agreeing to participate) as they arrive to participate in recreational activities on fresh water bodies with cyanobacteria blooms. Questionnaires will be administered to all study participants while they are on the beach and again when they leave the beach for the day. CDC plans to contact them by phone 7 days after their beach exposure to administer a final questionnaire. Water samples for levels of cyanobacterial toxins and water quality indicators, including microorganisms will also be examined. Blood samples will be collected from a subset of study participants who are exposed to recreational waters with blooms of *Microcystis aeruginosa*. Blood samples will be analyzed using a newly developed molecular assay for levels of microcystin L–R–one of the hepatotoxins produced by this organism. CDC will evaluate the probability of detecting (1) increases in symptoms after people engage in recreational activities in water bodies during cyanobacteria blooms, and (2) low levels of microcystins (<10 ng/ml of blood) in the blood of people who are exposed to very low levels of this toxin while engaged in recreational activities. There are no costs to respondents except their time to participate in the survey.

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Recruiting contact	2500	1	10/60	417
Pre-activity survey	2000	1	10/60	334
Post-activity survey	2000	1	10/60	334
Telephone follow-up survey	2000	1	10/60	334
Total				1,419

Dated: November 24, 2004.

B. Kathy Skipper,

Acting 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–0450X]

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 or send an e-mail to *omb@cdc.gov*. 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

Evaluation of the Poison Help Campaign to Enhance Public Awareness of the National Poison Toll-Free Number, Poison Center Access, and Poison Prevention—New—National Center for Injury Control and Prevention (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and brief description:

Every day more than 6,000 calls about poison emergencies are placed to poison control centers (PCCs) throughout the United States. Although PCCs clearly save lives and reduce healthcare costs, the system that delivers care and prevents poisoning is comprised of more than 131 telephone numbers and thousands of disjointed local prevention efforts. As a result public and professional access to an essential emergency service has been hampered by a confusing array of telephone numbers and by an inability to mount a full-fledged national poison center awareness campaign.

The Poison Control Center Enhancement and Awareness Act of 2000 (Pub. L. 106–174) was signed into legislation in February 2000 with the intent to provide assistance for poison prevention and to stabilize funding of regional PCCs. In October 1999, in response to the impending passage of this legislation, CDC and the Health Services Resource Administration (HRSA) began funding and administering a cooperative agreement with the American Association of Poison Control Centers (AAPCC). The agreement called for the establishment of a National Poison Prevention and Control Program. The purpose of this program is to support an integrated system of poison prevention and control services including: coordination of all PCCs through development, implementation, and evaluation of standardized public education; development of a plan to improve national toxicosurveillance and data systems; and support of a national public service media campaign.

The purpose of the national media campaign is to launch a national toll-free helpline entitled Poison Help (1–800–222–1222) that the general public, health professionals, and others can use to access poison emergency services and prevention information 24 hours a day, seven days a week. The campaign was launched nationally in January 2002 with a special interest in targeting high-risk populations such as parents of children under age 6, older adults between 60–80 years of age, and underserved groups who are often not reached effectively through public health communication efforts.

Two telephone surveys will be conducted to assess the reach and impact of campaign activities and the overall effectiveness of the awareness campaign. The High-Risk Population Survey will be conducted with parents of children under age 6 to assess their awareness of the national toll-free number, awareness of PCCs and the services they provide, and poison prevention knowledge. The High-Risk Population Survey was originally intended to also gather information from older adults ages 60–80, however, limited resources necessitate that the data collection focus on poisonings among young children, which represent more than half of all unintentional poisonings. The Helpline Caller Survey will be conducted with persons who have contacted a PCC to ascertain whether callers have seen or heard Poison Help prevention messages, their awareness of the 1–800–222–1222 number and how they learned of it, and how they rate the ease of accessing poison emergency services or

prevention information. There is no cost to respondents other than their time. The estimated annualized burden is 157 hours.

Annualized Burden Table:

Respondents	Number of respondents	Number of responses/respondents	Average burden/respondents (in hours)
Screened Households:			
Helpline Callers	430	1	.5/60
High-Risk Population	1400	1	1/60
Respondents:			
Helpline Callers	300	1	10/60
High-Risk Population	600	1	8/60

Dated: November 24, 2004.

B. Kathy Skipper,

Acting 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

[60Day–05AK]

Proposed Data Collections Submitted for Public Comment and Recommendations

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 for opportunity for public comment on proposed data collection projects, the Centers for Disease Control and Prevention (CDC) will publish periodic summaries of proposed projects. To request more information on the proposed projects or to obtain a copy of the data collection plans and instruments, call 404–498–1210 or send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS–E11, Atlanta, GA 30333 or send an e-mail to *omb@cdc.gov*.

Comments are invited on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology. Written comments should be received within 60 days of this notice.

Proposed Project

National Intimate Partner Violence Survey—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Intimate partner violence (IPV) is considered by many to be a serious problem. CDC considers IPV to be a ''substantial public health problem for Americans that has serious consequences and cost to individuals, families, communities and society.'' The past twenty years have witnessed an extraordinary growth in research on the prevalence, incidence, causes and effects of IPV. Various disciplines have contributed to the development of research on the subject including psychology, epidemiology, criminology and public health.

Still, there is a lack of reliable information on the prevalence of IPV and on trends over time. Estimates vary widely regarding the magnitude of the problem. This variance is due in large part to the different methods that are used to measure IPV and the context in which questions are asked about IPV. Thus, CDC is engaged in work to improve the quality of data, and hence knowledge about IPV. Part of this process includes comparing various ways of introducing questions about IPV and comparing information obtained from both men and women when questions about IPV victimization and perpetration are asked in differing order.

The purpose of this project is to administer questions, via telephone interviews, that measure both victimization and perpetration for various forms of intimate partner violence (IPV) including stalking, sexual violence, physical violence, and emotional control. The questions will be administered to a random sample of 1500 men and 1500 women ages 18–50. The survey instrument has been developed specifically for this study.

The overall benefit of this project is to determine the optimal order for asking questions about IPV victimization and perpetration and to compare and select the most useful context for introducing IPV questions (*i.e.*, health *vs.* crime *vs.* family conflict). Ultimately, this knowledge will assist the CDC in establishing an ongoing data collection system for monitoring IPV victimization and perpetration. CDC, National Center for Injury Prevention and Control (NCIPC) intends to contract with an agency to conduct the survey. The only cost to the respondents is the time involved to complete the survey.

Respondent	No. of respondents	No. of responses per respondent	Avg. burden number per responses (in hours)	Total burden hours
Female	1500	1	45/60	1125
Male	1500	1	45/60	1125
Total	3,000	.....	.....	2250