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| **This form is required for All VCOM proposals submitted through VT OSP.** |
| **Project Information** |
|       |  |       |  |       |  |       |
| Principal Investigator / Program Director | Phone |  | Fax |  | E-mail Address |
|       |
| Department & Campus |
|       |
| Project Title |

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| **Personnel and Departmental Information**  |
| Name |  | Project Role |  | Department & Campus |  | Proposed Effort |
|       |  |       |  |       |  |      % |
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| **Additional Information** |
| Yes | No |  |
| [ ]  | [ ]  | A **Research Financial Conflict of Interest Disclosure Form** (and Supplement Form if appropriate) has been completed by all members of the project team. |
| [ ]  | [ ]  | **Intellectual Property** such as ideas, proprietary data, computer software, inventions or patents is involved, or could potentially be developed from this project. |
| [ ]  | [ ]  | Commitment to **cost sharing or matching**? If yes, complete and attach Cost Share Approval Form. |

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| **Required Signatures** |
| As Principal Investigator, your signature below certifies the following: (1) The information submitted within the application is true, complete and accurate to the best of my knowledge; (2) any false, fictitious or fraudulent statements or claims may subject me to criminal, civil or administrative penalties; and (3) 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. |

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| Principal Investigator Signature |  | Date |
|  |  |       |  |       |
| Associate Dean Signature  | Printed Name |  | Date |

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| **Research Administration Review** |
| Name and Title | Greg S. Reaves, Director, Research Administration |  |
| Signature: |  | Date: |  |
| **Please send a copy of proposal and correspondences to:**Greg Reaves, Office of Research AdministrationVirginia College of Osteopathic Medicine, 2265 Kraft Drive, Blacksburg, VA 24060 | E-mail: greaves@vcom.vt.eduTel: 540.231.8239Fax: 540.231.5338 |