and others. Small modifications will also be made to questions on the use of electronic health records. This notice also covers a decrease in the sample size resulting from smaller budget allocations and oversampling in previous years. Due to this decrease, selected state estimates will not be available for 2016–2018 data.

The National Ambulatory Medical Care Survey (NAMCS) has been conducted intermittently from 1973 through 1985, and annually since 1989. The purpose of NAMCS, a voluntary survey, is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States. Ambulatory services are rendered in a wide variety of settings, including physicians' offices and hospital outpatient and emergency departments.

The NAMCS target universe consists of all office visits made by ambulatory patients to non-Federal office-based physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) who are engaged in direct patient care. In 2006, physicians and mid-level providers (*i.e.*, nurse practitioners, physician assistants, and nurse midwives) practicing in community health centers (CHCs) were added to the NAMCS sample, and these data will continue to be collected.

To complement NAMCS data, NCHS initiated the National Hospital Ambulatory Medical Care Survey (NHAMCS, OMB No. 0920–0278, expires 02/28/18) in 1992 to provide data concerning patient visits to hospital outpatient and emergency departments. NAMCS and NHAMCS are the principal sources of data on ambulatory care provided in the United States.

There is no cost to the respondents other than their time. Burden hours have seen a net reduction of 19,876 hours since the previously approved package, primarily due to a sample size decrease. Currently, there is not a plan to include state-based estimates in the future, unless funding is increased sufficiently to support oversampling in the states for which state based estimates are desired.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hrs.)	Total burden (in hrs.)
Office-based physicians	Physician Induction Interview (NAMCS–1).	2,590	1	45/60	1,943
	Patient Record form (NAMCS–30) (Physician abstracts).	259	30	14/60	1,813
	Prepare and transmit EHR (MU On-Boarding).	130	1	1	130
	Pulling, re-filing medical record forms (FR abstracts).	2,201	30	1/60	1,101
Community Health Centers	Induction Interview—service delivery site (NAMCS–201).	104	1	30/60	52
	Induction Interview—Providers (NAMCS–1).	234	1	30/60	117
	Patient Record form (NAMCS–30) (Provider abstracts).	23	30	14/60	161
	Pulling, re-filing medical record forms (FR abstracts).	211	30	1/60	106
Re-abstraction study	Pulling, re-filing medical record forms (FR abstracts).	72	10	1/60	12
Total					5,435

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. 2016–02581 Filed 2–9–16; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Initial Review

In accordance with Section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces a meeting for the initial review of applications in response to Funding Opportunity Announcement (FOA) SH16–001, Research and Methods in Health Statistics.

Time And Date: 10:00 a.m.–4:30 p.m., March 3, 2016 (Closed).

Place: Teleconference.

Status: The meeting will be closed to the public in accordance with provisions set forth in Section 552b(c)(4) and (6), Title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters For Discussion: The meeting will include the initial review, discussion, and evaluation of applications received in response to ''Research and Methods in Health Statistics'', FOA SH16–001.

Contact Person For More Information: Virginia S. Cain, Ph.D., Director of Extramural Research, National Center for Health Statistics, CDC, 3311 Toledo Rd., Room 7208, Hyattsville, MD, Telephone: (301) 458–4500.

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 the Centers for Disease Control and

Prevention and the Agency for Toxic Substances and Disease Registry.

Gary Johnson,

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

[FR Doc. 2016–02575 Filed 2–9–16; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Meeting of the Community Preventive Services Task Force (Task Force)

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of meeting.

SUMMARY: The Centers for Disease Control and Prevention (CDC) within the Department of Health and Human Services announces the next meeting of the Community Preventive Services Task Force (Task Force). The Task Force is an independent, nonpartisan, nonfederal, and unpaid panel. Its members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health, and are appointed by the CDC Director. The Task Force was convened in 1996 by the Department of Health and Human Services (HHS) to identify population health interventions that are scientifically proven to save lives, increase lifespans, and improve quality of life. CDC is mandated to provide ongoing administrative, research, and technical support for the operations of the Task Force. During its meetings, the Task Force (a) considers the findings of systematic reviews that assess the effectiveness and economics of community preventive services, programs, and policies, and (b) issues recommendations. Task Force recommendations are not mandates for compliance or spending. Instead, they provide information about evidence-based options that decision makers and stakeholders can consider when determining what best meets the specific needs, preferences, available resources, and constraints of their jurisdictions and constituents. The Task Force's recommendations, along with the systematic reviews of the scientific evidence on which they are based, are compiled in the *Guide to Community Preventive Services (The Community Guide).*

DATES: The meeting will be held on Wednesday, February 24, 2016 from 11:00 a.m. to 4:30 p.m. EST. Participants must pre-register for the meeting by 5 p.m. Monday, February 22, 2016.

