EIPs are designed to: (1) Address issues that the EIP network is particularly suited to investigate; (2) maintain sufficient flexibility for emergency response and new problems as they arise; (3) develop and evaluate public health interventions to inform public health policy and treatment guidelines; (4) incorporate training as a key function; and (5) prioritize projects that lead directly to the prevention of disease. Proposed respondents will include state health departments who may collaborate with one or more of the following: academic institutions, local health departments, public health and clinical laboratories, infection control professionals, and healthcare providers. Frequency of reporting will be determined as cases arise. The total estimated burden is 12,153 hours. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS *

Type of respondent	Form name	No. of respondents	No. of responses per respondent	Avg. burden per response (in hours)	Total burden (in hours)
State Health Department	ABCs Case Report Form	10	809	20/60	2697
State Health Department	Invasive Methicillin-resistant *Staphylococcus aureus* ABCs Case Report Form.	10	609	20/60	2030
State Health Department	ABCs Invasive Pneumococcal Disease in Children Case Report Form.	10	41	10/60	68
State Health Department	Neonatal Infection Expanded Tracking Form.	10	37	20/60	123
State Health Department	ABCs Legionellosis Case Report Form.	10	100	20/60	333
State Health Department	Campylobacter	10	637	20/60	2123
State Health Department	Cryptosporidium	10	130	10/60	217
State Health Department	Cyclospora	10	3	10/60	5
State Health Department	Listeria monocytogenes	10	13	20/60	43
State Health Department	Salmonella	10	827	20/60	2757
State Health Department	Shiga toxin producing E. coli	10	90	20/60	300
State Health Department	Shigella	10	178	10/60	297
State Health Department	Vibrio	10	20	10/60	33
State Health Department	Yersinia	10	16	10/60	27
State Health Department	Hemolytic Uremic Syndrome	10	10	60/60	100
State Health Department	All Age Influenza Hospitalization Surveillance Project Case Report Form.	10	400	15/60	1000
Total					12,153

Dated: November 27, 2012.

Ron A. Otten,

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

[FR Doc. 2012–29172 Filed 12–3–12; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day-13–0017]

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 Ron Otten, 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

Application for Training (0920–0017, Expiration 03/31/2013)—Revision—Scientific Education and Professional Development Program Office (SEPDPO), Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC offers public health training activities to professionals worldwide. Employees of hospitals, universities, medical centers, laboratories, State and Federal agencies, and State and local health departments apply for training to learn up-to-date public health practices. CDC's training activities include laboratory training, classroom study, online training, and distance learning. CDC uses two training application forms, the Training and Continuing Education Online New Participant Registration Form and the National Laboratory Training Network Registration Form, to collect information necessary to manage and conduct training pertinent to the agency's mission.

CDC requests OMB approval to continue to collect information through

these forms to (1) grant public health professionals the continuing education (CE) they need to maintain professional licenses and certifications, (2) create a transcript or summary of training at the participant's request, (3) generate management reports, and (4) maintain training statistics; and a revision that will allow CDC to comply with new continuing education accreditation organization requirements for collection of additional profession-specific data.

CDC is accredited by six different continuing education (CE) organizations to award CE: (1) The International Association for Continuing Education and Training (IACET) to provide Continuing Education Units (CEUs), (2) the Accreditation Council for Continuing Medical Education (ACCME) to provide Continuing Medical Education credits (CME), (3) the American Nurses Credentialing Center (ANNC) to provide Continuing Nurse Education credits (CNE), (4) the National Commission for Health Education Credentialing (NCHEC) to award CHES credit, (5) the Accreditation Council for Pharmacy Education (ACPE) to provide continuing pharmacy credit, and (6) the American Association of Veterinary State Boards to award Registry of Approved Continuing Education (RACE) credit. The accrediting organizations require a method of tracking participants who complete an educational activity and demographic data allows CDC to do so. Also, several of the organizations require a permanent record that includes the participant's name, address, and phone number, to facilitate retrieval of historical information about when a participant completed a course or several courses during a time period. This information provides the basis for a transcript or for determining whether a person is enrolled in more than one course. CDC uses the email address to verify the participant's electronic request for transcripts, verify course certificates, and send confirmation that a participant is registered for a course.

Tracking course attendance and meeting accrediting organizations' standards for reporting, require uniform standardized training application forms. The standardized data these forms request for laboratory training, classroom study, online training, and distance learning are not requested elsewhere. In other words, these forms do not duplicate requests for information from participants. Data are collected only once per course or once per new registration. The annual burden table has been updated to reflect an increase in distance learning to 6,792 burden hours; that is an average burden of 5 minutes per respondent. There is no cost to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	No. of respondents	No. of responses per respondent	Avg. burden per response (in hrs)	Total burden (in hrs)
Health Professionals	Training and Continuing Education Online New Participant Registration Form (36.5).	75,000	1	5/60	6,250
Laboratorians	National Laboratory Training Network Registration Form (32.1).	6,500	1	5/60	542
Total					6,792

Dated: November 26, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10418]

Agency Information Collection Activities: Proposed Collection; 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) 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 functions; (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:* Revision of a currently approved collection; *Title of Information Collection:* Annual MLR and Rebate Calculation Report and MLR Rebate Notices; *Use:* Under Section 2718 of the Affordable Care Act and implementing regulation at 45 CFR part 158, a health insurance issuer (issuer) offering group or individual health insurance coverage must submit a report to the Secretary concerning the amount the issuer spends each year on claims, quality improvement expenses, non-claims costs, federal and state taxes and licensing and regulatory fees, and the amount of earned premium. An issuer must provide an annual rebate if the amount it spends on certain costs compared to its premium revenue (excluding federal and states taxes and licensing and regulatory fees) does not meet a certain ratio, referred to as the medical loss ratio (MLR). An interim final rule (IFR) implementing the MLR was published on December 1, 2010 (75 FR 74865) and modified by technical corrections on December 30, 2010 (75 FR 82277), which added part 158 to Title 45 of the Code of Federal Regulations. The IFR was effective January 1, 2011. A final rule regarding selected provisions of the IFR was published on December 7, 2011 (76 FR 76574, CMS–9998–FC) and an interim final rule regarding an issue not included in issuers' reporting obligations (disbursement of rebates by non-federal governmental plans) was also published December 7, 2011 (76 FR 76596, CMS–9998–IFC2) Both rules published on December 7, 2011 and