certain circumstances to maintain compliance plans to help ensure their employees do not engage in, or become complicit to, human trafficking in their supply chain, and (iii) establishing requirements for training the Federal acquisition workforce.

For example, E.O. 13627:

- Expressly prohibits Federal contractors, contractor employees, subcontractors and subcontractor employees from (i) failing to disclose basic information or making material misrepresentations regarding the key terms, location, and conditions of employment, (ii) charging employees recruitment fees, (iii) destroying or denying access to an employee's identify documents, and (iv) failing to pay return transportation costs, with certain exceptions, where work is performed outside the United States and the employee is not a national of the country in which the work is taking place and who was brought into that country for the purpose of working on a U.S. Government contract or subcontract;
- Directs that for portions of contract and subcontract work (other than commercially available off-the-shelf items) performed outside the United States where the estimated value of the work performed abroad exceeds $500,000, federal contractors and subcontractors shall maintain an appropriate compliance program during the performance of the contract or subcontract, which shall include: an awareness program for employees, a process for employees to report trafficking-related legal violations, a wage and housing plan in applicable circumstances, and procedures to promote compliance by their subcontractors;
- Requires covered contractors and subcontractors to certify, both before receiving a contract and annually thereafter during the term of the contract or subcontract, to their maintenance of a compliance plan and their lack of engagement in (or remediation and referral of) any trafficking related activities; and
- Directs federal contracting officers to provide notification of trafficking-related violations by contractors or subcontractors to agency Inspectors General and agency officials responsible for suspension and debarment actions.

E.O. 13627 also instructs the Administrator for Federal Procurement Policy to develop guidance to assist agencies in training the Federal acquisition workforce regarding the anti-trafficking obligations of contractors and subcontractors.

Many similar (but not identical) provisions are contained in the ETGCA. In addition, the ETGCA amends title 18 of the United States Code to extend criminal prohibitions against fraudulent labor practices, including trafficking, to contractors and subcontractors overseas. Effective implementation of the trafficking safeguards provided by E.O. 13627 and the ETGCA will increase stability, productivity, and certainty in federal contracting and avoid the disruption and disarray caused by the use of trafficked labor and resulting investigative and enforcement actions.

The FAR Council seeks public comment on the most effective and least burdensome approaches for implementing E.O. 13627 and the ETGCA (which it currently plans to implement through one rulemaking). The input will be considered during the rulemaking process as the FAR Council develops and refines amendments to FAR Subpart 22.7 and other relevant FAR parts to address these actions.

The Council especially welcomes public comment on the following issues:

1. *Focus of guidance.* What requirements do you think are in greatest need of guidance to ensure the goals of E.O. 13627 and the ETGCA are met and what guidance do you recommend?

2. *Contractor practices.* Studies indicate that a number of private sector companies have established, or are in the process of establishing, codes of conduct to eliminate trafficked labor from their supply chains.

a. If you are a contractor, do you already have a code of conduct or plan that addresses trafficked labor? If so, what behavior does it address and what controls does it require? Does your entity perform a significant amount of work overseas? Based on your reading of E.O. 13627 and the ETGCA, what actions do you envision having to take as a government contractor (or subcontractor) beyond what you already are doing to be in compliance with these new requirements?

b. Either based on experience or research of the marketplace, what practices are most effective in prohibiting TIP by contractor and subcontractor employees? What practices will help contractor and subcontractor employees comply with the requirements of E.O. 13627 and the ETGCA?

3. *Oversight.* E.O. 13627 requires federal contractors and subcontractors to allow contracting agencies and other responsible enforcement agencies to have reasonable access to conduct audits, investigations, and other compliance activities. This provision is modeled after a similar requirement in E.O. 13126, which established requirements to ensure that federal agencies do not procure goods made by forced or indentured child labor. Have you had any experiences with the application of audits under E.O. 13126 that the Council should be aware of as it develops its implementing guidance?

