support staff) who are knowledgeable about the case in question. Researchers will request information on both the victim and alleged offender(s)—including demographic data, their academic and criminal records, and their relationship to one another. They will also collect data on the time and location of the death; the circumstances, motive, and method of the fatal injury; and the security and violence prevention activities in the school and community where the death occurred, before and after the fatal injury event. The total burden hours are estimated to be 70.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hrs.)
School Officials	35	1	1
Police Officials	35	1	1

Dated: August 18, 2003.

Nancy E. 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

[30 Day–65–03]

Proposed Data Collections Submitted for Public Comment and Recommendations

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) 498–1210. Send written comments to CDC, Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project: Levels of Selected Drinking Water Disinfection By-products in Whole Blood after Showering: The Effect of Genetic Polymorphisms—NEW—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Chlorine is the most commonly used chemical for disinfecting U.S. water supplies; however, chlorine reacts with organic compounds in the water to produce halogenated hydrocarbon by-products. Exposure to these disinfection by-products(DBPs) has been associated with liver and bladder cancer in humans and is suspected of other adverse health outcomes. We recently completed a study of household exposure to one class of DBPs in tap water, trihalomethanes (THMs) (Backer *et al.*, 2000). We found an increase in whole blood levels of one class of (THMs) after people showered or bathed in tap water. We also found that the increases fell roughly into two groups; one group was clustered around a higher level, the other a lower level. It is possible that this clustering is the result of individual variations in physiological characteristics or it could be the result of differences in the ability to metabolize THMs.

Since several polymorphically expressed enzymes are linked to the metabolism of DBPs, these physiologic and genetic differences may be important in determining an individual's risk for cancer and other health risks associated with exposure to these compounds. We plan to measure the change in blood concentration of DBPs after showering. We will then examine the association between people with different enzyme variants and post-exposure blood THM levels. The study will be conducted in two parts. Part 1 will involve recruiting 250 volunteers who do not have a history of lung problems and who are willing to participate in all aspects of the study. These 250 will be asked to provide some demographic information. They will also provide a buccal cell sample that will be analyzed in order to find a pool of 100 volunteers who have the genetic polymorphisms of interest. Part 2 will involve the 100 study subjects giving three blood samples before and three blood samples after taking a shower. A urine sample will be collected and stored for future use in evaluating urine levels of haloacetic acids (HAAs), another important class of drinking water DBPs. Air and water samples will also be collected.

Subjects will complete a brief questionnaire in order to obtain personal information that might impact the dose of volatized DBPs they receive. This data will be analyzed to determine whether the physiologic and genetic differences among individuals result in differences in blood THM levels after similar exposure. There are no costs to respondents.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hours)
Screening Interview	250	1	20/60
Consent Form	100	1	20/60
Questionnaire	100	1	20/60
Blood Samples	100	6	5/60
Shower	100	1	20/60
Urine Sample	100	2	10/60
Tap Water Sample	100	1	10/60
Misc. Study Activities	100	1	40/60
Remain at Study Site	100	1	2

Dated: August 18, 2003.

Nancy E. Cheal,

Acting Deputy 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 04011]

Grants for Injury Control Research Centers; Notice of Availability of Funds

Application Deadline: September 22, 2003.

A. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under sections 301(a) and 391(a) of the Public Health Service Act, (42 U.S.C. sections 280b(a) and 391(a)), as amended. The Catalog of Federal Domestic Assistance number is 93.136.

B. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 2004 funds for grants for Injury Control Research Centers (ICRC). This program addresses the ''Healthy People 2010'' focus area of Injury and Violence Prevention. A copy of ''Healthy People 2010'' is available at the following Internet address: *http://www.health.gov/healthypeople.*

The purposes of this program are:

1. To support injury prevention and control research on priority issues as delineated in: ''Healthy People 2010''; ''Reducing the Burden of Injury: Advancing Prevention and Treatment''; and the research priorities published in the CDC Injury Research Agenda, located at *http://www.cdc.gov/ncipc.*

2. To integrate, in the context of a national program, the disciplines of epidemiology, medicine, biomechanics and other engineering, biostatistics, public health, law and criminal justice, and behavioral and social sciences in order to prevent and control injuries more effectively.

3. To define the injury problem; identify risk and protective factors; develop and evaluate prevention and control interventions and strategies; and ensure widespread adoption of effective interventions and strategies.

4. To provide technical assistance to injury prevention and control programs within a geographic region.

Measurable outcomes of the program will be in alignment with the following performance goal for the National Center for Injury Prevention and Control (NCIPC): Develop new or improved approaches for preventing and controlling death and disability due to injuries.

C. Eligible Applicants

This announcement will provide funding for applicants in regions that do not have funded Injury Control Research Centers (ICRCs) and for applicants in regions that have funded Centers that must re-compete for funding.

Eligible applicants include nonprofit and for-profit organizations. Thus, universities, colleges, research institutions, hospitals, other public and private organizations, faith-based organizations, tribal organizations, State, Tribal, and local health departments, and small, minority and/or women-owned businesses are eligible for these grants. Non-academic applicant institutions should provide evidence of a collaborative relationship with an academic institution.

Eligible applicants are limited to organizations in Department of Health and Human Services (DHHS) Region II (New Jersey, New York, Puerto Rico, and Virgin Islands), Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia), Region IV (Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee), Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), Region IX (Arizona, California, Hawaii, Nevada, American Samoa, Guam, Mariana Islands, Marshall Islands, Micronesia, and Palau), and Region X (Alaska, Idaho, Oregon, and Washington).

Note: ICRC grant awards are made to the applicant institution/organization, not the Principal Investigator. Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant or loan.

B. Funding

Availability of Funds

Approximately $4,527,500 is expected to be available in FY 2004 to fund five awards. It is expected that each award will be $905,500 (total of direct and indirect costs). Applicants will be allowed to apply for $1,055,500 ($150,000 above the expected award amount to allow for the inclusion of the description of an additional large project as described in Section F. Content 4.b. (2).), but each award will be no more than $905,500 (total of direct and indirect costs). It is expected that each award will begin on or about September 1, 2004, and will be made for a 12-month budget period within a project period of up to five years. Applications that exceed the funding cap noted above will be excluded from the competition and returned to the applicant. Funding estimates may change.

Consideration will also be given to current grantees that submit a competitive supplement requesting one year of funding to enhance or expand existing projects, or to conduct one-year pilot studies. These awards will not exceed $150,000, including both direct and indirect costs. Supplemental awards will be made for the budget period to coincide with the actual budget period of the grant and are based on the availability of funds.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

Use of Funds

Center funding is to be designated for two types of activities. One type of activity is considered core and includes administration, management, general support services (*e.g.*, statistical, library, media relations, and advocacy) as well as activities associated with research development, technical assistance, and education (*e.g.*, seed projects, training activities, and collaborative and technical assistance activities with other groups). Funds may be allocated for trainee stipends, tuition remission, and trainee travel in accordance with the current rates for the United States Public Health Service agencies. Indirect costs for these trainee-related activities are limited to eight percent.

Defined research projects constitute the second type of activity, and ICRCs are encouraged to work toward addressing the breadth of the field. Core activities and defined research projects may each constitute between 25 percent and 75 percent of the operating budget, and should be balanced in such a way that the ICRC demonstrates productivity in research as well as teaching and service. Applicants with less demonstrated expertise in research are encouraged to devote a larger percentage of funds to defined research projects in order to establish their capability as research centers of excellence.

Grant funds will not be made available to support the provision of direct care. Studies may be supported