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 (in hours)
	School Health Education	640	1	20/60	213
	School Physical Education and Activity	640	1	40/60	427
	School Health Services	640	1	50/60	533
	School Nutrition Services	640	1	40/60	427
	School Healthy and Safe School Environment.	640	1	75/60	800
	School Mental Health and Social Services.	640	1	30/60	320
	School Faculty and Staff Health Promotion.	640	1	20/60	213
Classroom teachers	Classroom Health Education	1,229	1	50/60	1024
	Classroom Physical Education and Activity.	1,229	1	40/60	819
	Total				9,558

Kimberly S. Lane,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-13–13IF]

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

Pilot Project to Evaluate the Use of Exposure Control Plans for Bloodborne Pathogens in Private Dental Practices—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 Needlestick Safety and Prevention Act directing the Occupational Safety and Health Administration (OSHA) to revise the Bloodborne 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 BBP 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 bloodborne disease in the course of their work. However, exposure control plans for bloodborne pathogens, policies and standards for healthcare workers are based primarily on hospital data.

Approximately one-half of the 11 million healthcare workers in the United States are employed in non-hospital settings, including physician offices, home healthcare agencies, correctional facilities, and dental offices and clinics. Little information is known about the risk management practices in these non-hospital settings. In a small study conducted by the National Institute for Occupational Safety and Health (NIOSH) found that although seven of the eight correctional healthcare 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 purpose of this proposal is to understand how bloodborne pathogens exposure control plans are implemented in private dental offices, an important segment of the non-hospital based healthcare system. 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 private dental practices;

(2) determine whether 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; and

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

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 healthcare. 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 an inventory of existing exposure control plans; whether the plan or other resource is actively used to prevent occupational exposure to bloodborne pathogens; available resources and barriers to use such as relevant education materials, knowledge, costs, and availability. There are no costs to the respondents other than their time. OSAP is working with a publishing partner that has an email distribution list of 45,419 dentists, representing every state in the country. The list represents nearly one-third (32%) of the total population of working dentists in the United States.

The targeted number of completed questionnaires is estimated at about 22,700 (50% participation rate). The survey is estimated to take about 15 minutes for respondents to complete. This survey completion scenario yields an annualized hour burden estimate of 5,675 hours.

There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Avg. burden per response (in hrs)	Total burden (in hrs)
Private Dental Practices	BBP Exposure Control Plan Survey	22,700	1	15/60	5,675
Total	....	....	....	....	5,675

Kimberly S. Lane,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–13–0041]

Proposed Data Collections Submitted for Public Comment and Recommendations

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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

Registration of individuals with Amyotrophic Lateral Sclerosis (ALS) in the National ALS Registry—Revision—(0923–0041, Expiration 7/31/2013)—Agency for Toxic Substances and Disease Registry (ATSDR), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

On October 10, 2008, President Bush signed S. 1382: ALS Registry Act which amended the Public Health Service Act to provide for the establishment of an Amyotrophic Lateral Sclerosis (ALS) Registry. The activities described are part of the effort to create the National ALS Registry. The purpose of the registry is to: (1) Better describe the incidence and prevalence of ALS in the United States; (2) examine appropriate factors, such as environmental and occupational, that might be associated with the disease; (3) better outline key demographic factors (such as age, race or ethnicity, gender, and family history) associated with the disease; and (4) better examine the connection between ALS and other motor neuron disorders that can be confused with ALS, misdiagnosed as ALS, and in some cases progress to ALS. The registry will collect personal health information that may provide a basis for further scientific studies of potential risks for developing ALS.

After piloting methodology, on October 18, 2010, the Agency for Toxic Substances and Disease Registry (ATSDR) launched the registration component of the National ALS Registry *www.cdc.gov/als.*

The registration portion of the data collection is limited to information that can be used to identify an individual to assure that there are not duplicate records for an individual. Avoiding duplication of registrants due to obtaining records from multiple sources is imperative to get accurate estimates of incidence and prevalence, as well as accurate information on demographic characteristics of the cases of ALS.

In addition to questions required for registration, there are a series of short surveys to collect information on such things as military history, occupations, residential history, and family history that would not likely be available from other sources.