may have resulted in undocumented radiation exposures, characterizing radiological protection and monitoring practices, and identify co-workers and other witnesses as may be necessary to confirm undocumented information. In this process, NIOSH uses a computer assisted telephone interview (CATI) system, which allows interviews to be conducted more efficiently and quickly as opposed to a paper-based interview instrument. Both interviews are voluntary and failure to participate in either or both interviews will not have a negative effect on the claim, although voluntary participation may assist the claimant by adding important information that may not be otherwise available. NIOSH is requesting a three year approval for these data collection activities.

NIOSH uses the data collected in this process to complete an individual dose reconstruction that accounts, as fully as possible, for the radiation dose incurred by the employee in the line of duty for DOE nuclear weapons production programs. After dose reconstruction, NIOSH also performs a brief, voluntary final interview with the claimant to explain the results and to allow the claimant to confirm or question the records NIOSH has compiled. This will also be the final opportunity for the claimant to supplement the dose reconstruction record. Approximately 4,200 claimants will be interviewed with an average burden of one hour per response.

At the conclusion of the dose reconstruction process, the claimant submits a conclusion form to confirm that the claimant has no further information to provide to NIOSH about the claim at this time. The form notifies the claimant that signing the form allows NIOSH to forward a dose reconstruction report to DOL and to the claimant, and closes the record on data used for the dose reconstruction. Signing this form does not indicate that the claimant agrees with the outcome of the dose reconstruction. The dose reconstruction results will be supplied to the claimant and to the DOL, the agency that will utilize them as one part of its determination of whether the claimant is eligible for compensation under the Act. It is estimated that 8,400 claimants will complete the conclusion form which takes approximately 5 minutes per response.

The total estimated burden hours are 4,900. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Claimant	Initial interview	4,200	1	1	4,200
Claimant	Conclusion form OCAS–1	8,400	1	5/60	700
Total					4,900

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2014–26032 Filed 10–31–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day 15–15CK]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan and instruments, call 404–639–7570 or send comments to Leroy A. Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. 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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

Proposed Project

Improving the Impact of Laboratory Practice Guidelines (LPGs): A New Paradigm for Metrics—College of American Pathologists—NEW—Center for Surveillance, Epidemiology and Laboratory Services (CSELS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention is funding three 5-year projects collectively entitled ''Improving the Impact of Laboratory Practice Guidelines: A New Paradigm for Metrics''. An ''LPG'' is defined as written recommendations for voluntary, standardized approaches for medical laboratory testing that takes into account processes for test selection, sample

procurement and processing, analytical methods, and results reporting for effective diagnosis and management of disease and health conditions. LPGs may be disseminated to, and used by, laboratorians and clinicians to assist with test selection and test result interpretation. The overall purpose of these cooperative agreements is to increase the effectiveness of LPGs by defining measures and collecting information to inform better LPG creation, revision, dissemination, promotion, uptake, and impact on clinical testing and public health. The project will explore how these processes and their impediments and facilitators differ among various intended users of LPGs. Through this demonstration project, CDC seeks to understand how to customize LPG creation and promotion to better serve these intended users of LPGs. An important goal is to help organizations that sponsor the development of LPGs create a sustainable approach for continuous quality improvement to evaluate and improve an LPG's impact through better collection of information.

The CDC selected three organizations that currently create and disseminate LPGs to support activities under a cooperative agreement funding mechanism to improve the impact of their LPGs. The American Society for Microbiology, the Clinical and Laboratory Standards Institute, and the College of American Pathologists (CAP), will each use their LPGs as models to better understand how to improve uptake and impact of these and future LPGs. Only the CAP submission will be described in this notice.

The CAP project will address two LPGs that are important to clinical testing: immunohistochemistry test validation (IHC) and an algorithm for diagnosing acute leukemia (ALA). The ALA LPG is being co-developed with the American Society of Hematologists (ASH). The intended users of the CAP's IHC LPGs will include pathologists, clinical laboratory directors, and laboratory managers overseeing the IHC staining department. For the CAP's ALA LPG the intended users are pathologists and hematologists overseeing testing for acute leukemia. Thus, all these professionals will be surveyed by CAP.

