



NavicentHealthFoundation

Attention: Nena Gilreath
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(Inter office - Hospital MSC 78)
Or email to Gilreath.Nena@Navicenthealth.org
478-633-6189 FAX 478-633-4321

RESEARCH & EDUCATION AWARDS APPLICATION

(Application must be typed)

PRIMARY AUTHOR/RESEARCHER:

Primary Author/Researcher will be the contact person. Provide one name only.

WORK ADDRESS:

CGHS HOSPITAL BOX: (If Applicable)

WORK TELEPHONE:

FAX NUMBER:

E-MAIL ADDRESS:

TITLE OF RESEARCH PROJECT OR PROPOSAL:

AMOUNT OF GRANT REQUEST: (Not to exceed \$20,000)

ADDITIONAL AUTHORS/RESEARCHERS: (CV's not required.)

(REQUIREMENTS: The Primary or one additional Author/Researcher must be affiliated with Navicent Health or CGHS.)

<i>NAME</i>	<i>ADDRESS</i>	<i>WORK PHONE</i>

NAVICENT HEALTH FOUNDATION DEPARTMENT:

DEPARTMENT HEAD: (Chief or Senior Manager)

SENIOR VICE PRESIDENT FOR THE DEPARTMENT:

PRIMARY AUTHOR/RESEARCHER ASSURANCE: I agree to accept responsibility for the supervision, performance, and reporting requirements of this project if an award is made. I have not previously performed or reported on this proposal. I certify that the information contained in this application is true.

SIGNATURE OF PRIMARY AUTHOR/RESEARCHER TITLE

DATE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:
PROJECT TITLE:

SCIENTIFIC APPROACH - ABSTRACT/SUMMARY

Pages 2-4, Weighted 60%

in the space provided, using normal spacing and font size (not less than 11), state the project's goal(s) in concise clear terms, the hypothesis(es) of the project and the primary aims of the proposal. Detailed reference to methodologies and data evaluations should not be included on this page. Include a brief review of previous studies conducted by you and/or others related to your proposal.

DO NOT EXCEED THIS PAGE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

METHODOLOGIES APPROACH

In the space provided, using normal spacing and font size (not less than 11), explain in one or two pages the specific methodologies to be employed for the collection and interpretation of data used to test the proposed hypothesis(es).

CONTINUE ON NEXT PAGE IF NECESSARY

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

METHODOLOGIES APPROACH CONTINUED:

DO NOT EXCEED THIS PAGE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

PROJECT APPROPRIATENESS CRITERIA

Pages 5-6, Weighted 25%

In the space provided, using normal spacing and font size (not less than 11), respond to the following questions which reflect the criteria used to evaluate the appropriateness of proposals for funding.

What is the significance of this project regarding the improvement of community health?

What are the multi-disciplinary and/or interdepartmental characteristics of the project?

DO NOT EXCEED THIS PAGE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

PROJECT APPROPRIATENESS CRITERIA CONTINUED:

In the space provided, using normal spacing and font size (not less than 11), respond to the following questions.

How does this project provide opportunities to enhance educational and/or health provider skills?

What is the project's research significance to medical and clinical education?

DO NOT EXCEED THIS PAGE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

SCIENTIFIC CONTRIBUTIONS AND FUTURE RESEARCH

Page 7, Weighted 15%

In the space provided, using normal spacing and font size (not less than 11), clearly state the scientific contribution(s) this project is expected to make to the body of research in this field. Future research objectives and opportunities for future funding should be included.

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:
PROJECT TITLE:**

ADDITIONAL FUNDING

What other sources of funding have you applied for?

What grants have you applied for the last 5 years?

Have you received any Federal funding?

DO NOT EXCEED THIS PAGE

LAST NAME OF PRIMARY AUTHOR/RESEARCHER:

PROJECT TITLE:

BUDGET FOR PROPOSED PROJECT

NOTE: The Research and Education Award does not provide for salaries, travel expense or indirect costs.

CATEGORY	AMOUNT	ITEM(S)	JUSTIFICATION
PATIENT CARE COSTS COST/PATIENT			
ITEMIZED EQUIPMENT			
ITEMIZED SUPPLIES			
OTHER EXPENSES			
TOTAL			

Is this project seeking funding from other sources or has funding from additional sources been received? YES
NO

If yes, please identify sources and amounts below.

ADDITIONAL PAGES MAY BE ATTACHED TO JUSTIFY OR CLARIFY ANY EXPENSES LISTED IN THE BUDGET.

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:
PROJECT TITLE:**

APPROVAL OF DEPARTMENT HEAD (CHIEF/SENIOR MANAGER):

I have reviewed the described project with the primary author/sponsor. The project complies with the goals and objectives of the Navicent Health Foundation Research & Education Awards and the goals and objectives of my department. I approve the project and agree to allow the applicant to proceed if an award is made.

SIGNATURE

DATE:

APPROVAL OF VICE-PRESIDENT FOR THE DEPARTMENT:

I have discussed the proposed project with the applicant and the department head (chief/senior manager). I find the project to be in compliance with the goals and objectives of the Navicent Health Foundation and the goals and objectives of the Corporation. I approve the project.

SIGNATURE

DATE:

**This project does _____ does not _____ require approval from an institutional review board.
(Projects which involve patient participation or animal experimentation require approval.)**

If this project does require approval, attach letters of approval from the appropriate institutional review board.

Completed and signed application with all attachments and four copies must be submitted to Nena Gilreath at Navicent Health Foundation on or before July 1.

**LAST NAME OF PRIMARY AUTHOR/RESEARCHER:
PROJECT TITLE:**

**NAVICENT HEALTH FOUNDATION
RESEARCH & EDUCATION AWARDS APPLICATION CHECK-LIST**

_____ COMPLETED AND SIGNED APPLICATION FROM SENIOR VICE PRESIDENT

Initial _____ IF APPLICABLE, IRB (Institutional Review Board) LETTER OF APPROVAL, ATTACHED YES _____ NO _____

Initial _____ IF IRB LETTER IS NOT ATTACHED, WHAT DATE WAS IT SUBMITTED FOR APPROVAL _____

Initial _____ COMPLETED APPROVAL SHEET

Initial _____ CURRICULUM VITAE OF PRIMARY AUTHOR/RESEARCHER ONLY

Initial _____ FOUR COPIES OF COMPLETE APPLICATION AND DOCUMENTATION

Initial _____ OR _____ PREVIOUS NAVICENT HEALTH FOUNDATION AWARD (Please check one block.)
Initial YES NO

IF YES, WHAT WAS THE TOTAL AWARD? _____

IF YES, IN WHAT YEAR DID YOU RECEIVE THIS AWARD? _____

STATUS OF PREVIOUS AWARD

SIGNATURE OF PRIMARY AUTHOR/RESEARCHER TITLE

DATE:

FOUNDATION USE ONLY

DATE APPLICATION RECEIVED: _____

PRIMARY REVIEWERS: _____

DATE OF COMMITTEE REVIEW: _____

COMMITTEE ACTION: DATE _____: APPROVED DISAPPROVED APPROVED AMT: _____

DATE CANDIDATE NOTIFIED: _____ (date letter mailed)

CHECK ISSUED TO: _____ DATE _____

LOGGED IN FOLLOW-UP FILE: _____

FORMAT FOR PRELIMINARY AND FINAL REPORT: _____