4. *Burden considerations.* Both E.O. 13627 and the ETGCA make clear that plans and procedures shall be appropriate to the size and complexity of the contract and to the nature and scope of activities to be performed. As the Council develops regulations to implement this guiding principle and evaluates burden associated with potential guidance, it seek input on the following—

a. What are the types of personnel that you would anticipate being involved in developing and maintaining compliance plans and certifications (*e.g.,* compliance officers, attorneys, human capital specialists)?

b. What do you view to be the most significant drivers of cost in developing and maintaining the plan (*e.g.,* general corporate governance; and

c. What assumptions should the Council make about the amount of labor hours and associated costs required to meet the contractor responsibilities in E.O. 13627 and the law?

Dated: February 6, 2013.

William Clark,

Acting Director, Federal Acquisition Policy Division, Office of Governmentwide Acquisition Policy, Office of Acquisition Policy, Office of Governmentwide Policy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–13–0445]

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 or send

comments to Kimberly Lane, 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

School Health Policies and Practices Study (formerly titled School Health Policies and Programs Study, OMB No. 0920–0445, exp. 9/30/2012)—Reinstatement with Change—Division of Adolescent and School Health (DASH), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention, (CDC).

Background and Brief Description

A limited number of preventable behaviors, usually established during youth and often extended into adulthood, contribute substantially to the leading causes of mortality and morbidity during youth and adulthood. These risk behaviors include those that result in unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual behaviors that contribute to HIV infection, other STDs, and unintended pregnancies; unhealthy dietary behaviors; and physical inactivity.

School-based instruction on health topics offers the most systematic and efficient means of enabling youth people to avoid the health risk behaviors that lead to mortality and morbidity. CDC has previously examined the role schools play in addressing health risk behaviors through the School Health Policies and Programs Study (SHPPS, OMB NO. 0920–0445), a series of data collections conducted at the state, district, school, and classroom levels in 1994 (OMB No. 0920–0340, exp. 1/31/1995), 2000 (OMB No. 0920–0445, exp. 10/31/2002), 2006 (OMB No. 0920–0445, exp. 11/30/2008), and 2012 (OMB No. 0920–0445, exp. 9/30/2012).

CDC plans to reinstate data collection in 2014 and 2016 with changes. SHPPS will assess the characteristics of eight components of school health programs at the elementary, middle, and high school levels: health education, physical education, health services, mental health and social services, nutrition services, healthy and safe school environment, faculty and staff health promotion, and family and community involvement. This data collection will take place at the school- and classroom-levels in 2014 and at the district level in 2016. The school- and classroom-level data collection proposed for 2014 was approved for 2012 but was not conducted because of insufficient funds.

Sixteen questionnaires will be used: seven at the district level, seven at the school level and two at the classroom level. The school- and classroom-level questionnaires will be identical to those approved for data collection in 2012. The district-level questionnaires will include minor modifications to the 2012 questionnaires. For example, question wording will be revised to improve clarity. The school-level data collection also will include vending machine observations, which will yield the only nationally representative dataset of snack and beverage offerings available to students through school vending machines. These observations were a part of the 2012 study protocol but were not conducted because of insufficient funds.

The SHPPS data collection will have significant implications for policy and program development for school health programs nationwide. The results will be used by Federal agencies, state and local education and health agencies, the private sector, and others to support school health programs; monitor progress toward achieving health and education goals and objectives,; develop educational programs, demonstration efforts, and professional education/training; and initiate other relevant research initiatives to contribute to the reduction of health risk behaviors among our nation's youth. SHPPS data also will be used to provide measures for 14 Healthy People 2020 national health objectives. No other national source of data exists for these objectives. The data also will have significant implications for policy and program development for school health programs nationwide.

There are no costs to respondents other than their time.

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 Officials	State Recruitment Script (for 2014 study).	42	1	30/60	21
	State Recruitment Script (for 2016 study).	44	1	30/60	22
District Officials	District Recruitment Script (for 2014 study).	320	1	30/60	160
	District Recruitment Script (for 2016 study).	902	1	60/60	902
	District Health Education	685	1	30/60	343
	District Physical Education and Activity	685	1	40/60	457
	District Health Services	685	1	40/60	457
	District Nutrition Services	685	1	30/60	343
	District Healthy and Safe School Environment.	685	1	60/60	685
	District Mental Health and Social Services.	685	1	30/60	343
	District Faculty and Staff Health Promotion.	685	1	20/60	228
School Officials	School Recruitment Script	821	1	60/60	821

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;