

**TO:**               Hospital Sponsored Programs Office for:

Mount Sinai Beth Israel

Mount Sinai Hospital

Mount Sinai St. Luke’s

Mount Sinai West

**FROM:**        Project Director

Administrative Contact (if applicable)         

Project Director’s Site/Hospital

**DATE:**          

**RE:**                  **PROJECT DIRECTOR CERTIFICATION**

Please submit a **PROJECT DIRECTOR CERTIFICATION FORM** with initial grant or contract submissions only when Icahn School of Medicine at Mount Sinai is NOT an eligible applicant. Please return the completed form to [OGARA@chpnet.org](mailto:OGARA@chpnet.org)

The **PROJECT DIRECTOR CERTIFICATION** is a three part form:

1. The cost status section outlines anticipated cost/funding sources and documents Chair certification. When the project involves staff from more than one department, please use the second Chair certification section to indicate review and authorization from all involved departments.
2. The checklist section requests specific information for all projects, with specific subsections for authorization requirements based on the type of project.
3. Project Director certification.

**Please contact the Mount Sinai Health Systems Hospital Sponsored Programs Office with any questions or concerns. Please submit completed form to** [**OGARA@chpnet.org**](mailto:OGARA@chpnet.org)

**DEPARTMENTAL COST CERTIFICATION - CHAIR AUTHORIZATION SECTION**

**Project Title:**

**Sponsor ID Number (if any):**

**Sponsor (if applicable):**

**Check One**:

All costs are fully explained within the related agreement and budget.

If the project includes cost sharing, documentation of the authorized source and amount of cost sharing is attached.

I certify that the project is consistent with the mission of the Department and the institution, and that Departmental resources will be available to implement the project consistent with the intent of the proposal/agreement and this Project Director Certification form.

Print/Sign Date

Department Chair or Chair Authorized Designee

**SECONDARY DEPARTMENT COST CERTIFICATION - CHAIR AUTHORIZATION SECTION**

USE THIS SECTION ONLY IF MORE THAN ONE DEPARTMENT IS NOTED ON THE RELATED BUDGET

I certify that the project is consistent with the mission of the Department and the institution, and that Departmental resources will be available to implement the project consistent with the intent of the proposal/agreement and this Project Director Certification form.

Print/Sign Date

Department Chair or Chair Authorized Designee

**CHECKLIST SECTION**

|  |  |
| --- | --- |
| **ALL PROJECTS COMPLETE THIS SECTION** |  |
|  | Does the project involve interventional activities in which project-required services (i.e. routine care services) will be billed to patients or third party payers? If yes, complete the **MEDICARE COVERAGE ANALYSIS/RESEARCH BILLING CHECKLIST** form. |
|  | For projects involving human subjects including data, has the **PPHS/IRB APPLICATION** process been engaged? |
|  | Is this project sponsored by New York City or New York State? YES/NO       If so, is it subject to Minority and Women-Owned Business utilization requirements? YES/NO       See related regulations and guidance. |
|  | Status indication - New, Renewal, Continuation, Supplement, Revision, No-Cost Extension, Other |
|  | Project period - All years, if applicable |
|  | Amount - All years, if applicable. |
|  | **Attach BUDGET** showing all years (use sponsor-required form). It is institutional policy to collect full Facilities &Administration and fringe benefit rate costs from all funding sources. See **ADMINISTRATIVE INFORMATION SHEET** for specific costs and rates applicable to your project. |
|  | Is a subcontract/application involved? Is the hospital the prime applicant or prime contractor? If so, supply the name(s) of any sub-entity. Is the hospital a sub-applicant or subcontractor? If so, supply the name of the prime entity. For sub-applicants / subcontracts under the hospital as the prime, attach scope, budget, proposal and approval/Letter of Intent from subcontract institution if applicable. |
|  | Does the project narrative or budget involve cost-sharing (including in-kind) commitments? If yes, please complete **COST SHARING FORM** |
| **SPECIAL PROJECT AUTHORIZATIONS** |  |
|  | Is this a QUALITY IMPROVEMENT activity? YES/NO  If yes, has hospital or system Quality Management Director reviewed and approved? |

**PROJECT DIRECTOR CERTIFICATION SECTION**

I certify that I have used all reasonable diligence in preparing this certification statement and to the best of my knowledge the contents are true and complete.

Print/Sign Date

Project Director