

Signature:

California Department of Public Health Center for Infectious Diseases, Immunization Branch RFA 24-10715 Attachment 2

Application Cover Sheet

Please list the Executive Di	BL 1244 F 4 B1 4 M 1 4 B		
Please list the Executive Director or Manager overseeing the Program.			
Full Name (First and Last N	ame): Title:		
Mailing Address (Street, P.O. Box, City, State, Zip Code):			
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Telephone Number:	Email Addres	SS:	
Please list the Hepatitis B Demo Project Contact.			
Full Name (First and Last N			
i uli Naille (i list aliu Last N	ame). Hite.		
Mailing Address (Street, P.O. Box, City, State, Zip Code):			
Telephone Number:	Email Addres	ss:	
Places list the Inveising Contact/Pemittenes Contact			
Please list the Invoicing Contact/Remittance Contact.			
Full Name (First and Last N	ame): Title:		
Mailing Address (Street, P.O. Box, City, State, Zip Code):			
maning Address (Street, 1.5. Box, Sity, State, Lip Sode).			
Talambana Namaban	For all Address		
Telephone Number:	Email Addres	SS:	
Please list the Agreement Signatory with the authority to enter into a grant			
agreement with the State of California. (Note: For Local Health Jurisdictions this			
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person may be the Chair of the County Board of Supervisors.)			
Full Name (First and Last Name): Title:			
Mailing Address (Street, P.O. Box, City, State, Zip Code):			
3			
	DUNS (Data Universal	EEIN /Employer	
	•	FEIN (Employer	
Telephone Number:	Number System):	Identification Number):	
Budget Period: 7/1/2025—12	2/31/2027		
Budget Period: 7/1/2025—12			
Budget Period: 7/1/2025—12 Total Amount Requested fo			
Total Amount Requested fo	r 2.5 Years: \$650,000		
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Date: