collection of information to OMB for review and clearance.

Adoption of the FDA Food Code by Local, State, and Tribal Governments—42 U.S.C. 243(a) (OMB Control Number 0910–0448)—Extension

FDA has developed its model Food Code to assist and promote consistent implementation of national food safety regulatory policy among the local, State, and tribal governmental agencies that have primary responsibility for the regulation or oversight of retail level food operations. The FDA Food Code provides a scientifically sound technical and legal basis for regulating the retail segment of the food industry. Authority for providing such assistance is derived from section 311(a) of the Public Health Service Act (42 U.S.C. 243(a)). Under 31 U.S.C. 1535, FDA provides assistance to other Federal agencies such as the Indian Health Service (IHS).

Nationwide adoption of the model FDA Food Code is an important step toward the agency's goal for consistent, scientifically sound, and risk-based food safety standards and practices. A current, comprehensive, and accurate inventory of food code adoptions by States and U.S. territories, local, and tribal governments is necessary to determine the status of up-to-date protection of the U.S. population and to identify areas where assistance to these governments may promote the adoption of regulations based on the FDA Food Code.

This collection effort, which began in 2001, has had remarkable success with 97 percent participation from State and territorial governmental agencies. FDA contracted with the Association of Food and Drug Officials (AFDO) to conduct the initial survey using the OMB approved survey form. The rulemaking process that local, State, territorial, and tribal governmental agencies must follow to adopt the model FDA Food Code is often a long and complicated process that can extend for several years. For this reason, many agencies have reported that they are still in the rulemaking process to adopt or update their food codes. Thus, FDA believes that extension of OMB approval of the survey is needed in order to keep the current database accurate and up-to-date. The contractor will collect the information electronically and/or telephonically and will be able to provide respondents with previous survey responses already in the database. Respondents to this information collection are States and U.S. territories, local, and tribal governmental agencies.

In the **Federal Register** of April 14, 2010 (71 FR 19405), FDA published a 60-day notice requesting public comment on the proposed collection of information. No comments were received.

FDA estimates the burden of this collection of information as follows:

TABLE 1.—ESTIMATED ANNUAL REPORTING BURDEN[1]

Food Code Survey	No. of Respondents	Annual Frequency per Response	Total Annual Responses	Hours per Response	Total Hours
Respondents	75	4	300	1	300

[1] There are no capital costs or operating and maintenance costs associated with this collection of information.

This estimate is based on FDA's experience and the number of updates received in the past 3 years. FDA estimates that 75 respondents will provide four quarterly updates each, resulting in an estimated 300 total annual responses. The agency estimates that each quarterly update will take about 1 hour. Of the 75 respondents, those who amend their regulations with changes unrelated to the risk factors and interventions, and those who are not adopting model FDA Food Code provisions, but are incorporating certain Conference for Food Protection recommendations only, will likely need only annual contact.

Dated: June 18, 2010.

Leslie Kux,

Acting Assistant Commissioner for Policy.

[FR Doc. 2010–15337 Filed 6–23–10; 8:45 am]

BILLING CODE 4160–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Notice of Establishment

Pursuant to Section 10413, Part V of the Patient Protection and Affordable Care Act (which established Section 399NN of the Public Health Service Act, as amended); Public Law 111–48, the Director, Centers for Disease Control and Prevention (CDC), announces the establishment of the Advisory Committee on Breast Cancer in Young Women.

This committee is established to assist in creating a national evidence-based public education and media campaign to provide age-appropriate messages and materials to: (1) Increase awareness of good breast health habits; (2) identify risk factors based on familial, racial ethnic and cultural backgrounds; (3) encourage young women and healthcare professionals to increase early detection of breast cancers; and (4) increase the availability of health information and other resources for young women diagnosed with breast cancer.

The Advisory Committee on Breast Cancer in Young Women will advise the Secretary, HHS, the Assistant Secretary for Health, and the Director, CDC regarding the formative research, development, implementation and evaluation of evidence-based activities designed to prevent breast cancer (particularly among those at heightened risk) and promote the early detection and support of young women who develop the disease. The advice provided by the Committee will assist in ensuring scientific quality, timeliness, utility, and dissemination of credible appropriate messages and resource materials.

For more information, contact Ena Wanliss, M.S., Lead Public Health Advisor, CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control, 4770 Buford Highway, Mailstop K–57, Chamblee, Georgia 30316, Telephone: 770–488–4225.

The Director, Management Analysis and Services Office, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities for both CDC and the Agency for Toxic Substances and Disease Registry.

