

# Certificate of Proposal (COP)

The University of Texas Health Science Center at San Antonio

Office of Sponsored Programs (OSP)

210-567-2340 / grants@uthscsa.edu

This form is required by OSP with all externally sponsored proposals and agreements.

Instructions and definitions of terms can be found online at <http://research.uthscsa.edu/osp/forms/copinstructions.doc>.

Project Title: \_\_\_\_\_

Sponsor: \_\_\_\_\_ Due Date: \_\_\_\_\_

Prime Sponsor (if flow-through): \_\_\_\_\_ Deadline Type: \_\_\_\_\_ Postmark \_\_\_\_\_ Receipt \_\_\_\_\_

FOA or RFP # or title: \_\_\_\_\_

Activity Type: Research Clinical Study Training Services Testing Other: \_\_\_\_\_

Project Status: New Resubmission Competitive Renewal Non-Competing Grant Progress Report Supplement

If renewal or continuation: Grant #: \_\_\_\_\_ Current HSC PGID #: \_\_\_\_\_

## Investigator(s) Information

INVESTIGATOR(S) CERTIFICATION: My signature below certifies that (1) I am not delinquent on any federal debt; (2) I am not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from current transactions by any federal department or agency; (3) I have not and will not lobby any federal agency on behalf of this award; (4) The information submitted within the application is true, complete, and accurate to the best of my knowledge; (5) I understand that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties; (6) I agree to accept responsibility for the scientific conduct of the project; and (7) I will be responsible for meeting the requirements of the award, including, but not limited to providing the proper stewardship of sponsored funds, submitting all required technical progress reports on a timely basis, properly disclosing all inventions to the Office of Technology Commercialization, and adhering to all federal compliance requirements.

<b>Principal Investigator/Project Director:</b> _____	Employee ID #: _____
Department: _____	School _____
Phone #: _____	Annual Committed Effort on Project: _____ %
Center/Institute Affiliation(s):	VA Appointment with compensation:
Barshop      CTRC      CHA	
GCCRI      IIMS      RII	
	_____ (signature)

<b>Participating Investigator:</b> _____	Employee ID #: _____
Department: _____	School _____
Phone #: _____	Annual Committed Effort on Project: _____ %
Center/Institute Affiliation(s):	VA Appointment with compensation:
Barshop      CTRC      CHA	
GCCRI      IIMS      RII	
	_____ (signature)

<b>Participating Investigator:</b> _____	Employee ID #: _____
Department: _____	School _____
Phone #: _____	Annual Committed Effort on Project: _____ %
Center/Institute Affiliation(s):	VA Appointment with compensation:
Barshop      CTRC      CHA	
GCCRI      IIMS      RII	
	_____ (signature)

(If additional participating investigators are involved, attach additional sheets as necessary – continuation page available at [http://research.uthscsa.edu/osp/forms/cop\\_cont.pdf](http://research.uthscsa.edu/osp/forms/cop_cont.pdf))

Proposed Project Dates (mm/dd/yyyy): \_\_\_\_\_ Budget Requested: \_\_\_\_\_

Initial Period: \_\_\_\_\_ to \_\_\_\_\_ Direct \$ \_\_\_\_\_ F&A \$ \_\_\_\_\_ Total \$ \_\_\_\_\_

Entire Period: \_\_\_\_\_ to \_\_\_\_\_ Direct \$ \_\_\_\_\_ F&A \$ \_\_\_\_\_ Total \$ \_\_\_\_\_

FOR CLINICAL TRIALS ONLY: number of patients anticipated for enrollment: \_\_\_\_\_

Contact for proposal questions/pickup: \_\_\_\_\_  
name phone number

Location of Project: \_\_\_\_\_ on campus \_\_\_\_\_ off campus, identify: \_\_\_\_\_  
(room and/or building)

F&A (Indirect Cost) Rate Applied: \_\_\_\_\_ %

Project Key Words (at least one required):

--	--	--	--

Will project involve the use of:

Vertebrate animals or animal tissues/fluids?	Yes	No	If yes, IACUC is:	Pending	Approved
IACUC Approval Date: _____	Protocol # _____				

