Stony Brook Research

INSTITUTIONAL AND/OR SPONSOR APPROVAL REQUEST FORM

Date of Request: _____ Principal Investigator:_____ Department:_____

Award # _____or original COEUS #_____ (**required by SOM**) Budget Period Start/End Date: _____

Changes/Modifications to existing outgoing Subaward Request** (if applicable): Y☐ N ☐ If Yes, a purchase requisition, http://research.stonybrook.edu/sites/default/files/PROC0065.pdf, for each subaward must be sent to OSP@stonybrook.edu

Compliance approvals (check all that apply) IRB: Y☐N ☐ Approval #: _____IACUC: Y☐N ☐ Approval #: _____
Recombinant DNA: Y☐N ☐ Approval #:_____Radioactive Materials: Y☐N ☐ Approval #:_____

TYPE OF REQUEST (⚠Warning: This form does not apply to new, renewal, resubmission, or supplemental proposals, NIH training grants or change in PI. For these instances, a new COEUS application is required).

1. ☐ **Budget Revision for incoming and/or established award***
   Please attach a copy of the current budget, the requested revised budget, and the rebudget justification.
2. ☐ **Faculty, Investigators and/or Key Personnel change***, except PI. As stated above, Change in PI requires full COEUS application.

   a. Have new faculty or key personnel been added to the project since the last reporting period or original proposal?
   ☐Yes ☐ No

   b. Has faculty effort increased or decreased from last reporting period or original proposal?
   ☐Yes ☐ No (If yes, please complete Revised Effort on page 2).

   c. Have salary offset funds been changed since the last reporting period or from the amount originally budgeted?
   ☐Yes ☐ No
3. ☐ **Carry forward***. Submit supporting documentation as required by sponsor to your OSP representative.
4. ☐ **Non-competing continuation or annual progress report*.** Submit budget and supporting documentation to your OSP representative.
5. ☐ **No-Cost Extension (NCE)*** Requested Extension ☐12 months ☐Other _____Funds remaining: $_____
   Revised Effort: Y☐N ☐ (If yes, please complete Revised Effort on page 2).

   One of the following criteria must be applicable for NCEs:
   ☐Additional time beyond the established expiration date is required to ensure adequate completion of originally approved project
   ☐Continuity of support is required while a competing continuation application is under review
   ☐The extension is necessary to permit an orderly phase out of a project that will not receive continued support
   ☐Other _____

   Is this a second NCE request? Y☐ N ☐ If Yes, please attach a brief plan for use of remaining funds and justification. Extensions may not be exercised merely for the purpose of using unobligated balances. There must be a programmatic justification for the NCE, with no change in the project's originally approved scope and no additional funds required.

Print Name & Initial:

PI: _____ CO-I: _____ CO-I: _____ CO-I: _____

Dept.Chair: _____ Dept.Chair: _____ Dept.Chair: _____ Dept.Chair: _____

Dean: _____ Dean: _____ Dean: _____ Dean: _____

All of the above requests may require sponsor's prior approval. Please consult with your OSP representative.
For **1-5, please obtain Chair and Dean endorsements if there are changes in faculty effort, increase in cost share effort and/or changes in credit split, with the exception of SOM which requires signatures on **all** effort changes. For all other schools, decrease in cost-shared effort is PI's responsibility to notify Chair and Dean. FCOI training must be current.*
*** Mark the Subaward Request box only for amendments of existing agreements. It does not apply to new subward requests. Examples include: adding additional money to the current budget period, obligating carryforward from a previous year, deobligation without terminating, no cost extensions.*

Revised Effort:

Name and Department	*% Reimbursed (offset to IFR)	% Not Reimbursed (cost-shared)	% Direct Salary from Grant
Name and Role: Current Effort	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY
Revised Effort Effective date:	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY
Name and Role: Current Effort	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY
Revised Effort Effective date:	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY
Name and Role: Current Effort	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY
Revised Effort Effective date:	____ PM ____ % ☐ AY ☐ CY IFR Acct #_____ Or SOM Offset**	____ PM ____ % ☐ AY ☐ CY	____ PM ____ PM ____ PM Or ____ %____ %____ % ☐ AY ☐ SUM ☐CY

*Applies to SUNY employees only PM = Person Months AY = Academic Year CY = Calendar Year
** SOM Clinical Research Offset Agreement

Credit Split:

PI Name	Department/Unit	% Credit Must Total 100%

Total 100%