interactions |
| Biobanking & Genomic Analysis | Flow Cytometry | Micro CT (RAYO) |
| Optical Imaging Facility | X-ray Crystallography | Mass Spectrometry Laboratory |
| Bioinformatics & Computational Genomics (BCG) | | No Core Facilities used |

Will the project include a subaward/consortium to any other institution(s)? YES NO
 If yes, list institution(s): _____

Have you and all of the key project personnel completed the annual Report of Financial Interests (COI) as required by Health Science Center policy? YES NO
If disclosure has not been submitted, or if there have been any changes of circumstances related to the disclosure, complete or modify online at <http://vpr.uthscsa.edu/iDisclose/>

Have you and all of the key project personnel completed the Conflict of Interest training as required by Health Science Center policy? YES NO
If no, complete online at <http://kc.uthscsa.edu/kc/login.asp>

Do you or any of the key project personnel have consulting arrangements, hold board membership, serve as an officer or key employee, have line management responsibilities, or own substantial equity holdings with the sponsor, subcontractor or potential vendor? YES NO

Do you believe that the proposal contains ideas, processes, or principles that could be commercialized or that may be of interest to industry? YES NO

Will the project involve collaboration with a foreign entity or government or travel outside of the U.S.? YES NO

Does the project involve research in controlled areas and/or controlled technology as defined by the Department of Commerce (EAR) or Department of State (ITAR)? YES NO

Will the project require new space? YES NO

Will the project require renovations to existing space? YES NO

UPON AWARD:

In what department/center/institute/other unit should the primary project ID be established?

(Department Name) (Department ID #)

Who will be authorized signatories on the primary project ID?

| | |
|-------------|--------------------|
| Name: _____ | Employee ID# _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

NOTES: Please use this space to provide any additional information that may be helpful in reviewing this proposal.

Health Science Center Endorsements

DEPARTMENT CHAIR SIGNATURE(S): By signing below, the Department Chair(s) certify that this project corresponds with the goals and objectives of the department, and that agreement has been reached regarding the type and amount of departmental resources that will be required to assist the PI(s) in completing the project.

Primary PI's Department Chair _____ (date) _____

Department Chair Signatures for Participating Investigators (as necessary):

Dept _____ Chair _____ (date) _____

Dept _____ Chair _____ (date) _____

Dept _____ Chair _____ (date) _____

(If more signatures are required, attach additional signature sheets as necessary)

CENTER/INSTITUTE DIRECTOR SIGNATURE: *required when resources or space of a Center or Institute will be utilized in the conduct of the project.* By signing below, the Director(s) certify that this project is consistent with the goals and objectives of the Center/Institute, and that agreement has been reached regarding the type and amount of Center/Institute resources that will be required to assist the PI(s) in completing the project.

Center/Institute _____ Director _____ (date) _____

Center/Institute _____ Director _____ (date) _____

(If more signatures are required, attach additional signature sheets as necessary)

DEAN'S SIGNATURE: *OSP is responsible for obtaining Dean signatures when necessary.* By signing below, the Dean certifies that this project conforms to the Rules and Regulations of the Board of Regents, supports the teaching and research objectives of the school, that resources necessary to conduct the project are available or have been approved, and that all exceptions noted are satisfactory.

Dean _____ (date) _____

OSP Reviewer/Date