AOFAS Research Grant Application Guide

You are about to complete the application for the **AOFAS Research Grants Program**. To streamline the application process, please prepare all required information and documents before beginning your application.

This guide outlines key eligibility requirements, application instructions, and examples of the required **Research Strategy** and **Biographical Sketch** documents.

Eligibility Requirements

The following are two key eligibility requirements for the AOFAS Research Grants Program. Additional requirements can be found in the **AOFAS Research Grants Program Policy and Guidelines** available in the application portal and on the AOFAS website.

1. AOFAS Membership Requirement

At least one Principal Investigator (PI) or Co-Investigator (CI) must be an AOFAS member in good standing and belong to one of the following membership categories:

- Active Member
- Candidate Member
- International Member

2. Prior Grant Limitation

An investigator may not receive more than **two AOFAS Research Grants within any four consecutive-year period**.

Grant Application Instructions

1. Access the Application

The application is available through **ProposalCentral**. Log in to ProposalCentral and search for "**American Orthopaedic Foot & Ankle Society"** under **Grant Opportunities**.

2. Prepare Your Responses

For convenience and to save time, please prepare your application documents to be uploaded in ProposalCentral before completing the application. You may save your progress and return to your application at any time prior to submission.

3. Upload the Research Strategy

You must upload a **Research Strategy** document for your study.

File naming convention:

ResearchStrategy_FirstThreeWordsOfStudyTitle

Example:

ResearchStrategy_CorrelationRegressionOf

To support the blinded review process, please remove identifying information whenever possible. Do **not** include:

- Principal Investigator (PI) or Co-Investigator (CI) names
- Institution names
- Laboratory names

4. Upload Biographical Sketches

A **Biographical Sketch** must be uploaded for each PI and CI.

An example is provided below, and the template can be found in the **Download Templates & Instructions** section of the application portal.

File naming convention:

BIO_LastName_FirstThreeWordsOfStudyTitle

Example:

BIO_Smith_CorrelationRegressionOf

5. Upload Attestation and Disclosure Forms

Templates for both forms can be found in the **Download Templates & Instructions** section of the application portal.

Attestation Form

- One Attestation Form must be signed by all investigators (PIs and CIs).
- Upload the completed form to the application portal.

File naming convention:

Attestation_FirstThreeWordsOfStudyTitle

Disclosure Form

- Each PI and CI must complete and upload an individual Disclosure Form.

Questions?

If you have questions regarding the application process, please contact **research@aofas.org**.
Thank you for your interest in the AOFAS Research Grants Program.

Research Grant Application
Example Research Strategy

(version 2021Aug12)

Direction:
1) Address the following regarding your study:
SIGNIFICANCE
INNOVATION
APPROACH
TIMELINE
REFERENCES

2) Must be 6 pages or less. Use the example document below.

Research Strategy Example document

Significance

Osteochondral defects (OCDs) of the talus refer to focal lesions of the talar articular cartilage and subchondral bone. They are common with acute ankle trauma, as 50% of sprains and 73% of fractures have been associated with talar OCDs. [1] While less frequent, idiopathic cases have also been reported[2]. Current strategies for surgical management fall into two categories: restoration and replacement. The primary restorative technique is microfracture, in which penetration of the subchondral bone recruits marrow-derived stem cells to replace cartilage lesions with biomechanically inferior fibrocartilage. It is regarded as the standard treatment, although utilization has been questioned for large lesions (>150 mm^2) and those with a considerable cystic component.[3] Alternative techniques aim to replace defects with bone grafts or chondrocytes harvested and cultured *in vitro,* and include chondrocyte implantation, particulated juvenile cartilage allograft, and osteochondral grafts. Prior studies have evaluated the efficacy of current restoration strategies compared with microfracture[3–13] ; however, in part due to the lack of large comparative studies, there are no widely accepted guidelines for treatment.

