aircraft crashes occur in Alaska. Between 1990–1998 there were 823 commuter and air taxi crashes in the U.S., of which 229 (28 percent) were fatal, resulting in 653 deaths. Alaska accounted for 304 (37 percent) of the total crashes, 49 of which were fatal (21 percent of the U.S. fatal crashes), resulting in 131 deaths (20 percent of all U.S. deaths) (NTSB Aviation Accident Database, 1999). Aviation crashes are now the leading cause of occupational fatalities in Alaska.

To address this compelling occupational issue in Alaska, Congress supported implementation of a federal initiative to reduce aviation-related injuries and fatalities. The initiative is a three-year commitment led by a partnership of four federal agencies who share an interest in promoting aviation safety and preventing aircraft crashes—the Federal Aviation Administration (FAA), the National Transportation Safety Board (NTSB), National Weather Service (NWS), and the National Institute for Occupational Safety and Health (NIOSH). The purpose of this joint initiative is to reduce the number of aircraft crashes and deaths, and promote aviation safety within the air transportation industry in Alaska.

This initiative complements another federal/industry initiative to reduce aviation fatalities—the Capstone Program. The Capstone Program, currently implemented in the Bethel, Alaska area includes installation of improved avionics in aircraft used in FAR part 135 operations, an improved ground infrastructure for weather information, data link communications and Flight Information Services, and the development of new GIS-based non-precision instruction approaches at remote airports.

As part of these initiatives, air carrier operators and pilots will be surveyed to obtain information on what they perceive are the risks and hazards contributing to aircraft accidents in Alaska, their opinion about current safety programs, and what they think could be done to improve aviation safety. This information will be analyzed to identify common risk factors, compare them to risk factors identified from analysis of accident reports and published literature, and assess the effectiveness of current and new potential safety interventions. These findings will be useful to Alaska's air transportation industry for trend information to evaluate interventions.

To reduce the total respondent burden and increase efficiency in data collection, we are coordinating and combining the information gathering process for both the joint initiative and a safety study of the Capstone initiative into one effort. The joint initiative will conduct two statewide surveys: Approximately 400 participants in the air carrier operator survey and 500 participants in the pilot survey. The Capstone safety study will add questions to both surveys for respondents in the implementation area, and in addition will continue to survey pilots using Capstone equipment for the duration of that program (through fall 2002). Follow up surveys to assess the effectiveness of the implementation measures would re-survey approximately half of the original statewide sample: about 200 air carrier operators and 250 pilots.

We will use the results of the initial statewide surveys to (1) recommend ways to improve air transportation safety; (2) identify measures to put the recommendations into effect; and (3) guide the ongoing research. Follow up surveys will assess the effectiveness of the program and identify potential improvements. We will use the results of the Capstone study surveys to assess the effectiveness of that program and to recommend improvements. The information can be obtained only from the respondents, as it requests information on skills, knowledge, attitudes, and business practices for which no other source is available. The total annual burden for this collection is 670 hours.

Respondents	Number of respondents	Number of responses per respondent	Avg. burden per response (in hrs.)
Operators Survey	200	1	30/60
Capstone Questions for Capstone area Operators	30 (subset of 200)	1	15/60
Pilot Survey	400	1	30/60
Capstone Questions for Capstone area Pilots	50 (subset of 400)	1	15/60
Capstone Pilots not in AIASI Survey	100	1	30/60
Follow-up survey of Operators	200	1	30/60
Follow-up survey of Pilots	400	1	60

Dated: May 10, 2001.

Nancy E. Cheal,

Acting Associate Direct for Policy Planning, and Evaluation, Centers for Disease Control and Prevention (CDC).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 DAY–35–01]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 639–7090. Send written comments to CDC, Desk Officer; Human Resources and Housing Branch, New Executive Office Building, Room 10235; Washington, DC 20503. Written comments should be received within 30 days of this notice.

Proposed Project

National Disease Surveillance Program—I. Case Reports (0920–0009)—Extension—National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC). Formal surveillance of 22 separate reportable diseases has been ongoing to meet the public demand and scientific interest for accurate, consistent, epidemiologic data. These ongoing diseases include: Bacterial meningitis,

dengue, hantavirus, HIV/AIDS, Idiopathic CD4+T-lymphocytopenia, Kawasaki syndrome, Legionellosis, lyme disease, malaria, Mycobacterium avium Complex Disease, plague, Reye Syndrome, tick-borne Rickettsial Disease, toxic shock syndrome, toxocariasis, trichinosis, typhoid fever, and viral hepatitis. Case report forms enable CDC to collect demographic, clinical, and laboratory characteristics of cases of these diseases. This information is used to direct epidemiologic investigations, to identify and monitor trends in reemerging infectious diseases or emerging modes of transmission, to search for possible causes or sources of the diseases, and to develop guidelines for the prevention of treatment. It is also used to recommend target areas in most need of vaccinations for certain diseases and to determine development of drug resistance.

