Boston University Medical Campus
Office of Sponsored Programs

BOSTON UNIVERSITY

Transmittal Form for All Non-competing and Continuation Applications

eSNAP: ☐ Yes   ☐ No

A. General Project Information

Principal Investigator: _____ Unit/Dept Number: _____

Project Title: _____

Current Grant Number: _____ Source Number: _____

Agency Deadline: _____   Agency: _____

Project Location: _____   Changed from previous submission? ☐ YES   ☐ NO
Do not use this form if the project location has changed. Use the proposal summary form instead.

Is the unspent balance >25% of the current year award?   ☐ YES   ☐ NO

Effective Dates for Continuation Year of Project: FROM: _____   TO: _____

Outgoing Subcontracts: ☐ YES, # of subcontracts: _____   ☐ NO

   If yes, list subcontracts: _____

Department Administrator Name: _____   Phone #: _____

B. Assurances

Assurance(s):	YES	NO	Protocol Number(s)	Most Recent Approval Date for Each Protocol
IRB / Human Subjects	☐	☐		
IACUC / Animals	☐	☐		
Other IBC	☐	☐		
Radioisotopes	☐	☐		
Recombinant DNA (rDNA)	☐	☐		
Select Agents	☐	☐		

Provide copy of any updated assurances for these areas since previous application.

C. Certification

PI Assurance: I certify that: (1) in conducting the proposed program, I am familiar with and will adhere to applicable Boston University/Boston Medical Center policies including, but not limited to, human and animal research, conflict of interest, misconduct in research, and patents and technology transfer (http://www.bu.edu/research/about/ethics/); (2) the information submitted within the application is true, complete, and accurate to the best of the my (the PI's) knowledge; (3) any false, fictitious, or fraudulent statements or claims may subject me (as the PI) to criminal, civil, or administrative penalties; (4) I (as the PI) 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; and (5) I will abide, as applicable, by the Federal clinical trials (http://clinicaltrials.gov/) and NIH Public Access (http://publicaccess.nih.gov) regulations.

_____   _____   _____   _____
PI signature   *Date*   *Department Administrator signature*   *Date*

NIH policy statement: http://grants.nih.gov/grants/policy/policy.htm

---

OSP-MED Only: **RA Reviewer initial/date:** _____ / _____

Current Year Award: _____   **Cumulative Balance:** _____   **% Current Balance:** _____

OSP-MED Signature: _____   **Date:** _____

85 East Newton Street, M-921, Boston, MA 02118 ● Tel: 617-638-4600 ● Fax: 617-638-4686