Meeting Accessibility: This Task Force meeting will be dedicated entirely to Task Force methods. The meeting will therefore be a one-day session held via webinar rather than the traditional in-person meeting. There will be a 100-participant limit for the Web meeting, provided on a first-come, first-served basis. All participants must register for the meeting by 5 p.m. EST on Monday, February 22, 2016. Participants will receive registration confirmation with meeting instructions within two business days.

FOR FURTHER INFORMATION CONTACT: To register, send an email with name and contact information to Onslow Smith, Center for Surveillance, Epidemiology and Laboratory Services; Centers for Disease Control and Prevention, 1600 Clifton Road NE., MS–E–69, Atlanta, GA 30329. Telephone: (404) 498–6778. Email: *CPSTF@cdc.gov.*

SUPPLEMENTARY INFORMATION:

Purpose: During the February 2016 meeting, the Community Preventive Services Task Force (Task Force) will discuss proposed methods for increasing throughput of Task Force findings (*i.e.,* how to increase the number of Task Force findings that are produced in a given time period), while maintaining adequate quality of the underlying reviews; adequate usefulness for decision makers; and sufficient attention to priority topics.

Matters to be discussed: Community Guide methods and procedures.

Dated: February 4, 2016.

Sandra Cashman,

Executive Secretary, Centers for Disease Control and Prevention.

[FR Doc. 2016–02619 Filed 2–9–16; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Closed-Circuit Escape Respirators; Approval of Cap 3 Device for Underground Coal Mining

AGENCY: National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The National Institute for Occupational Safety and Health (NIOSH) and the Mine Safety and Health Administration (MSHA) have approved the first large-capacity (Cap 3) closed-circuit escape respirator (CCER) for use in underground coal mining, under the NIOSH new regulatory standard. Accordingly, respirator manufacturers may continue to manufacture, label, and sell large-capacity CCERs approved under the former regulatory standard (those CCERs with a rated service time of greater than 50 minutes) for underground coal mining approved under the former regulatory standard until January 4, 2017.

FOR FURTHER INFORMATION CONTACT: David Chirdon, NIOSH National Personal Protective Technology Laboratory (NPPTL), 626 Cochrans Mill Road, Pittsburgh, PA 15236; 412–386–4000 (this is not a toll-free phone number).

SUPPLEMENTARY INFORMATION: In March 2012, the Department of Health and Human Services (HHS) published a final rule establishing a new standard, codified in 42 CFR part 84, subpart O, for the certification of closed-circuit escape respirators (CCERs) by the National Institute for Occupational Safety and Health (NIOSH) within the Centers for Disease Control and Prevention (CDC). The new standard was originally designed to take effect over a 3-year transition period. However, in a final rule published on August 12, 2015, HHS determined that extending the concluding date for the transition was necessary to allow sufficient time for respirator manufacturers to meet the demands of the mining, maritime, railroad, and other industries.[1] Pursuant to the August 2015 final rule, the continued manufacturing, labeling, and selling of CCERs approved under the former standard in Subpart H was authorized until either April 9, 2015 or 1 year after the date that NIOSH first approves a CCER model under the capacity rating categories Cap 1 (for mining applications) and Cap 3 (mining and non-mining) described in 42 CFR 84.304, whichever date came later.

In accordance with 42 CFR 84.301, NIOSH and the Mine Safety and Health Administration (MSHA) have approved the first large-capacity (Cap 3) CCER for use in underground coal mining, under the standards published in 42 CFR part 84, subpart O. Approval number TC–13G–0005 was issued to Ocenco, Inc., on January 4, 2016 for a Cap 3 CCER,

[1] 80 FR 48268.