Prior to entering into this cooperative agreement project with the CDC, the CAP had already completed a baseline IHC LPG information collection from laboratories that used IHC testing. Subsequent to this data collection, the CAP created and disseminated an IHC LPG in a peer reviewed journal. Because of this prior baseline assessment, the CAP will only need to collect post-dissemination data. For their ALA LPG *CAP/ASH Algorithm for Initial Work-Up of Acute Leukemia,* the CAP will conduct both a baseline and a post-dissemination survey. Because there are uncertainties concerning the specific focus group probes for the IHC LPG and the ALA LPG, this notice only provides a description of our collection of post-dissemination information for the IHC LPG and the baseline ALA LPG.

The CAP hopes to achieve an 80% response rate, or 2,668 out of 3,335 potential respondents. This represents laboratories known to be currently performing IHC testing based upon their participation in CAP's IHC proficiency testing (PT) program and 450 additional laboratories identified by CDC using previous CMS Part B reimbursement claims for IHC testing. The response rate for the baseline IHC survey was approximately 70% but through more focused promotion the CAP hopes to increase participation. We have identified a total of 3,335 (2,885 CAP-accredited + 450 non-CAP-accredited) laboratories that will be targeted by the IHC post-dissemination survey.

CAP-accredited laboratories that are enrolled in IHC PT will receive surveys with their PT mailings. Non-CAP-accredited laboratories will be surveyed via the US postal system, with a fax-back mechanism.

The CAP will need to collect both baseline and post-guideline dissemination data for the ALA LPG. CAP will allow only one response per computer internet protocol address. The CAP has a database of pathologists who have indicated specialization in hematopathology; these hematopathologists will be invited to participate. The CAP hopes to achieve an 80% response rate with their individual data collections, or 880 (80% × 1100 pathologists listed in the CAP database).

The baseline survey for the ALA guideline includes questions about individual practices for diagnosing various types of acute leukemia and individual and laboratory reporting practices. The link to the baseline survey for the ALA guideline will be disseminated via email to hematopathologists in CAP's database, who will be provided a link to the Qualtrics site that hosts the survey.

The CAP and CDC will strive to ensure a high response rate for their IHC and ALA surveys. CAP plans to advertise both surveys. Similarly, the CAP plans to maximize response rates for non-CAP-accredited laboratories by sending reminders through the US postal system. The CAP will also try to maximize response rates for the ALA survey by advertising it through various channels.

For burden calculation, we assume one response per laboratory. We assume respondents for the IHC survey will include (1) pathologists, (2) laboratory directors, and (3) other laboratory managers of IHC laboratories, which may consist of graduate level scientists (Ph.D.s and Masters level), approximately in a 25%:25%:50% distribution, respectively. We assume respondents for the ALA surveys will include pathologists and hematologists that sign out cases, approximately in a 95%:5% distribution, respectively.

The IHC baseline survey, which was conducted prior to this CAP–CDC cooperative agreement, took 15 minutes to complete. The IHC post-dissemination survey and the ALA baseline survey are also expected to take 15 minutes. Each survey will be pilot tested with nine or fewer respondents before deployment to assure that they require 15 minutes or less to complete. CDC is requesting a one-year OMB approval to collect the information. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Pathologist	IHC	834	1	15/60	209
	ALA	1,045	2	15/60	523
Laboratory Directors	IHC	834	1	15/60	209
Laboratory Managers	IHC	1,667	1	15/60	417
Hematologist	ALA	55	2	15/60	28

ESTIMATED ANNUALIZED BURDEN HOURS—Continued

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Total					1,386

Leroy A. Richardson,

Chief, Information Collection Review Office, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

[FR Doc. 2014–26030 Filed 10–31–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of a meeting of the Board of Scientific Counselors, NIDA.

The meeting will be closed to the public as indicated below in accordance with the provisions set forth in section 552b(c)(6), Title 5 U.S.C., as amended for the review, discussion, and evaluation of individual intramural programs and projects conducted by the National Institute on Drug Abuse, including consideration of personnel qualifications and performance, and the competence of individual investigators, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Board of Scientific Counselors, NIDA.

