KCNQ2 CURE ALLIANCE GRANT APPLICATION	Date Submitted:
TITLE OF PROJECT:	
APPLICANT NAME:	HIGHEST DEGREE(S)
POSITION TITLE:	APPLICANT'S CURRENT INSTITUTION
ACADEMIC RANK:	
DIVISION:	
DEPARTMENT:	
E-MAIL ADDRESS: TEL: FAX:	MAILING ADDRESS
DATES OF PROPOSED PROJECT (MM/DD/YYYY) From: Through:	PROPOSED BUDGET
Name: Address: TEL: FAX: EIN:	SIGNING OFFICIAL FOR Name: Title: Address: TEL: FAX: EMAIL ADDRESS:

APPLICANT ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I 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 this application.

SIGNATURE OF APPLICANT: _____ **DATE:**_____

SIGNING OFFICIAL ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge and accept the obligation to comply with the grantor's terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

SIGNATURE OF SIGNING OFFICIAL: _____ **DATE:**_____