**The Trustees of Columbia University in the City of New York**

**SPONSORED PROJECTS ADMINISTRATION**

**SUBRECIPIENT PROPOSAL FACE PAGE**

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| --- | --- |
| **PRIME INSTITUTION Legal/Corporate Name:**  The Trustees of Columbia University in the City of New York | **SUBRECIPIENT INSTITUTION Legal/Corporate Name:** |
| Principal Investigator: | Principal Investigator: |
| Department: | Department: |
| **Medical Center:** 630 West 168th Street, Box 49 | Address: |
| New York, NY 10032-3702 | City:       State:  Full Postal Code (**ZIP+4**): |
| **grants-office@columbia.edu** Ph:(212) 305-4191 | Email:       Phone#: |
| EIN# 135598093  Unique Entity Identifier (UEI)# QHF5ZZ114M72 | EIN #:  Unique Entity Identifier (UEI)# |
|  |  |
| **Morningside:** 615 West 131st Street, 6th Floor, Mail Code 8725 | **Project/Performance Site Congressional District:** |
| New York, NY 10027-7922 | For-Profit:  Non-Profit:  Fiscal Year End: |
| **ms-grants-office@columbia.edu** Ph:(212) 854-6851 |  |
| EIN# 135598093 Unique Entity Identifier (UEI)# F4N1QNPB95M4 | Is your institution on the **list of compliant institutions and entities** in the **FDP FCOI Clearinghouse**?  Yes  No |

Prime Funding Sponsor:

Title of Project:

Dates of Proposed Project Period:

Dates of Initial Budget Period:

**Estimated Total Costs (Direct and Indirect):**

First Year Direct: $      First year Indirect: $      Total: $

Project Total Direct: $      Project Total Indirect: $      Project Total: $

Human Research Subjects: Y  N  IRB Approval:  Pending  Approval Date:

Laboratory Animals: Y  N  IACUC Approval:  Pending  Approval Date:

Fixed Amount Subaward: Y  N  Cost Reimbursement Subaward: Y  N

Per Patient/Fixed Rate Subaward: Y  N  Cost per Patient: $

**AUTHORIZED OFFICIAL:**

Name:       Title:

Address:

Email Address:       Telephone Number:

We agree to abide by the prime sponsor’s policies and are prepared to negotiate the necessary inter-institutional agreements consistent with those policies.

**SIGNATURES:**

Subrecipient Principal Investigator:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_