Date: November 20, 2014.

Closed: 8:00 a.m. to 6:00 p.m.

Agenda: To review and evaluate personal qualifications and performance, and competence of individual investigators.

Place: Intramural Research Program, National Institute on Drug Abuse, NIH, Johns Hopkins Bayview Campus, Baltimore, MD 21223.

Contact Person: Joshua Kysiak, Program Specialist, Biomedical Research Center, Intramural Research Program, National Institute on Drug Abuse, NIH, DHHS, 251 Bayview Boulevard, Baltimore, MD 21224, 443–740–2465, *kysiakjo@nida.nih.gov.*

(Catalogue of Federal Domestic Assistance Program Nos.: 93.279, Drug Abuse and Addiction Research Programs, National Institutes of Health, HHS)

Dated: October 28, 2014.

Michelle Trout,

Program Analyst, Office of Federal Advisory Committee Policy.

[FR Doc. 2014–26025 Filed 10–31–14; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the Joint meeting of the National Cancer Advisory Board (NCAB) and NCI Board of Scientific Advisors (BSA).

The meeting will be open to the public as indicated below, with attendance limited to space available. Individuals who plan to attend and need special assistance, such as sign language interpretation or other reasonable accommodations, should notify the Contact Person listed below in advance of the meeting.

A portion of the Joint NCAB/BSA meeting will be closed to the public in accordance with the provisions set forth in section 552b(c)(6), Title 5 U.S.C., as amended for the review, discussion, and evaluation of individual intramural programs and projects conducted by the National Cancer Institute, including consideration of personnel qualification and performance, and the competence of individual investigators, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Advisory Board; *ad Hoc* Subcommittee on Global Cancer Research.

Open: December 1, 2014, 6:00 p.m. to 7:30 p.m.

Agenda: Discussion on Global Cancer Research.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, Maryland 20814.

Contact Person: Dr. Edward Trimble, Executive Secretary, NCAB ad Hoc Subcommittee on Global Cancer Research, National Cancer Institute, National Institutes of Health, 9609 Medical Center Drive, Room 3W–562, Bethesda, MD 20892, (240) 276–5796, *trimblet@mail.nih.gov.*

Name of Committee: National Cancer Advisory Board and NCI Board of Scientific Advisors.

Open: December 2, 2014, 8:30 a.m. to 5:15 p.m.

Agenda: Joint meeting of the National Cancer Advisory Board; and NCI Board of Scientific Advisors; NCI Board of Scientific Advisors Concepts Review, NCI Director's report, and presentations.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, C Wing, 6th Floor, Conference Room 10, Bethesda, MD 20892.

Closed: December 2, 2014, 5:15 p.m. to 6:00 p.m.

Agenda: Review of intramural program site visit outcomes and the discussion of confidential personnel issues.

Place: National Institutes of Health, 9000 Rockville Pike, Building 31, C Wing, 6th Floor, Conference Room 10, Bethesda, MD 20892.

Contact Person: Dr. Paulette S. Gray, Executive Secretary, National Cancer Institute, National Institutes of Health, 9606 Medical Center Drive, Room 7W–444, Bethesda, MD 20892, (240) 276–6340.

Any interested person may file written comments with the committee by forwarding the statement to the Contact Person listed on this notice. The statement should include the name, address, telephone number and when applicable, the business or professional affiliation of the interested person.

In the interest of security, NIH has instituted stringent procedures for entrance onto the NIH campus. All visitor vehicles, including taxicabs, hotel, and airport shuttles will be inspected before being allowed on campus. Visitors will be asked to show one form of identification (for example, a government-issued photo ID, driver's license, or passport) and to state the purpose of their visit. Information is also available on the Institute's/Center's home page: NCAB: *http://deainfo.nci.nih.gov/advisory/ncab/ncab.htm,* BSA: *http://deainfo.nci.nih.gov/advisory/bsa/bsa.htm,* where an agenda and any additional information for the meeting will be posted when available.

(Catalogue of Federal Domestic Assistance Program Nos. 93.392, Cancer Construction; 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control, National Institutes of Health, HHS)