Notifiable Diseases. The estimated annualized burden is 4927 hours.

Type of respondents	Number of respondents	Frequency of response	Average time per response (in hours)	Annual hour burden (in hours)
Weekly Morbidity Report Respondent Burden				
States	50	52	1	2600
Territories	5	52	1@1 4@ 30/60	156
Cities	2	52	1	104
Subtotals	57			2860
CDC 43.5 Weekly Mortality Report Respondent Burden				
City health officers or Vital statistics registrars	122	52	12/60	1269
Annual Summary Respondent Burden				
States	50	1	14	700
Territories	5	1	14	70
Cities	2	1	14	28
Subtotals				798
Totals	179			4927

Dated: February 18, 2004.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–29–04]

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: Building Capacity to Fluoridate: Key Informant Interviews to Understand Community Water Fluoridation—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Since the first fluoridation of a public water system in Grand Rapids, Michigan in 1945, fluoridation of community water supplies has dramatically reduced the prevalence of dental caries in the United States. Scientific evidence compiled over nearly six decades demonstrates that adjusting the fluoride concentration of public water systems is a safe, cost-effective, and equitable intervention that benefits everyone in a given community regardless of financial status.

The percentage of the U.S. population living in areas with fluoridated water grew steadily from 1945 to the mid-1970s. Adoption of fluoridation is ultimately a choice made by community decision makers and often is put before the public for vote as a referendum. In spite of survey findings that roughly 70 percent of the U.S. population favors fluoridation, referenda since the 1980's have often resulted in community decisions not to fluoridate. Thus, the rate of increase in access to fluoridated water among those on public water systems has slowed. In 2000, 65.8 percent of this population had access to fluoridated water, still far short of the 75 percent fluoridation target set in both the *Healthy People 2000* and *2010* objectives.

The purpose of this research is to identify and describe the variables that influence community fluoridation decisions made by public vote and provide enhanced knowledge that may be useful to communities considering fluoridation.

In-person interviews will be conducted with 7 to 13 key participants in fluoridation referendum campaigns at 8 sites where fluoridation has been rejected or accepted within the last three years. Key participants in the campaigns will vary slightly by site. A total of 80 interviews will be conducted. The expected participants will include:

- State or local health department staff
- Campaign directors
- Local elected officials
- Outside political consultants
- Grassroots leaders
- Media representatives

The estimated annualized burden is 140 hours.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
Respondent Screening	43	1	10/60
Political Professionals	16	1	100/60
Civic and Grassroots Leaders	16	1	100/60

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)
Media Representatives	16	1	100/60
Health care providers	16	1	100/60
Local Officials	16	1	100/60

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Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–20–04]

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: REACH 2010 Evaluation, OMB No. 0920–0502—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

The REACH 2010 Demonstration Program is a part of the Department of Health and Human Services' response to the President's Race Initiative and to the Healthy People 2010 goal to eliminate disparities in the health status of racial and ethnic minorities. The purpose of REACH 2010 is to demonstrate that adequately funded community-based programs which are designed and led by the communities they serve can reduce health disparities in infant mortality, deficits in breast and cervical cancer screening and management, cardiovascular diseases, diabetes, HIV/AIDS, and deficits in childhood and adult immunizations. The communities served by REACH 2010 include: African American, American Indian, Hispanic American, Asian American, and Pacific Islander. Seventeen communities were funded in Phase I to construct Community Action Plans (CAP). In Phase II, 26 communities will receive funding to implement their CAP. This data collection is for the Phase II communities.

As part of the President's Race Initiative, it is imperative that REACH 2010 demonstrate success in reducing health disparities among racial and ethnic minority populations. Toward that end, it is of critical importance that CDC collects uniform survey data from each of the 26 communities funded for the Phase II REACH 2010 Demonstration Program. The same survey will be conducted in each community; it will contain questions that are standard public health performance measures for each health priority area. Surveys will be administered by either telephone or household interview. These surveys will be administered annually using a different sample from each community. The total annualized burden for this data collection is 8,138 hours.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Introductory Call	29,647	1	2/60
Questionnaire	26,000	1	15/60
Respondent Reliability Assessment	2,600	1	15/60

Dated: February 18, 2004.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–03–04]

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: EEOICPA Special Exposure Cohort Petition Forms (42 CFR part 83)—NEW—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background

On October 30, 2000, the Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA), 42 U.S.C. 7384–7385 [1994, supp. 2001] was enacted. It established a compensation program to provide a lump sum payment of $150,000 and medical benefits as compensation to