

**DARTMOUTH COLLEGE/DARTMOUTH HITCHCOCK MEDICAL CENTER (DC/DHMC)
PROPOSAL ROUTING FORM**

OSP USE ONLY:

PROJECT #: _____

PLEASE TYPE

PRINCIPAL INVESTIGATOR: _____ DEPT: _____ PHONE: _____
 % Effort – 9 or 12 Month: _____ % Effort – Off-term _____

CO-INVESTIGATOR: _____ DEPT: _____ PHONE: _____
 % Effort – 9 or 12 Month: _____ % Effort – Off-term _____

PROGRAM: [] NCCC [] CECS [] CEHS [] ISTS

PROJECT TITLE (250 char. max.) _____

SPONSOR: _____ DEADLINE DUE DATE: _____

PROGRAM SOLICITATION: Number: _____ Title: _____
 (If response to a specific solicitation, provide PA, PAR, RFA, or RFP number. If a Special Appropriation, indicate Public Law reference (e.g., PL 107-XX) and Federal Fiscal Year of the appropriation.)

PURPOSE: [] RESEARCH (RE) [] INSTRUCTION (IN) [] FELLOWSHIP (FS) [] FINANCIAL AID (FA)
 [] EQUIPMENT (EQ) [] CLINICAL TRIAL (CL) [] OTHER/SPECIFY (OS) _____

MECHANISM: [] GRANT (G) [] CONTRACT (C) [] COOPERATIVE AGREEMENT (A) [] SUB RECIPIENT (S)

TYPE: [] NEW (N) [] NON-COMPETING RENEWAL (C) [] COMPETING RENEWAL (R) [] SUPPLEMENT (S)

THIS IS A CONTINUATION OF ACCOUNT #: _____

BUDGET REQUESTED FROM SPONSOR

PERIOD	START DATE	STOP DATE	DIRECT \$	INDIRECT \$*	TOTAL \$
1st	_____	_____	_____	_____	_____
2nd	_____	_____	_____	_____	_____
3rd	_____	_____	_____	_____	_____
4th	_____	_____	_____	_____	_____
5th	_____	_____	_____	_____	_____
Overall	_____	_____	_____	_____	_____

OSP ONLY:

* INDIRECT COST RATE AND NOTES: _____

SUB RECIPIENTS: Does this proposed budget include any sub recipients? [] YES [] NO

This budget complies with all relevant pricing policies of Dartmouth Hitchcock Medical Center and/or Dartmouth College and complies with relevant federal guidelines. The budget covers the direct costs of all service providers. Any resources required but not covered by the budget (e.g., office space, computers) will be provided by the department.

 Department Financial Officer

COST-SHARING (if required)	
_____	Salaries & Benefits
_____	Indirect Costs
_____	Other (Identify): _____
Approved: _____	Dean/Designee
	MATCHING FUNDS
Approved: _____	Development Officer

REQUIRED SIGNATURES:

I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. 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 this application.

PRINCIPAL INVESTIGATOR DATE

DEPARTMENT CHAIR DATE

DEAN/DESIGNEE DATE

SPONSORED PROJECTS DATE

SIGNATURES AS NEEDED (e.g. MHMH, Hitchcock Clinic, VA Hospital, Co-investigator's department chair, etc.):

DATE

DATE

FOUNDATION RELATIONS OFFICER DATE

CLINICAL RESEARCH DHMC FINANCIAL ADMINISTRATOR DATE

CONTACT PERSON FOR PICKUP: NAME: _____

PHONE: _____