**INDIANA TRAUMATIC SPINAL CORD AND BRAIN INJURY RESEARCH**

***ACTIVITY-BASED THERAPY PROGRAM***

**2021 APPLICATION**

PROGRAM DIRECTOR :  EMAIL:

ORGANIZATIONAL AFFILIATION:

INSTITUTIONAL EIN or DUNS NUMBER, if appropriate:

TITLE OF PROPOSAL:

ADDRESS WHERE WORK WILL BE PERFORMED:

MECHANISM FOR APPLICATION:

Activity based therapy program for traumatic spinal cord injury patients

Activity based therapy program for traumatic brain injury patients

RESUBMISSION: [ ] YES [ ]  NO

\*If yes, please address or respond to the comments from the reviewers and submit it with the copy of the reviewer’s comments in the submission as supplemental information.

BUDGET PERIOD (maximum 24 months):

From: **07/01/2022** (Month/Day/Year) To: (Month/Day/Year)

AMOUNT REQUESTED:

Total $ (may not exceed $150,000)

REQUIRED SIGNATURE: The undersigned agrees to accept responsibility for the scientific and technical conduct of the project and for provision of required progress reports if a grant is awarded as the result of this application.

**Funding for this award will come from the Indiana State Department of Health.**

APPLICANT SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPED NAME AND TITLE OF APPLICANT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSTITUTIONAL OFFICIAL\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*by this signature you are attesting to approval and support of the time and effort specified by the program director and other faculty/staff on this application.

TYPED NAME AND TITLE OF INSTITUTIONAL OFFICIAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

UPLOAD INSTRUCTIONS: Upload using the application and ‘Start a Submission’ link found here: [CTSI ABT Link](https://indianactsi.org/translational-research-development/open-funding-opportunities#ABT202111)

Principal Investigator/Program Director (Last, first, middle): **YEAR 1**

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| **DETAILED BUDGET FOR YEAR 1 BUDGET PERIOD****DIRECT COSTS ONLY** | FROM07/01/2022 | THROUGH      |
| PERSONNEL *(Applicant organization only)* |  | % |  | DOLLAR AMOUNT REQUESTED *(omit cents)* |
| NAME | ROLE ONPROJECT | TYPEAPPT.*(months)* | EFFORTONPROJ. | INST.BASESALARY | SALARYREQUESTED | FRINGEBENEFITS | TOTAL |
|       | PrincipalInvestigator |     |     |      |      |      |      |
|       | Collaborator |       |       |       |       |       |       |
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|  **SUBTOTALS** |        |       |       |
| CONSULTANT COSTS |      |
| SUPPLIES  |      |
| TRAVEL |      |
| PATIENT CARE COSTS |      |
| OTHER EXPENSES |      |
| TOTAL DIRECT COSTS FOR YEAR 1 BUDGET PERIOD |  |

BUDGET JUSTIFICATION:

 Principal Investigator/Program Director (Last, first, middle): **YEAR 2**

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| **DETAILED BUDGET FOR YEAR 2 BUDGET PERIOD****DIRECT COSTS ONLY** | FROM07/01/2023 | THROUGH      |
| PERSONNEL *(Applicant organization only)* |  | % |  | DOLLAR AMOUNT REQUESTED *(omit cents)* |
| NAME | ROLE ONPROJECT | TYPEAPPT.*(months)* | EFFORTONPROJ. | INST.BASESALARY | SALARYREQUESTED | FRINGEBENEFITS | TOTAL |
|       | PrincipalInvestigator |     |     |      |      |      |      |
|       | Collaborator |       |       |       |       |       |       |
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|  **SUBTOTALS** |        |       |       |
| CONSULTANT COSTS |      |
| SUPPLIES  |      |
| TRAVEL |      |
| PATIENT CARE COSTS |      |
| OTHER EXPENSES |      |
| TOTAL DIRECT COSTS FOR YEAR 2 BUDGET PERIOD |  |

BUDGET JUSTIFICATION:

Principal Investigator/Program Director (Last, first, middle):

**Additional pages as per the RFA**

***In lieu of Biographical Sketches, resumes or CVs may be substituted.***

OMB No. 0925-0001 and 0925-0002 (Rev. 03/2020 Approved Through 02/28/2023)

BIOGRAPHICAL SKETCH

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FIVE PAGES.**

NAME:

eRA COMMONS USER NAME (credential, e.g., agency login):

POSITION TITLE:

EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable. Add/delete rows as necessary.)

| INSTITUTION AND LOCATION | DEGREE(if applicable) | Completion DateMM/YYYY | FIELD OF STUDY |
| --- | --- | --- | --- |
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**A. Personal Statement**

**B. Positions and Honors**

**C. Contributions to Science**

**D. Additional Information: Research Support and/or Scholastic Performance**