ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (hours)
Student Program Participant	Student Outcome Survey Baseline Attachment D.	15,048	1	45/60
Student Program Participant	Student Outcome Survey Mid-Term Attachment F.	14,652	1	45/60
Student Program Participant	Student Outcome Survey Follow-up Attachment E.	14,256	1	45/60
School data extractor	School Indicators Attachment G:	44	342	15/60
Parent Program Participant	Parent Outcome Baseline Survey Attachment H	2,424	1	1
Parent Program Participant	Parent Outcome Follow-up Survey Attachment EEEE.	2,181	1	1
Educator	Educator Outcome Survey Attachment I	1,584	2	30/60
Student Brand ambassador	Brand Ambassador Implementation Survey Attachment J.	80	2	20/60
School leadership	School Leadership Capacity and Readiness Survey Attachment K.	22	1	1
Parent Curricula Implementer	Parent Program Fidelity 6th Grade Session 1–Session 6 Attachment L–Q.	264	3	15/60
Parent Curricula Implementer	Parent Program Fidelity 7th Grade Session 1, 3, 5 Attachment R–T.	132	3	15/60
Student Curricula Implementer	Student Program Fidelity 6th Grade Session 1–Session 6 Attachment U–Z.	924	1	15/60
Student Curricula Implementer	Student Program Fidelity 7th Grade Session 1–Session 7 Attachment AA–GG.	1078	1	15/60
Student Curricula Implementer	Student Program Fidelity 8th Grade Session 1–Session 10 (comprehensive) Attachment HH–QQ.	1540	1	15/60
Communications Coordinator	Communications Campaign Tracking Attachment RR.	4	4	20/60
Local Health Department Representative.	Local Health Department Capacity and Readiness Attachment SS.	16	1	2
Student Program Participant	Student participant focus group guide (time spent in focus group) Attachment ZZ.	80	1	1.5
Student Curricula Implementer	Student curricula implementer focus group guide (time spent in focus group) Attachment AAA.	80	1	1
Parent Curricula Implementer	Parent curricula implementer focus group guide (time spent in focus group) Attachment BBB.	80	1	1
Student Curricula Implementer	Safe Dates 8th Grade Session 1–Session 10 (standard) Attachment CCC–LLL.	1540	1	15/60
Student Master Trainer	Student program master trainer TA form Attachment DDDD.	12	50	10/60

Dated: February 21, 2012.

Kimberly S. Lane,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2012–4561 Filed 2–24–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-12–12EV]

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 404–639–7570 and send comments to Kimberly S. Lane, CDC Reports Clearance Officer, 1600 Clifton Road MS–D74, Atlanta, GA 30333 or send an email 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

Ensuring compliance with the OSHA Bloodborne Pathogens Standard among Non-Hospital Healthcare Facilities—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention estimate that healthcare workers sustain nearly 600,000 percutaneous injuries annually involving contaminated sharps. In

response to both the continued concern over such exposures and the technological developments which can increase employee protection, Congress passed the Needle-stick Safety and Prevention Act directing OSHA to revise the blood borne pathogens (BBP) standard to establish requirements that employers identify and make use of effective and safer medical devices. That revision was published on January 18, 2001, and became effective April 18, 2001.

The revision to OSHA's blood-borne pathogens standard added new requirements for employers, including additions to the exposure control plan and maintenance of a sharps injury log.

OSHA has determined that compliance with these standards significantly reduces the risk that workers will contract a blood-borne disease in the course of their work. However, blood-borne pathogens programs, policies, and standards for health care workers are based primarily on hospital data. Approximately one-half of the 11 million health care workers in the United States are employed in non-hospital-based settings, such as physician offices, home healthcare agencies, correctional facilities, or dental offices and clinics. Little information is known about the risk management practices in these non-hospital settings. A small study conducted by the National Institute for Occupational Safety and Health (NIOSH) found that although seven of the eight correctional health care facilities visited had written exposure control plans, only two were reviewed and updated annually as required by the OSHA BBP Standard. One reason postulated for non-compliance was that hospital-based standards, policies, and programs may not be appropriate to non-hospital settings. It is important to identify effective methods for using exposure control plans in non-hospital settings and to verify whether the specificity and relevance of bloodborne pathogen training and educational materials for non-hospital facilities can positively impact compliance in dental settings.