The primary focus of this study is to investigate midterm outcomes across the spectrum of arthroscopic techniques for treating OCDs of the talus. With a breadth of pre-, intra-, and postoperative data collection points and a cohort compiled from multiple high volume arthroscopists, this study aims to bring clarity to the decision-making algorithm for talar OCDs. In addition to comparative analyses of OCD procedures, we intend to investigate OCDs in the context of concomitant pathology. With operative data on ankle instability, anterior and posterior impingement, peroneal tendinopathy, fracture status, and Achilles tendinopathy, this study is equipped to analyze variations in outcomes with concomitant lesions.

The paucity of available outcomes data from prospective studies limits current recommendations for treatment strategies. Achievement of this study's aims will provide an adequately powered evidence base to guide clinical decision-making with talar OCDs.

Innovation

Limitations in statistical power are widespread in the orthopedic literature. [14] These problems are especially relevant in the arthroscopic management of talar OCDs, as the number of arthroscopists capable of managing talar OCDs is limited by the field's recent emergence, and the extent of procedural variation with this pathology demands a large cohort for comparative analyses. A single institution may be limited in volume to evaluate the suite of available cartilage restoration techniques, particularly if performed at low frequencies. A multicenter prospective study may alleviate these concerns. Our collaboration across seven orthopedic foot and ankle specialty sites allows for robust analysis of the relationship between treatment method and clinical outcome.

While multicenter collaboration improves data volume, precautions must be taken to minimize the variation inherent with collection at multiple sites. While unable to control for all factors, standardizations required of this study include pre-operative management, intra-operative consistency, and post-operative rehabilitation protocols. The seven eligible sites perform an average of 23 OCD arthroscopies per year, and have agreed to adhere to a group-wide protocol for data collection. For primary OCDs without

concomitant pathology, patients must fail a conservative regimen of NSAIDs, physical therapy, and rest for 4-6 months before being considered for arthroscopic intervention. Intra-operative approaches and techniques at each site have been reviewed by the Principal Investigator for significant variation relative to the other co-investigators. Compliance monitoring across multiple sites takes place via the Surgical Outcomes System (SOS) software, verified by support staff for accuracy and presented at monthly meetings between study coinvestigators. Rehabilitation protocols for OCDs and other concomitant pathologies have been established.

Multicenter collaboration is facilitated through SOS, a cloud-based, secure repository with a module customized specifically for this study. Automated email and text messages have been incorporated to remind patients prior to follow-up time points. Given that automatic electronic reminders yield response rates deemed insufficient for the purposes of this study [15], each site is required to designate support staff to make personal phone calls to non-compliant patients.

Approach

All study procedures are considered routine. Criteria for study inclusion are an arthroscopy performed specifically for an OCD or an OCD identified during arthroscopic treatment of other ankle pathologies, and completed pre-operative outcomes questionnaires. Exclusion criteria are evidence of osteoarthritis, the presence of rheumatologic diseases such as rheumatoid arthritis, SLE, or crystalline diseases, a previous history of ankle joint infection, joint malalignment secondary to previous trauma, or an inability to be contacted by phone or email. Each of the seven participating centers will collect and store data using the previously described SOS system. Data collection will take place preoperatively, intraoperatively and at two and five years postoperatively as described below:

Chart-Derived Preoperative Measures

(1) Height and weight
(2) Smoker (y/n)
(3) Pre-operative use of narcotics (y/n)
(4) Neuropathy (y/n)
(5) Osteoporosis (y/n)
(6) Workman's compensation case (y/n)
(7) Marijuana use (y/n)
(8) Diabetic (y/n)
(9) Use of vitamin D supplement (y/n)
(10) Collagen disease (marfans/ehlersdanlos) (y/n)
(11) Symptoms
- *a. Pain with activity*
- *b. Catching/locking*
- *c. Shoe wear limitations*
- *d. Pain at rest*
- *e. Recurrent swelling*

(12) Duration of symptoms (months)
(13) Mechanism of injury
- *a. Slip/fall*
- *b. Motor vehicle accident*
- *c. Sports related*
- *d. Insidious*
- *e. Other*

