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

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–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

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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–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

covered employees suffering from designated illnesses incurred as a result of their exposure to radiation, beryllium, or silica while in the performance of duty for the Department of Energy and certain of its vendors, contractors and subcontractors. This legislation also provided for payment of compensation for certain survivors of these covered employees.

EEOICPA instructed the President to designate one or more Federal Agencies to carry out the compensation program. Accordingly, the President issued Executive Order 13179 (''Providing Compensation to America's Nuclear Weapons Workers'') on December 7, 2000 (65 FR 77487), assigning primary responsibility for administration of the compensation program to the Department of Labor (DOL). The executive order directed the Department of Health and Human Services (HHS) to perform several technical and policymaking roles in support of the DOL program.

Among other duties, the executive order directed HHS to establish and implement procedures for considering petitions by classes of nuclear weapons workers to be added to the ''Special Exposure Cohort'' (the ''Cohort''), various groups of workers selected by Congress whose claims for cancer under EEOICPA can be adjudicated without demonstrating that their cancer was ''at least as likely as not'' caused by radiation doses they incurred in the performance of duty. In brief, EEOICPA authorizes HHS to designate such classes of employees for addition to the Cohort when NIOSH lacks sufficient information to estimate with sufficient accuracy the radiation doses of the employees, if HHS also finds that the health of members of the class may have been endangered by the radiation dose the class potentially incurred. HHS must also obtain the advice of the Advisory Board on Radiation and Worker Health (the ''Board'') in establishing such findings. On March 7, 2003, HHS proposed procedures for adding such classes to the Cohort in a notice of proposed rulemaking at 42 CFR part 83.

The proposed HHS procedures would authorize a variety of individuals and entities to submit petitions, as specified under § 83.7. Petitioners would be required to provide the information specified in § 83.9 to qualify their petitions for a complete evaluation by HHS and the Board. HHS has developed two petition forms to assist the petitioners in providing this required information efficiently and completely. Petition Form A is a one-page form to be used by EEOICPA cancer claimants for whom NIOSH will have attempted to conduct dose reconstructions and will have determined that available information is not sufficient to complete the dose reconstruction on the majority of petitioners. The form addresses the informational requirements specified under § 83.9(a) and (b). NIOSH expects these claimant-petitions will comprise the majority of petitions. Petition Form B, accompanied by separate instructions, is intended for all other petitioners. The form addresses the informational requirements specified under § 83.9(a) and (c). Forms A and B can be submitted electronically as well as in hard copy. Petitioners should be aware that HHS is not *requiring* petitioners to use the forms. Petitioners can choose to submit petitions as letters or in other formats, but petitions must meet the informational requirements referenced above. NIOSH expects, however, that all petitioners for whom Form A would be appropriate will actually make use of the form, since NIOSH will provide it to them upon determining that their dose reconstruction cannot be completed and encourage them to submit the petition. NIOSH expects the large majority of petitioners for whom Form B would be appropriate will also use the form, since it provides a simple, organized format for addressing the informational requirements of a petition.

NIOSH will use the information obtained through the petition for the following purposes; to: (a) Identify the petitioner(s), obtain their contact information, and establish that the petitioner(s) is qualified and intends to petition HHS; (b) establish an initial definition of the class of employees being proposed to be considered for addition to the Cohort; (c) determine whether there is justification to require HHS to evaluate whether or not to designate the proposed class as an addition to the Cohort (such an evaluation involves potentially extensive data collection, analysis, and related deliberations by NIOSH, the Board, and HHS); and, (d) target an evaluation by HHS to examine relevant potential limitations of radiation monitoring and/or dosimetry-relevant records and to examine the potential for related radiation exposures that might have endangered the health of members of the class. Finally, under § 83.16, petitioners may contest the proposed decision of the Secretary to add or deny adding classes of employees to the cohort by submitting evidence that the proposed decision relies on a record of either factual or procedural errors in the implementation of these procedures. NIOSH estimates that the time to prepare and submit such a challenge is 45 minutes. Because of the uniqueness of this submission, NIOSH is not providing a form. The submission should be in a letter format. The total annual burden for this data collection is 54 hours.

CFR reference	Respondents	Number of respondents	Number of responses per respondent	Average burden per respondent (in hours)
83.9	Form A	80	1	3/60
83.9	Form B	10	1	5
83.9	Authorization	4	1	3/60

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–31–04]

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: Survey of Chronic Fatigue Syndrome and Chronic Unwellness in Georgia—New—National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC).

Congress commissioned CDC to develop research that estimates the magnitude of chronic fatigue syndrome (CFS) in the United States with special consideration of under-served populations (children and racial/ethnic minorities); describe the clinical features of CFS; and identify risk factors and diagnostic markers. CDC is currently planning a study in Georgia to estimate the prevalence of CFS and other fatigue illnesses and to determine whether or not there are differences in occurrence of fatigue illness across metropolitan, urban, rural populations and in racial and ethnic populations.

In 2001, OMB approved the information collection, National Telephone Survey of Chronic Fatigue Syndrome, under OMB Number 0920–0498. In July 2001, CDC conducted a pilot survey to determine feasibility of a national study and to test procedures for this national survey of CFS. The pilot study showed that clinical evaluation to confirm classification of CFS was not practical on a national level, and the planned follow-on national survey was not conducted.

CDC has since modified the concept of the National Survey of CFS by limiting data collection to one southern U.S. state (Georgia). This modified research is better able to serve the objectives of the National Survey of CFS and additional CDC objectives. Reasons supporting this statement are listed below.

- Logistics. A difficulty in the Pilot Test was matching subjects and physicians for clinical evaluations because subjects were scattered across the continent. Focusing on a single state allows operation of regional clinics and greater opportunities for collaboration between and among CDC, Emory University, and consultants.
- Metropolitan, urban, and rural differences. Pilot Test results suggest no regional differences in the occurrence of CFS-like illnesses between and among the Midwest, south, west, and northeast, so concentrating on one state (Georgia) should provide more generalized information. Pilot Test findings suggested that further exploration of urban and rural differences might prove useful. Again, Georgia well-serves such a study with a major metropolitan center (Atlanta), urban areas (Macon and Warner Robins), and rural populations (in counties surrounding Macon) with well-defined regional differences.
- Racial/ethnic differences. The prevalence of CFS in other than the white population has not been definitively measured, although some studies indicate CFS prevalence in minority populations may be higher than generally thought. Georgia has well-characterized urban and rural as well as white, black, and Hispanic populations of varying socioeconomic status living in the regions to be studied. The presence of these populations is ideal for public health surveys. Taken together, the proposed Georgia survey will produce estimates of the prevalence of CFS in metropolitan, urban, and rural populations and will elucidate racial/ethnic differences in CFS in these populations.

The proposed study replicates the Sedgwick County Study and the National Pilot Test using similar methodology and data collection instruments. The study begins with a random-digit-dialing telephone survey to identify fatigued, unwell, and well individuals, followed by detailed telephone interviews to obtain additional data on participant health status. As a result of the telephone interviews, eligible subjects will be asked to participate in clinical evaluations. CDC will estimate the prevalence of CFS and other fatigue illnesses in metropolitan, urban, and rural Georgia and in racial and ethnic populations. CDC will compare prevalence estimates from this proposed study of the Georgia population to estimates obtained for Sedgwick County to ascertain whether or not Sedgwick County findings can be generalized to other populations. The estimated annualized burden is 6,257 hours.

Respondents	Number of respondents	Number responses per respondent	Avg. burden per response (in hours)
Screener interview	19,344	1	7/60
Telephone interview	8,000	1	30/60