objectives in Healthy People 2010, an initiative of the U.S. Department of Health and Human Services (HHS). The YRBS provides data to measure at least 10 of the health objectives and 3 of the 10 Leading Health Indicators established by Healthy People 2010. In addition, the YRBS can identify racial and ethnic disparities in health risk behaviors. No other national source of data measures as many of the Healthy People 2010 objectives addressing adolescent behaviors as the YRBS. The data also will have significant implications for policy and program development for school health programs nationwide.

In Spring 2009 and Spring 2011, the YRBS will be conducted among nationally representative samples of students attending public and private schools in grades 9–12. Information supporting the YRBS also will be collected from school administrators and teachers. The table below reports the number of respondents annualized over the 3-year project period.

There are no costs to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Administrators	Recruitment Script for the Youth Risk Behavior Survey.	230	1	30/60	115
Teachers	Data Collection Checklist for the Youth Risk Behavior Survey.	400	1	15/60	100
Students	Youth Risk Behavior Survey	8,000	1	45/60	6,000
Total					6,215

Dated: February 7, 2008.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E8–2832 Filed 2–14–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–08–0337]

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 404–639–5960, send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, 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 Blood Lead Surveillance System (OMB No. 0920–0337)—Revision—National Center for Environmental Health (NCEH), Coordinating Center for Environmental Health and Injury Prevention (CCEHIP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Blood Lead Surveillance System (NBLSS) would like to continue its effort to collect information related to lead exposure among children less than six years old. The overarching goal of this system is to establish Childhood Lead Surveillance Systems at the state and national levels. This is a revision request in addition to a 3-year revision with an increase in the burden hours and inclusion of the adult blood lead surveillance system. As part of this effort we would like to revise this application to include 3 additional State and local Childhood Lead Poisoning Prevention Programs (CLPPP) who report to the NBLSS. These three programs were added to help provide a more comprehensive picture of childhood lead poisoning in the United States.

The objectives for developing this system are three-fold. First, we would like to use surveillance data to estimate the extent of elevated blood-lead levels (BLLs) among children less than 6 years old. This is important because it will allow us to systematically track the management and follow-up of those children found to be poisoned with lead.

Our next objective for the development of this system is to examine potential sources of lead exposure. Although we've been successful in eliminating atmospheric lead with the use of unleaded gasoline and have continued to make strides in the elimination of household sources of lead commonly found in paint and dust, recent events have highlighted other potentially hidden sources of lead. This system will allow us to track the burden of such hidden sources and will help us eliminate such threats with the establishment of laws aimed at preventing the importation of such goods into our nation. The establishment of such laws will of course be a joint effort between several federal agencies; however, this surveillance system will help facilitate our efforts.

The final objective of this system is to facilitate the allocation of resources for lead poison prevention activities. The allocation of federal resources to State surveillance systems are based on reports of blood-lead tests from laboratories. Ideally, laboratories report results of all lead tests to the state health department. State health departments

then send reports to CDC using de-identified data. It is from these reports that CDC is able to determine funding levels.

In addition to reporting child blood lead levels, many laboratories also report adult blood lead levels. Thus, this OMB request would also like to include the Adult Blood Lead Epidemiology and Surveillance Program (ABLES). The ABLES Program is a state-based surveillance system under which participating States provide information to CDC's National Institute for Occupational Safety and Health (NIOSH) on laboratory reported blood lead levels among adults. For all adults (16 and older) the State will provide data on all laboratory reports when the adult's blood lead level is equal to or greater than 25 mcg/dl. These data are to be consolidated into a single data submission by task time periods.

The ABLES program ultimately aims to collect the complete list of variables for all blood lead tests, including blood lead levels less than 25 mcg/dl, and urges all States to progressively supply this information as it becomes available. All data submissions must be delivered in the supplied format providing a field for 20 variables, even if some variables have no data available at the time.

The use of both Childhood Lead Surveillance System and the ABLES Program will allow us to systematically track pockets of exposure to lead. It will also allow us to fully understand exposure potential and ways in which to prevent future sources of lead poisoning. Both systems are invaluable and will no doubt help us as we continue our stride in the elimination of lead poisoning in our nation.

There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN TABLE

Respondents	Number of respondents	Number of response per respondent	Average burden per response (in hrs.)	Total burden hours
State and Local Health Departments for Child Surveillance	42	4	2	336
State and Local Health Departments for Adult Surveillance	40	4	2	320
Total				656

Dated: February 6, 2008.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E8–2836 Filed 2–14–08; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10242, CMS–10165, CMS–10251, CMS–R–218 and CMS–10252]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* New collection; *Title of Information Collection:* Revisions to Payment Policies Under the Physician Fee Schedule, Other Changes to Payment Under Part B, and Revisions to Payment Policies for Ambulance Services for CY 2008 (42 CFR 424.36—Signature Requirements); *Use:* Section 42 CFR 424.33(a)(3) states that all claims must be signed by the beneficiary or the beneficiary's representative (in accordance with 42 CFR 424.36(b)). Section 42 CFR 424.36(a) states that the beneficiary's signature is required on a claim unless the beneficiary has died or the provisions of 424.36(b), (c), or (d) apply. The statutory authority requiring a beneficiary's signature on a claim submitted by a provider is located in section 1835(a) and in 1814(a) of the Social Security Act (the Act), for Part B and Part A services, respectively. The authority requiring a beneficiary's signature for supplier claims is implicit in sections 1842(b)(3)(B)(ii) and in 1848(g)(4) of the Act. Because it is very difficult to obtain a beneficiary's signature (or the signature of a person authorized to sign on behalf of the beneficiary) on a claim when the beneficiary is being transported by ambulance in emergency situations, CMS is proposing that, for emergency ambulance transport services, an ambulance provider or supplier may submit the claim without a beneficiary's signature, as long as certain documentation requirements are met. The information collected will be used by CMS contractors (both, fiscal intermediaries and carriers) that process and pay emergency ambulance transport claims. *Form Number:* CMS–10242 (OMB#: 0938–New); *Frequency:* Reporting: Hourly, Daily, Weekly, Monthly and Yearly; *Affected Public:* Business or other for-profit and Not-for-profit institutions; *Number of Respondents:* 9,000; *Total Annual Responses:* 6,500,000; *Total Annual Hours:* 541,667.

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Electronic Health Record; *Use:* The purpose of this demonstration project is to reward the delivery of high-quality care supported by the adoption and use of electronic health records in small to medium-sized primary care physician practices. While this is separate and distinct from the Medicare Care Management Performance (MCMP) Demonstration, it expands upon the foundation created by the MCMP Demonstration, which was mandated by Section 649 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. The electronic health record demonstration will be operational for a 5-year period and will be operated