(14) Other preoperative diagnoses
- *a. Anxiety*
- *b. Depression*
- *c. Fibromyalgia*
- *d. Parkinson's*
- *e. Peripheral Arterial Disease*
- *f. Renal insufficiency*
- *g. Stroke*
- *h. Venous stasis*
- *i. Rheumatoid arthritis*
- *j. Lumbar radiculopathy*

Patient Reported Measures (Preoperative, and at 2- and 5-years post-op)

(1) Foot and Ankle Ability Measure (FAAM) Sports Subscale
(2) Foot Function Index
(3) VR-12 Health Index
(4) Visual Analog Pain Scale (Foot)

Surgeon Reported Measures

(1) Length/width/depth of defect post-debridement (mm)
(2) Contained or noncontained
(3) Hepple MRI
(4) ICRS grade
(5) Primary/revision surgery
(6) Accessory portals used
(7) Location of talar lesion
(8) Procedure type
a. Chondroplasty
b. Microfracture
i. Microfracture awl or drilling/power pick
c. Autologous cartilage graft
i. ACI
ii. MACI
iii. Minced cartilage graft
iv. Other
d. Allograft cartilage graft
i. Minced juvenile
ii. Acellular scaffold
iii. Arthrex BioCartilage
iv. Cartiform
v. Other
e. Orthobiologic
i. Blood
ii. Plasma
iii. PRP (plasma-based system or buffy coat system)
iv. Bone marrow aspirate/concentrate
v. Adipose aspirate/concentrate
f. Osteochondral grafting
i. OATS autograft
ii. OATS allograft
iii. Bone graft + allogenic cartilage graft
iv. Synthetic plug
v. Bulk allograft
vi. Average diameter and number of plugs used
(9) Bone defect treatment alone (y/n)
a. Antegrade drilling (y/n)
b. Subchondroplasty (y/n)
c. Retrograde drilling (y/n)
(10) Concomitant Pathologies
a. Lateral ankle instability
b. Medial ankle instability
c. Anterior impingement
d. Posterior impingement
e. Peroneal tendinopathy
f. Medial malleolar fracture
g. Lateral malleolar fracture
h. Posterior malleolar fracture
i. Achilles tendinopathy

Our joint-specific outcome measures are consistent with prior talar OCD studies: the Foot Function Index[16] and the Foot and Ankle Ability Measure Sports Subscale[17]. The Veterans RAND 12-item Health Survey (VR-12) has been employed as a measure of overall physical and mental health in ankle pathology outcomes studies [18,19], and a visual analogue scale is included to measure changes in pain.

All staff entering data into the registry are members of the clinical care team, including physician assistants, nurses, medical assistants, and front office personnel. These professionals already have access to patient data and have completed CITI training in handling data from human research studies. The data entered into the SOS will be stripped of PHI and will be protected with password authentication for access to the data set. Information collected on the patient will remain confidential and professionals collecting data will maintain confidentiality of the patient throughout the process. Researchers from facilities that are not participating in the care of the patient may see the ID number, but will not be able to access personal information about the patient including their name. Chart-derived measures will be completed by clinical staff prior to operation date, and surgeon-reported measures within one day of performing the operation. Patient-reported outcomes are completed at two and five years after surgery.

Each patient is provided with an informational pamphlet upon consenting to participate in the study.

We have implemented standardized mechanisms of following up with patients beyond email and text message reminders from the data collection software. The clinical staff member responsible for compliance at each site will send the SOS reminder after a personal phone call to the patient. Attempts at contact will be made once a week starting at the time point and extending one month beyond. With no response, a personalized email and letter from the surgeon will be sent. Finally, a 10$ Amazon gift card will be offered after 2 months of attempted contact and exhaustion of all other follow-up methods. We have recommended that each site keep a log of patient contact for accountability purposes.