The purposes of this proposal are to insure that bloodborne pathogens exposure control plans are effectively implemented in private dental offices and dental clinics, an important segment of the non-hospital based healthcare system; and to understand how effective implementation strategies may be applied to other healthcare settings. The proposed work will draw on research-to-practice principles and will be assisted by a strong network of dental professional groups, trade associations, and government agencies. Specific objectives are to:

(1) inventory existing exposure control plans in dental healthcare settings.

(2) determine if the exposure control plan or other resource is actively used to prevent occupational exposures.

(3) determine available resources and barriers to use such as relevant educational materials, knowledge, costs, availability, etc.

(4) develop strategies to overcome key barriers to compliance.

(5) report lessons learned applicable to the entire health sector.

The Organization for Safety, Asepsis and Prevention (OSAP) is a unique group of dental educators and consultants, researchers, clinicians, industry representatives, and other interested persons with a collective mission to be the world's leading advocate for the safe and infection-free delivery of oral care. OSAP supports this commitment to dental workers and the public through quality education and information dissemination. OSAP's unique membership includes the variety of partners critical to gather the data on compliance with the OSHA bloodborne pathogens standard, identify barriers and develop strategies to overcome barriers to compliance.

OSAP will be conducting a Web survey of private dental practices in the United States. Information collected will include current level of existing exposure control plans in various dental healthcare settings; whether the plan or other resource is actively used to prevent occupation exposures; available resources and barriers to use such as relevant education materials, knowledge, costs, and availability. OSAP is working with a publishing partner that has a double-opt-in email distribution list of 45,419 dentists. The dentists in the email list represent every state in the country. The list represents 32% of the total population of working dentists in the United States.

The average open rate for this list is 12.76%, which would represent 5,768 dentists. The targeted number of completed questionnaires is estimated at about 566 (10% participation rate is assumed since there will be an incentive and one reminder). The survey is estimated to take about 10 minutes for respondents to complete.

There are no costs to the respondents other than their time.

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)
Private Dental Practices	BBP Exposure Control Plan Survey	566	1	10/60	94
Total					94

Kimberly S. Lane,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2012–4557 Filed 2–24–12; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–0493]

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 404–639–7570 and send comments to Kimberly Lane, CDC Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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

2013 and 2015 National Youth Risk Behavior Surveys (YRBS)(OMB No. 0920–0493)—Reinstatement with change—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The purpose of this request is to obtain OMB approval to reinstate with change, the data collection for the National Youth Risk Behavior Survey (YRBS), a school-based survey that has been conducted biennially since 1991. OMB approval for the 2009 YRBS and 2011 YRBS expired November 30, 2011 (OMB no. 0920–0493). CDC seeks a three-year approval to conduct the YRBS in Spring 2013 and Spring 2015. Minor changes incorporated into this reinstatement request include: An updated title for the information collection to accurately reflect the years in which the survey will be conducted and minor changes to the data collection instrument.

The YRBS assesses priority health risk behaviors related to the major preventable causes of mortality, morbidity, and social problems among both youth and young adults in the United States. Data on health risk behaviors of adolescents are the focus of approximately 65 national health objectives in Healthy People 2020, an initiative of the U.S. Department of Health and Human Services (HHS). The YRBS provides data to measure 20 of the health objectives and 1 of the Leading Health Indicators established by Healthy People 2020. 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 2020 objectives addressing adolescent health risk behaviors as the YRBS. The data also will have significant implications for policy and program development for school health programs nationwide.

In Spring 2013 and Spring 2015, 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 state-, district-, and school-level 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. The total estimated annualized burden hours are 6,215.

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 (in hours)
State Administrators	State-level Recruitment Script for the Youth Risk Behavior Survey.	17	1	30/60	8
District Administrators	District-level Recruitment Script for the Youth Risk Behavior Survey.	80	1	30/60	40
School Administrators	School-level Recruitment Script for the Youth Risk Behavior Survey.	133	1	30/60	67
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 Burden					6,215

Kimberly Lane,

Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. 2012–4553 Filed 2–24–12; 8:45 am]

BILLING CODE 4163–18–P