

# Foundation for Angelman Syndrome Therapeutics FAST TRAC Grant Application

Leave Blank - FAST Use Only				
Number	Date Received			
Funding Authorization Number				

Title of the Application (Not to exceed 70 characters)	e of the Application (Not to exceed 70 characters) Applicant Organization			
Applicant Name (Last, First, Middle)	Degree	Position Title		
Mailing Address	E-mail Address	Department		
	Telephone	Fax		
For Fellowship Applicants Only				
Applicant Mentor (Last, First, Middle) Positio	n Title	Institution		
US Co-Mentor if required (Last, First, Middle) Positio	n Title	Institution		
Vertebrate Animals	Human Subjec	ts Research		
⊖Yes ⊖No	⊖Yes ⊖Nc			
If "Yes", IACUC Approval Date Animal Welfare Assura	ance # If "Yes", Provid	de IRB Review Date Federal Wide Assurance #		
Administrative Official to be Notified if Award is Made				
(Name, Title, Address, and Telephone)		Dates of Proposed Support		
	Official's E-mail Address	From To		
	Entity Identification Nun	nber Total Costs Requested		
	Type of Organization	Fiscal Year End Date		
Principal Investigator Assurance: I certify that these statement indicated potential overlaps in funding on the budget page.				
provide required progress reports if a grant is awarded.	ragice to accept responsion	is for the scientific conduct of the project and to		
Signature of Applicant		Date		
Applicant Organization Assurance: I certify that the information knowledge. I agree that any grant received as a result of this regulations issues by the Foundation for Angelman Syndrome	application is subject to the g			
Name of Official Signing for the Applicant Organization	n (Print) Title of Official			
Signature of Official	ı · [	Date		
	Page 1			



### **Table of Contents**

Face Page	1
Table of Contents	2
Abstract	_ 3
Lay Abstract	_ 4
Budget	
Other Support - List Current and Pending Grants for the Applicant	
Facilities	
Biographical Sketch - in current NIH Format, not to exceed three pages	
Research Plan - Follow Formatting Instructions, not to exceed 5 pages including figures	
References	
Appendices	

To insert PDF pages for the Biographical Sketch, Research Plan, References and any additional pages, complete the fillable form. In Acrobat, select "Print" and choose the option to print the completed form as a PDF. This will convert the fillable form to a PDF document that will allow pages to be added or deleted. The form will NO LONGER be able to be modified on the resulting PDF.

Applications must be submitted electronically to grants@CureAngelman.org. Only PDF forms will be accepted and reviewed. Any questions about the application process, or suitability of a request should be directed to science@CureAngelman.org.

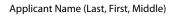
The Foundation for Angelman Syndrome Therapeutics P.O.Box 608 Downers Grove, Illinois 60515-0608 Phone: 630-852-3278 Toll Free: 866-783-0078 Fax: 630-852-3270



Abstract - State the objective and specific aims and relevance to Angelman Syndrome. Do not exceed the space on this page



Lay Abstract - Describe the project in non-technical language understandable by a person not trained in science. This is an important part of the application and considered in funding decisions. If award is made, this text will be used in FAST publications and press releases.





# **Budget and Justification**

Budget Item	Category	Amount Requested

Budget Justification - please add an additional page if needed.



Applicant Name (Last, First, Middle)

Budget Justification - continued



Other Support - List Current and Pending Support. Indicate amount of overlap with the current application.



#### **Facilities and Resources**

Laboratory

Clinical

Animal

Computer

Office

Other

Major Equipment and Additional Information



## Budget

DETAILED BUDGET FOR GRANT PERIOD <u>(1 Year Only)</u> (DIRECT COSTS ONLY)				FROM		THROUGH		
PERSONNEL %			DO	LLAR AMOU	NT REQUES	TED (omit cents)		
NAME	ROLE ON PROJECT	TYPE APPT. (months)	EFFORT ON PROJ.	INST BASE SALARY		SALARY EQUESTED	FRINGE BENEFITS	
				<b> </b>	<u> </u>			
	+		 	<u> </u>	+			
					+			
	<b>—</b>				Ţ			
			 	<u> </u>	+			
	SUBTOTALS			└>				
CONSULTANT COSTS					<u> </u>			
SUPPLIES (Itemize by category)								
PATIENT CARE COSTS	INPATIENT OUTPATIENT							
OTHER EXPENSES (Itemize by catego								
TOTAL DIRECT COSTS FOR	GRANT PERIO	D				$\longrightarrow$		
TOTAL INDIRECT COSTS FOR	GRANT PERIO	D				$\longrightarrow$		
TOTAL COSTS FOR GRANT PE	RIOD			_		$\longrightarrow$		