

FY23 Nurse Educator Fellowship Program

ATTACHMENT A

Uniform Application for State Grant Assistance		
Agency Completed Section		
1.	Type of Submission	<input type="checkbox"/> Pre-application <input checked="" type="checkbox"/> Application <input type="checkbox"/> Changed / Corrected Application
2.	Type of Application	<input checked="" type="checkbox"/> New <input type="checkbox"/> Continuation (i.e. multiple year grant) <input type="checkbox"/> Revision (modification to initial application)
3.	Date / Time Received by State	Completed by State Agency upon Receipt of Application
4.	Name of the Awarding State Agency	Illinois Board of Higher Education
5.	Catalog of State Financial Assistance (CSFA) Number	601-00-1591
6.	CSFA Title	Nurse Educator Fellowship Grant
Catalog of Federal Domestic Assistance (CFDA) X Not applicable (No federal funding)		
7.	CFDA Number	N/A
8.	CFDA Title	N/A
9.	CFDA Number	N/A
10.	CFDA Title	N/A
Funding Opportunity Information X Not Applicable		
11.	Funding Opportunity Number	N/A
12.	Funding Opportunity Title	N/A
Competition Identification X Not Applicable		
13.	Competition Identification Number	N/A
14.	Competition Identification Title	N/A

Applicant Completed Section		
Applicant Information		
15.	Legal Name (Name used for DUNS registration and grantee pre-qualification)	
16.	Common Name (DBA)	

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17.	Employer / Taxpayer Identification Number (EIN, TIN)	
18.	Organizational DUNS number	
19.	SAM Cage Code	
20.	Business Address	Street address, City, County, State, County, Zip + 4
Applicant's Organizational Unit		
21.	Department Name	
22.	Division Name	
Applicant's Name and Contact Information for Person to be Contacted for <i>Program</i> Matters involving this Application		
23.	First Name	
24.	Last Name	
25.	Suffix	
26.	Title	
27.	Organizational Affiliation	
28.	Telephone Number	
29.	Fax Number	
30.	Email address	
Applicant's Name and Contact Information for Person to be Contacted for <i>Business/Administrative Office</i> Matters involving this Application		
31.	First Name	
32.	Last Name	
33.	Suffix	
34.	Title	
35.	Organizational Affiliation	
36.	Telephone Number	
37.	Fax Number	
38.	Email address	
Areas Affected		
39.	Areas Affected by the Project (cities, counties, state-wide)	

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40.	Legislative and Congressional Districts of Applicant	
41.	Legislative and Congressional Districts of Program / Project	
Applicant's Project		
42.	Description Title of Applicant's Project	Nurse Educator Fellowship
43.	Proposed Project Term	Start Date: Date of last signature on agreement. End Date: June 30, 2023
44.	Estimated Funding (include all that apply)	X Amount Requested from the State: <input type="checkbox"/> Applicant Contribution (e.g., in kind, matching): <input type="checkbox"/> Local Contribution: <input type="checkbox"/> Other Source of Contribution: <input type="checkbox"/> Program Income: <p style="text-align: right;">Total Amount \$10,000</p>
<p>Applicant Certification:</p> <p>By signing this application, I certify (1) to the statements contained in the list of certifications* and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances* and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil or administrative penalties. (U.S. Code, Title 18, Section 1001)</p> <p>(*) The list of certification and assurances, or an internet site where you may obtain this list is contained in the Notice of Funding Opportunity. If a NOFO was not required for the award, the state agency will specify required assurances and certifications as an addendum to the application.</p> <p style="text-align: center;"><input type="checkbox"/> I agree</p>		
Authorized Representative		
45.	First Name	
46.	Last Name	
47.	Suffix	
48.	Title	
49.	Telephone Number	
50.	Fax Number	
51.	Email Address	
52.	Signature of Authorized Representative	
53.	Date Signed	