Human subjects?	Yes	No	If yes, IRB is:	Pending	Approved
IRB Approval Date: _____	Protocol # _____				

Check all that apply:

recombinant DNA	infectious agents	chemical carcinogens	radioisotopes	select agents or toxins
-----------------	-------------------	----------------------	---------------	-------------------------

List: \_\_\_\_\_

**Institutional Core Facilities:**

Bioanalytics & Single-Cell (BASiC)	Biomolecular NMR	Center for Macromolecular Interactions
Biobanking & Genomic Analysis	Flow Cytometry	Micro CT (RAYO)
Optical Imaging Facility	X-ray Crystallography	Mass Spectrometry Laboratory
Bioinformatics & Computational Genomics (BCG)		No Core Facilities used

Will the project include a subaward/consortium to any other institution(s)? YES NO  
 If yes, list institution(s): \_\_\_\_\_

Have you and all of the key project personnel completed the annual Report of Financial Interests (COI) as required by Health Science Center policy? YES NO  
*If disclosure has not been submitted, or if there have been any changes of circumstances related to the disclosure, complete or modify online at <http://vpr.uthscsa.edu/iDisclose/>*

Have you and all of the key project personnel completed the Conflict of Interest training as required by Health Science Center policy? YES NO  
*If no, complete online at <http://kc.uthscsa.edu/kc/login.asp>*

Do you or any of the key project personnel have consulting arrangements, hold board membership, serve as an officer or key employee, have line management responsibilities, or own substantial equity holdings with the sponsor, subcontractor or potential vendor? YES NO

Do you believe that the proposal contains ideas, processes, or principles that could be commercialized or that may be of interest to industry? YES NO

Will the project involve collaboration with a foreign entity or government or travel outside of the U.S.? YES NO

Does the project involve research in controlled areas and/or controlled technology as defined by the Department of Commerce (EAR) or Department of State (ITAR)? YES NO

Will the project require new space? YES NO

Will the project require renovations to existing space? YES NO

**UPON AWARD:**

In what department/center/institute/other unit should the primary project ID be established?

(Department Name)	(Department ID #)

Who will be authorized signatories on the primary project ID?

Name: _____	Employee ID# _____
_____	_____
_____	_____
_____	_____

NOTES: Please use this space to provide any additional information that may be helpful in reviewing this proposal.

### Health Science Center Endorsements

**DEPARTMENT CHAIR SIGNATURE(S):** By signing below, the Department Chair(s) certify that this project corresponds with the goals and objectives of the department, and that agreement has been reached regarding the type and amount of departmental resources that will be required to assist the PI(s) in completing the project.

Primary PI's Department Chair \_\_\_\_\_ (date) \_\_\_\_\_

Department Chair Signatures for Participating Investigators (as necessary):

Dept \_\_\_\_\_ Chair \_\_\_\_\_ (date) \_\_\_\_\_

Dept \_\_\_\_\_ Chair \_\_\_\_\_ (date) \_\_\_\_\_

Dept \_\_\_\_\_ Chair \_\_\_\_\_ (date) \_\_\_\_\_

*(If more signatures are required, attach additional signature sheets as necessary)*

**CENTER/INSTITUTE DIRECTOR SIGNATURE:** *required when resources or space of a Center or Institute will be utilized in the conduct of the project.* By signing below, the Director(s) certify that this project is consistent with the goals and objectives of the Center/Institute, and that agreement has been reached regarding the type and amount of Center/Institute resources that will be required to assist the PI(s) in completing the project.

Center/Institute \_\_\_\_\_ Director \_\_\_\_\_ (date) \_\_\_\_\_

Center/Institute \_\_\_\_\_ Director \_\_\_\_\_ (date) \_\_\_\_\_

*(If more signatures are required, attach additional signature sheets as necessary)*

**DEAN'S SIGNATURE:** *OSP is responsible for obtaining Dean signatures when necessary.* By signing below, the Dean certifies that this project conforms to the Rules and Regulations of the Board of Regents, supports the teaching and research objectives of the school, that resources necessary to conduct the project are available or have been approved, and that all exceptions noted are satisfactory.

Dean \_\_\_\_\_ (date) \_\_\_\_\_

\_\_\_\_\_  
OSP Reviewer/Date