No ubiquitous standard exists for post-operative rehabilitation with OCD procedures. A discussion between participating sites, along with consideration of the recommendations from the International Consensus Meeting on Cartilage Repair of the Ankle,[20] yielded the following guidelines for this study:

Microfracture

- *Time until range of motion: 1-2 weeks*
- *Length of immobilization, defined as total time in a boot, cast, splint, or brace: 4-8 weeks*
- *Time until weight bearing: 4-6 weeks. No high impact weight bearing for a minimum of 3 months*

Autologous chondrocyte implantation, particulated juvenile cartilage allograft, and osteochondral grafts

- *Time until range of motion: 1-2 weeks*
- *Length of immobilization: 6-12 weeks*
- *Time until weight bearing: 6 weeks. No high impact weight bearing for a minimum of 4-6 months*

Anterior impingement, posterior impingement and sinus tarsi. Synovectomy/debridement

- *Time until range of motion: 1-2 weeks*
- *Length of immobilization: 2-4 weeks*
- *Time until weight bearing: 1-2 weeks.*

Ankle instability repair or reconstruction

- *Time until range of motion: 1-2 weeks*
- *Length of immobilization: 6 weeks*
- *Time until weight bearing: 2 weeks*

In cases with concomitant pathology, the rehabilitation protocol that requires the longest protection period after the operation will be adopted.

One foreseeable problem is compliance with patient-reported outcomes. In our experience with registries involving multiple centers, completion rate of surgeon forms typically outpaces patient completion rates dramatically. An emphasis on patient compliance with this study is reflected in the requirement of clinical staff with the explicit responsibility and financial incentive for personal follow-up, and standardization across centers for mechanisms of data collection. A potential limitation is the rapid evolution of talar OCD procedures, specifically whether the landscape of operative strategies today will be relevant at final follow-up in five years. We are unable to account for future changes to standard practice; however, given the similarity of recommended techniques five years ago[21] to those more recently[22] and the incorporation of six procedural options in our collection strategy, we hope to buffer against future changes in the field.

An *a priori* fixed effects ANOVA power analysis for 6 groups with $\alpha = 0.05$ and a small to medium effect size ($f=0.175$) yielded a total sample size of 426 required to reach a power of 0.8. Given the average of 23 arthroscopic procedures at each of the seven centers, we estimate three years of data collection (483 cases) to be sufficient. Interpretation of the data will occur with the assistance of a biostatistician, and we anticipate three avenues of analysis. First, a paired *t*-test will be performed to compare preoperative and postoperative patient-reported outcomes for each procedure type to assess improvement over time. Next, we will carry out multivariate linear regression to uncover associations between pre-operative or intra-operative factors and midterm subjective outcomes. Subsequently, we will stratify patients by procedure type while controlling for differences in baseline characteristics, and analyze changes in outcome scores to compare effectiveness by treatment type. The possibility of stratification by concomitant pathology to investigate the effect of multiple simultaneous lesions may be possible depending on the cohort size.

All centers have agreed to the benchmarks for success: >80% follow-up at all time points, and achieving the predicted cohort volume.

Project Timeline:

Date – Event
Date - Event
Date - Event

References

1. Barry MJ, Edgman-Levitan S. Shared decision making--pinnacle of patient-centered care. *N Engl J Med*. 2012;366(9):780–781. doi:10.1056/NEJMp1109283.

2. Bartunek J, Trullen J, Bonet E, Sauquet A. Sharing and expanding academic and practitioner knowledge in health care. *J Health Serv Res Policy*. 2003;8 Suppl 2:62–68. doi:10.1258/135581903322405199.

3. Berger K. Informed consent: information or knowledge? *Med Law*. 2003;22(4):743–750.

4. Cargo M, Mercer SL. The Value and Challenges of Participatory Research: Strengthening Its Practice. *Annu Rev Public Health*. 2008;29(1):325–350. doi:10.1146/annurev.publhealth.29.091307.083824.

5. Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Soc Sci Med*. 1999;49(5):651–661. doi:10.1016/s0277-9536(99)00145-8.

6. Coulter A, Stilwell D, Kryworuchko J, Mullen PD, Ng CJ, van der Weijden T. A systematic development process for patient decision aids. *BMC Medical Informatics and Decision Making*. 2013;13(Suppl 2):S2. doi:10.1186/1472-6947-13-S2-S2.

7. Drake ER, Engler-Todd L, O'Connor AM, Surh LC, Hunter A. Development and Evaluation of a Decision Aid About Prenatal Testing for Women of Advanced Maternal Age. *J Genet Couns*. 1999;8(4):217–233. doi:10.1023/A:1022998415890.

8. Elwyn G. Developing a quality criteria framework for patient decision aids: online international Delphi consensus process. *BMJ*. 2006;333(7565):417–0. doi:10.1136/bmj.38926.629329.AE.

9. Fiset V, O'Connor AM, Evans W, Graham I, Degrasse C, Logan J. Development and evaluation of a decision aid for patients with stage IV non-small cell lung cancer. *Health Expect*. 2000;3(2):125–136. doi:10.1046/j.1369-6513.2000.00067.x.

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11. Golden-Biddle K, Reay T, Petz S, et al. Toward a communicative perspective of collaborating in research: the case of the researcher-decision-maker partnership. *J Health Serv Res Policy*. 2003;8 Suppl 2:20–25. doi:10.1258/135581903322405135.

12. Hertzog MA. Considerations in determining sample size for pilot studies. *Res Nurs Health*. 2008;31(2):180–191. doi:10.1016/S0895-4356(03)00141-0.

13. Hoffman AS, Bateman DR, Ganoe C, et al. Development and Field Testing of a Long-Term Care Decision Aid Website for Older Adults: Engaging Patients and Caregivers in User-Centered Design. Bowers BJ, ed. *The Gerontologist*. 2019;60(5):935–946. doi:10.1007/s11764-017-0649-5.

14. Hooiveld T, Molenaar JM, van der Heijde CM, Meijman FJ, Groen TP, Vonk P. End-user involvement in developing and field testing an online contraceptive decision aid. *SAGE Open Medicine*. 2018;6(4):205031211880946. doi:10.1016/j.pec.2010.10.011.

15. Jull J, Giles A, Graham ID. Community-based participatory research and integrated knowledge translation: advancing the co-creation of knowledge. December 2017:1–9. doi:10.1186/s13012-017-0696-3.

BIOGRAPHICAL SKETCH for Principal Investigators & Co-Investigators

Provide the following information for the Senior/key personnel and other significant contributors.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME	POSITION TITLE
Lastname, First Name	*Associate Professor of Psychology*

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, include postdoctoral training and residency training if applicable.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	MM/YY	FIELD OF STUDY

A. Personal Statement

(Blue = Sample)
The goal of the proposed research is to investigate the interaction between drug abuse and normal aging processes. Specifically, we plan to measure changes in cognitive ability and mental and physical health across a five-year period in a group of older drug users and matched controls. I have the expertise, leadership and motivation necessary to successfully carry out the proposed work. I have a broad background in psychology, with specific training and expertise in key research areas for this application. As a postdoctoral fellow at Berkeley, I carried out ethnographic and survey research and secondary data analysis on psychological aspects of drug addiction. At the Division of Intramural Research at the National Institute on Drug Abuse (NIDA), I expanded my research to include neuropsychological changes associated with addiction. As PI or co-Investigator on several university- and NIH-funded grants, I laid the groundwork for the proposed research by developing effective measures of disability, depression, and other psychosocial factors relevant to the aging substance abuser, and by establishing strong ties with community providers that will make it possible to recruit and track participants over time. In addition, I successfully administered the projects (e.g. staffing, research protections, budget), collaborated with other researchers, and produced several peer-reviewed publications from each project. As a result of these previous experiences, I am aware of the importance of frequent communication among project members and of constructing a realistic research plan, timeline, and budget. The current application builds logically on my prior work, and I have chosen co-investigators (Drs. Gryczynski and Newlin) who provide additional expertise in cognition, gerontology and geriatrics. During 2005-2006 my career was disrupted due to family obligations. However, upon returning to the field I immediately resumed my research projects and collaborations and successfully competed for NIH support. In summary, I have a demonstrated record of accomplished and productive research projects in an area of high relevance for our aging population, and my expertise and experience have prepared me to lead the proposed project.