Because of the distinct nature of each of the diseases, the number of cases reported annually is different for each. The total annualized burden is 34,038 hours (131,307 × .259225).

Respondents	Number of respondents	Number of responses per respondent	Average burden respondent (in hours)
Health care workers	55	131,307	0.259225

Dated: May 10, 2001.

Nancy Cheal,

Acting Associate Director for Policy, Planning, and Evaluation Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 01132]

American Indian/Alaska Native Core Capacity Building Programs; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2001 funds for a cooperative agreement program for American Indian/Alaska Native (AI/AN) Core Capacity Building Programs. This program addresses the ''Healthy People 2010'' focus areas of Maternal, Infant, and Child Health, Cancer, Heart Disease and Stroke, Diabetes, Human Immunodeficiency Virus (HIV), and Immunization and Infectious Diseases.

The purpose of the program is for AI/AN Communities to build core capacity and augment existing programs to reduce disparities in health outcomes for one or more of the designated health priority areas. In addition, the funding will be provided to AI/AN communities that demonstrate need based on high prevalence and related morbidity and mortality and have limited infrastructure and resources to address health disparities.

''Core capacity'' is defined as the development of infrastructure and support strategies, including networking, partnership formation, and coalition building to raise and maintain community awareness and support, as well as national awareness of the health priority area needs of AI/AN populations. Core capacity programs include basic health promotion, disease prevention and control functions, ability to capture data, program coordination related to primary and secondary prevention, scientific capacity, training and technical assistance, and culturally competent intervention strategies for addressing the health priority area needs of AI/AN populations.

Background

In 1997, President Clinton committed the nation to an ambitious goal by the year 2010 to eliminate disparities in health status experienced by racial and ethnic minority populations in key areas, while continuing the progress we have achieved in improving the overall health of the American people. In support of this effort, the Department of Health and Human Services (DHHS) identified six health priority areas in which racial and ethnic minorities experience serious health disparities: Infant Mortality, Deficits in Breast and Cervical Cancer Screening and Management, Cardiovascular Diseases, Diabetes, Human Immunodeficiency Virus (HIV) Infections/Acquired Immunodeficiency Syndrome (AIDS), and Deficits in Child and/or Adult Immunizations. On behalf of the DHHS-wide collaborative effort, the Centers for Disease Control and Prevention (CDC) is coordinating and managing a major component of activities to support this initiative.

B. Eligible Applicants

Eligible applicants are federally recognized AI/AN tribal governments and corporations, non-federally recognized tribes and other organizations that qualify under the Indian Civil Rights Act, State Charter Tribes, Urban Indian Health Programs, Indian Health Boards, Inter-Tribal Councils, and other tribal organizations, including urban and eligible inter-tribal consortia.

Tribal organizations, inter-tribal consortia, and urban organizations are eligible if incorporated for the primary purpose of improving AI/AN health and represent such interests for the tribes, Alaska Native Villages and corporations, or urban Indian communities located in its region. AI/AN tribes or urban communities represented may be located in one state or in multiple states. An urban organization is defined as a non-profit corporate body situated in an urban center eligible for services under Title V of the Indian Health Care Improvement Act, PL 94–437, as amended.

Minimal Requirements

1. Application

The application must target American Indian or Alaska Native communities and must address one or more of the following six health priority area(s): Infant Mortality, Deficits in Breast and Cervical Cancer Screening and Management, Cardiovascular Diseases, Diabetes, Human Immunodeficiency Virus (HIV) Infections/Acquired Immunodeficiency Syndrome (AIDS), and Deficits in Child and/or Adult Immunizations. Activities for health priority areas that are not under these categories will not be considered.

2. Tax-exempt Status

For those applicants applying as a private, non-profit organization, proof of tax-exempt status must be provided with the application. Tax-exempt status is determined by the Internal Revenue Service (IRS) Code, Section 501(c)(3). Any of the following is acceptable evidence:

a. A reference to the organization's listing in the IRS's most recent list of