****

American Academy of Clinical Neuropsychology Foundation

Outcome Studies Grant Program

Evaluating Neuropsychological Services in Dementia, TBI, CVA, Epilepsy, and ADHD

**Title of Project:**

**Principal Investigator:**

**For AACNF office use only:**

**Project #**

**Rating #**

Date received: Date sent to review:

Assigned Reviewers

 1)

 2)

 3)

Ratings 1) Date reviews received: 1)

 2) 2)

 3) 3)

**The AACNF application form and instructions were developed in collaboration with the Clinical Research Grants Program of the National Academy of Neuropsychology**

** Office Use Only**

 *Outcome Studies* **Project # \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 *Grant Program* **Rating # \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**AACNF OUTCOME STUDIES GRANT PROGRAM APPLICATION – 2023**

|  |
| --- |
| 1. Title of Project

  |
| 2. Investigator Identification a. Principal Investigator Name (last, first, middle, degrees, affiliation) b. Secondary Investigator(s) Name (last, first, middle, degrees, affiliation)  |
| c. Mailing address (street, city, state, zip) |
| c. Telephone (number and extension) Alt. Number (number and extension) |
| d. Email address  |
| 3. Dates of entire proposed project: From: Through: |
| 4. Amount requested: |
| 1. Human subjects: The AACNF human subjects requirement for this grant will be satisfied by:

 \_\_\_ a successfully approved IRB application obtained from my institution or, \_\_\_ an application arranged through an outside recognized agency(Please note that a monetary award will not be made until such a review has been completed) |
| 6. Student required research. Is this grant intended to underwrite dissertation, thesis, or other required student research? \_\_\_ Yes \_\_\_ No |
| Investigator: I agree to accept responsibility for the scientific conduct of the project. In addition, I certify that the statements herein are true and complete to the best of my knowledge, and accept the obligation to comply with the terms and conditions of the AACNF Outcome Studies Grants Committee if a grant is awarded as a result of this application.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature DateInvestigator (Print Name): |
|  |
| **Detailed Budget**-**Personnel** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| NAME | % TIME | SALARY | BENEFITS $ | TOTALS (Salary & Benefits) |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

|  |
| --- |
| BUDGET: Equipment and Other Costs |

|  |  |
| --- | --- |
| Description | Cost |
|  |  |

**BUDGET JUSTIFICATION** (use continuation page if necessary): Describe the specific functions of the personnel. Explain and justify budgeted equipment, supplies, and any other miscellaneous or unusual expenses.

|  |
| --- |
|  |

**A. PROPOSAL OVERVIEW: Summarize the purpose and intent of the project (one paragraph):**

**B.** **BACKGROUND & SIGNIFICANCE FOR EVALUATING OUTCOMES OF**

 **CLINICAL NEUROPSYCHOLOGICAL SERVICES:**

**C. EXPERIMENTAL DESIGN AND METHODS (Please be detailed regarding number of subjects, methodology, planned analysis, etc)**:

**D. LITERATURE CITED:**

**E. BIOGRAPHICAL SKETCH**

## F. AFFIRMATION

I do hereby acknowledge that I have read and agree to the ethical principles of psychologists held by the American Psychological Association and that I have read and agree to related regulations regarding research with human subjects. Should I have any questions regarding interpretation of these guidelines and principles, I agree to seek consultation with a minimum of two members of the American Academy of Clinical Neuropsychology Foundation Outcome Studies Grant Program or other established professional psychology organization to clarify any such interpretations. I further agree that any necessary interpretations of these principles and guidelines will be made in a manner that most favors the protection of any participant in any research conducted under funding received from the American Academy of Clinical Neuropsychology Foundation.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principle Investigator Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Investigator Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Investigator Date

Indemnification Agreement

Successful principle investigators will be required to sign an Indemnity Agreement before a monetary award can be made. These forms are designed to ensure that the AACN Foundation cannot be held financially culpable in connection with any award which is made. In the event that the investigator is associated with an institution or agency where the research will be conducted, an authorized institutional representative will also need to sign the form. This form does not need to be signed at this time, but the investigator and institution(s) (if any) must agree to the statement below in this application:

The Individual(s) and Institutions / Agency(s) listed below agree(s) to defend, indemnify, and hold harmless the American Academy of Clinical Neuropsychology Foundation from all claims, injuries, damages and costs (including court costs and attorney fees), judgments, fines, settlements, or other liability arising from all work and research conducted pursuant to a grant from the American Academy of Clinical Neuropsychology Foundation.

Please indicate agreement by listing the following:

Investigators (names and telephone):

**Name** **Telephone**

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Institution / Agency(s) (if any) (one per institution)**

First Institution (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name-Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title/Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Second Institution (name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name-Authorized Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title/Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*All successful applicants will need to sign a formal indemnification agreement prior to the disbursal of any funds.*