B. Positions and Honors

Positions and Employment

1998-2000 Fellow, Division of Intramural Research, National Institute of Drug Abuse, Bethesda, MD
2000-2002 Lecturer, Department of Psychology, Middlebury College, Middlebury, VT
2001- Consultant, Coastal Psychological Services, San Francisco, CA
2002-2005 Assistant Professor, Department of Psychology, Washington University, St. Louis, MO
2007- Associate Professor, Department of Psychology, Washington University, St. Louis, MO

Other Experience and Professional Memberships

1995- Member, American Psychological Association

SAMPLE

1998-	*Member, Gerontological Society of America*
1998-	*Member, American Geriatrics Society*
2000-	*Associate Editor, Psychology and Aging*
2003-	*Board of Advisors, Senior Services of Eastern Missouri*
2003-05	*NIH Peer Review Committee: Psychobiology of Aging, ad hoc reviewer*
2007-11	*NIH Risk, Adult Addictions Study Section, member*

Honors

2003	*Outstanding Young Faculty Award, Washington University, St. Louis, MO*
2004	*Excellence in Teaching, Washington University, St. Louis, MO*
2009	*Award for Best in Interdisciplinary Ethnography, International Ethnographic Society*

C. Selected Peer-reviewed Publications (Selected from 42 peer-reviewed publications)

Most relevant to the current application

1. *Merryle, R.J. & Hunt, M.C. (2004). Independent living, physical disability and substance abuse among the elderly. Psychology and Aging, 23(4), 10-22.*
2. *Hunt, M.C., Jensen, J.L. & Crenshaw, W. (2007). Substance abuse and mental health among community-dwelling elderly. International Journal of Geriatric Psychiatry, 24(9), 1124-1135.*
3. *Hunt, M.C., Wiechelt, S.A. & Merryle, R. (2008). Predicting the substance-abuse treatment needs of an aging population. American Journal of Public Health, 45(2), 236-245. PMCID: PMC9162292*
4. *Hunt,M.C., Newlin, D.B. & Fishbein, D. (2009). Brain imaging in methamphetamine abusers across the life-span. Gerontology, 46(3), 122-145.*
5. *Hunt, M.C. & Sher, K.A. (2009). Successful intervention models for older drug-abusers: Research across the life-span. American Psychologist, in press. NIHMSID: NIHMS99135*

Additional recent publications of importance to the field (in chronological order)