Dated: June 18, 2010.

Elaine L. Baker,

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

[FR Doc. 2010–15293 Filed 6–23–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Legislative Changes to Primary Care Loan Program Authorized Under Title VII of the Public Health Service Act

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: On March 23, 2010, President Obama signed into law the Affordable Care Act (ACA), Public Law 111–148. Section 5201 of the ACA changes the Primary Care Loan (PCL) program by: (1) Reducing the number of years for the primary health care service requirement; (2) lowering the interest rate for service default; and (3) eliminating the HHS requirement that parental financial information be submitted for independent students.

SUPPLEMENTARY INFORMATION: The PCL program was created through the Health Professions Education Extension Amendments of 1992 (Pub. L. 102–408), which established a new requirement for the use of the Health Professions Student Loan funds for allopathic and osteopathic schools. The PCL program strives to increase the number of primary care physicians by providing long-term, low interest rate loans to full-time students with financial need pursuing a degree in allopathic or osteopathic medicine. Below are details on how the ACA changes Section 723 of the Public Health Service Act (PHSA) regarding administration of the PCL program.

Primary Health Care Service Requirement

Under the PCL program, students were required to enter and complete a residency training program in primary health care and practice in primary health care until the PCL borrower's loan was repaid in full. The ACA change requires that for any new PCLs made on or after March 23, 2010, the PCL borrowers are to enter and complete residency training in primary health care and practice in primary health care for either 10 years (including the years spent in residency training) or through the date on which the loan is repaid in full, whichever occurs first. (Section 5201(a)(1)(B) of the ACA).

Service Default Interest Rate

In the past, PCL borrowers who did not fulfill the service requirements and began practicing in a discipline or specialty other than primary health care were penalized by having their interest rate on the PCL recalculated at 18 percent. The ACA change requires that borrowers who receive a PCL on or after March 23, 2010, and fail to comply with the service requirements of the program will have their loans begin to accrue interest at an annual rate of 2 percent greater than the rate the student would pay if compliant. (Section 5201(a)(3) of the ACA.)

Parental Financial Information Requirement for Independent Students

Prior to enactment of the new law, independent students were required to provide parental financial information to the school's financial aid office so that the school could consider all financial resources available to the independent student for a PCL. The ACA change eliminates the HHS requirement for independent students to provide parental financial information to determine financial need. At its discretion, a school may still require parental financial information for independent students seeking a PCL. (Section 5201(b) of the ACA.) For this program, an independent student is a student who is at least 24 years of age and has been independent for a minimum of 3 years. Dependent students are still required to submit parental financial information.

The ACA changes to the PCL program will require a participating school to revise its PCL master promissory note for new loans made on or after March 23, 2010, to be consistent with the ACA.

Dated: June 21, 2010.

Mary K. Wakefield,

Administrator.

[FR Doc. 2010–15354 Filed 6–23–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket Nos. FDA–2009–M–0317, FDA–2009–M–0369, FDA–2009–M–0370, FDA–2009–M–0485, FDA–2009–M–0536, FDA–2009–M–0540]

Medical Devices; Availability of Safety and Effectiveness Summaries for Premarket Approval Applications

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) is publishing a list of premarket approval applications (PMAs) that have been approved. This list is intended to inform the public of the availability of safety and effectiveness summaries of approved PMAs through the Internet and the agency's Division of Dockets Management.

ADDRESSES: Submit written requests for copies of summaries of safety and effectiveness data to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Please cite the appropriate docket number as listed in table 1 of this document when submitting a written request. See the **SUPPLEMENTARY INFORMATION** section for electronic access to the summaries of safety and effectiveness.

FOR FURTHER INFORMATION CONTACT: Nicole Wolanski, Center for Devices and Radiological Health, Food and Drug Administration, 10903 New Hampshire Ave., Bldg. 66, rm. 1650, Silver Spring, MD 20993, 301–796–6570.

SUPPLEMENTARY INFORMATION:

I. Background

In the **Federal Register** of January 30, 1998 (63 FR 4571), FDA published a final rule that revised 21 CFR 814.44(d) and 814.45(d) to discontinue individual publication of PMA approvals and denials in the **Federal Register**. Instead, the agency now posts this information on the Internet on FDA's home page at *http://www.fda.gov*. FDA believes that this procedure expedites public notification of these actions because announcements can be placed on the Internet more quickly than they can be published in the **Federal Register**, and FDA believes that the Internet is accessible to more people than the **Federal Register**.

In accordance with section 515(d)(4) and (e)(2) of the Federal Food, Drug, and