1. *Gryczynski, J., Shaft, B.M., Merryle, R., & Hunt, M.C. (2002). Community based participatory research with late-life addicts. American Journal of Alcohol and Drug Abuse, 15(3), 222-238.*
2. *Shaft, B.M., Hunt, M.C., Merryle, R., & Venturi, R. (2003). Policy implications of genetic transmission of alcohol and drug abuse in female nonusers. International Journal of Drug Policy, 30(5), 46-58.*
3. *Hunt, M.C., Marks, A.E., Shaft, B.M., Merryle, R., & Jensen, J.L. (2004). Early-life family and community characteristics and late-life substance abuse. Journal of Applied Gerontology, 28(2),26-37.*
4. *Hunt, M.C., Merryle, R. & Jensen, J.L. (2005). The effect of social support networks on morbidity among elderly substance abusers. Journal of the American Geriatrics Society, 57(4), 15-23.*
5. *Hunt, M.C., Pour, B., Marks, A.E., Merryle, R. & Jensen, J.L. (2005). Aging out of methadone treatment. American Journal of Alcohol and Drug Abuse, 15(6), 134-149.*
6. *Hunt, M.C., Marks, A.E., Venturi, R., Crenshaw, W. & Ratonian, A. (2007). Community-based intervention strategies for reducing alcohol and drug abuse in the elderly. Addiction, 104(9), 1436-1606. PMCID: PMC9000292*
7. *Merryle, R. & Hunt, M.C. (2007). Randomized clinical trial of cotinine in older nicotine addicts. Age and Ageing, 38(2), 9-23. PMCID: PMC9002364*
8. *Hunt, M.C., Jensen, J.L. & Merryle, R. (2008). The aging addict: ethnographic profiles of the elderly drug user. NY, NY: W. W. Norton & Company.*
9. *Hunt, M.C. (2009). Contrasting ethnicity with race in the older alcoholic. The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, in press. PMCID: PMC Journal – In Process.*
10. *Hunt, M.C. (2009). Intervening successfully with the older methadone patient. Journal of Applied Gerontology, 13(4), 67-79.*

SAMPLE

D. Research Support

Ongoing Research Support

R01 DA942367-03 Hunt (PI) 09/01/08-08/31/13
Health trajectories and behavioral interventions among older substance abusers
The goal of this study is to compare the effects of two substance abuse interventions on health outcomes in an urban population of older opiate addicts.
Role: PI

R01 MH922731-05 Merryle (PI) 12/15/07-11/30/12
Physical disability, depression and substance abuse in the elderly
The goal of this study is to identify disability and depression trajectories and demographic factors associated with substance abuse in an independently-living elderly population.
Role: Co-Investigator

Faculty Resources Grant, Washington University 08/15/09-08/14/11
Opiate Addiction Database
The goal of this project is to create an integrated database of demographic, social and biomedical information for homeless opiate abusers in two urban Missouri locations, using a number of state and local data sources.

Completed Research Support

K02 AG442898 Hunt (PI) 02/01/02-01/31/05
Drug Abuse in the Elderly
Independent Scientist Award: to develop a drug addiction research program with a focus on substance abuse among the elderly.
Role: PI

R21 AA998075 Hunt (PI) 01/01/02-12/31/04
Community-based intervention for alcohol abuse
The goal of this project was to assess a community-based strategy for reducing alcohol abuse among older individuals.
Role: PI

SAMPLE

AOFAS Research Grants Application Attestation

(version 2020July9)

Direction: Everyone listed in the application form must read and approve this attestation and provide an electronic signature. PIs, CIs, the Department Chair, Grant Administrator, Financial Officer need to sign this form. The group can use 1 document with all signatures in it.

I certify that statements in this application are true, complete, and accurate to the best of my knowledge. I accept the obligation to comply with the terms and conditions in the application instructions and in the AOFAS Research Grant Policies and Guidelines. 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 my department or organization to administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required INTERIM PROGRESS REPORT, FINAL REPORT, FAI MANUSCRIPT SUBMISSION, and ABSTRACT SUBMISSION if a grant is awarded as a result of this application.

Grant #: _____

Name	Signature	Date	Role
			Primary Investigator
			Co-Investigators
			Department Chair
			Grant Administrator
			Financial Officer
			Applicant (The person filling out the application form but not an PI, CI, chair, administrator, nor officer)
			Other (Please indicate role)

AOFAS Research Grants Application
Disclosure/Conflict of Interest

(version 5/20/2022)

Direction: Principal Investigators & Co-Investigators must fill out a disclosure statement. Please indicate the organization, your role, and dates (if applicable). The Department Chair, Grant Administrator, and Financial Officer do NOT need to sign this disclosure statement.

PI or CI name: _____

PI or CI email: _____

Organization	*Your Role*	*Dates (if applicable)*
<ExamplePharmaceuticalCompany>	*<Paid consultant>*	*<Jan2022 to present>*