to purchase the Mexican plant, the majority permits Rhodia to acquire additional North American capacity and perhaps ensures that the PPA market will act noncompetitively in the future. In my view, the majority's unwillingness to make a minor correction now could squander a valuable opportunity to protect North American PPA consumers.

[FR Doc. 00–6988 Filed 3–20–00; 8:45 am]

BILLING CODE 6750–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Minority Health; Notice of a Cooperative Agreement With the National Minority AIDS Council

AGENCY: Office of the Secretary, Office of Minority Health, HHS.

ACTION: Notice of a cooperative agreement with the National Minority AIDS Council.

The Office of Minority Health (OMH), Office of Public Health and Science, announces its intent to continue support of the umbrella cooperative agreement with the National Minority AIDS Council (NMAC). This cooperative agreement will continue the broad programmatic framework in which specific projects can be supported by various governmental agencies during the project period.

The purpose of this cooperative agreement is to assist NMAC in expanding and enhancing its activities relevant to HIV prevention, services, treatment, and research in racial and ethnic minority populations, with the ultimate goal of improving the health status of minorities and disadvantaged people.

The OMH will provide technical assistance and oversight as necessary for the implementation, conduct, and assessment of the project activities. On an as-needed basis, OMH will assist in arranging consultation from other government agencies and non-government agencies.

Authority: This cooperative agreement is authorized under Section 1707(e)(1) of the Public Health Service Act, as amended.

Background

Assistance will continue to be provided to NMAC. During the last 3 years, NMAC has successfully demonstrated the ability to work with health agencies on activities relevant to HIV prevention, services, treatment, and research in racial and ethnic minority populations, with the ultimate goal of improving the health status of minorities and disadvantaged people. The NMAC is uniquely qualified to continue to accomplish the purposes of this cooperative agreement because it has the following combination of factors:

- It has developed, expanded, and managed an infrastructure to coordinate and implement various educational programs within local communities and organizations that deal extensively with HIV in each of the four racial and ethnic minority populations served by OMH. The Council established national initiatives, e.g., conferences, public policy education programs (including policy forums), technical assistance programs, and publications (including newsletters, action alerts and training manuals), that provide a foundation upon which to develop, promote, and manage HIV-related education and health related programs aimed at preventing and reducing unnecessary morbidity and mortality rates among racial and ethnic minority populations.
- It has established itself and its members as a national association with professionals who serve as leaders and experts in planning, developing, implementing, promoting, and evaluating HIV-related education and policy campaigns, both nationally and locally, aimed at reducing the impact of HIV in minority communities.
- It has developed a base of critical knowledge, skills, and abilities related to serving minority individuals and organizations with a range of HIV-related health and social problems. Through collective efforts of its members, community-based organizations, and volunteers, NMAC has demonstrated (1) the ability to work with minority and non-minority organizations, the Federal Government, academic institutions, and health groups on mutually beneficial education, research, and health endeavors relating to the goal of health promotion and disease prevention among racial and ethnic minority populations; (2) the national leadership necessary to focus the nation's attention on minority-related HIV issues; and (3) the leadership needed to assist health-care professionals to work more effectively with racial/ethnic minority communities.
- It has developed a national network of individuals; community-based organizations; and state, regional, and national health and civil rights organizations committed to addressing the HIV prevention, service, treatment, and research needs of individuals affected and infected by HIV and AIDS.

This cooperative agreement will be continued for an additional five-year project period with 12-month budget periods. Depending upon the types of projects and availability of funds, it is anticipated that this cooperative agreement will receive approximately $100,000 per year. Continuation awards within the project period will be made on the basis of satisfactory progress and the availability of funds.

Where To Obtain Additional Information

If you are interested in obtaining additional information regarding this cooperative agreement, contact Ms. Cynthia Amis, Office of Minority Health, 5515 Security Lane, Suite 1000, Rockville, Maryland 20852 or telephone (301) 594–0769.

OMB Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance Number for this cooperative agreement is 93.004.

Dated: March 10, 2000.

Nathan Stinson, Jr.,

Deputy Assistant Secretary for Minority Health.

[FR Doc. 00–6896 Filed 3–20–00; 8:45 am]

BILLING CODE 4160–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

Office of Minority Health; Availability of Funds for Grants for the Bilingual/Bicultural Service Demonstration Grant Program

AGENCY: Office of the Secretary, Office of Minority Health.

ACTION: Notice of Availability of Funds and Request for Applications for the Bilingual/Bicultural Service Demonstration Grant Program.

Authority: This program is authorized under section 1707(e)(1) of the Public Health Service Act, as amended by Public Law 105–392.

Purpose

The purpose of this Fiscal Year 2000 Bilingual/Bicultural Service Demonstration Grant Program is to:

(1) Improve and expand the capacity for linguistic and cultural competence of health care professionals and paraprofessionals working with limited-English-proficient (LEP) minority communities; and

(2) Improve the accessibility and utilization of health care services among the LEP minority populations.

These grants are intended to demonstrate the merit of programs that involve partnerships between minority community-based organizations and health care facilities in a collaborative effort to address cultural and linguistic barriers to effective health care service delivery and to increase access to effective health care for the LEP minority populations living in the United States.

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of Healthy People 2010, a PHS-led national activity announced in January 2000 to eliminate health disparities and improve years and quality of life. More information on the Health People 2010 objectives may be found on the Healthy People 2010 web site: *http://www.health.gov/healthypeople.* Copies of the Healthy People 2010: Conference Edition Volumes I and II can be purchased by calling (301) 468–5960 (cost $22.00). Another reference is the *Healthy People 2000 Review–1998–99.* One free copy may be obtained from the National Center for Health Statistics (NCHS), 6525 Belcrest Road, Room 1064, Hyattsville, MD 20782 or telephone (301) 436–8500 (DHHS Publication No. (PHS) 99–1256). This document may also be downloaded from the NCHS web site *http://www.cdc.gov/nchs.*

Background

Large numbers of LEP minorities are linguistically isolated. According to the 1990 U.S. Census, 31.8 million persons or 13 percent of the total U.S. population (ages 5 and above) speak a language other than English at home. Almost 2 million people do not speak English at all and 4.8 million people do not speak English well. The 1990 U.S. Census also found that various minority populations and subgroups are linguistically isolated: approximately 4 million Hispanics; approximately 1.6 million Asians and Pacific Islanders; approximately 282,000 Blacks; and approximately 77,000 Native Americans and Alaska Natives.

Research has suggested that culture provides a unique concept of disease, risk factors, and preventive actions.[1] Definitions of health and illness are often culturally determined and therefore, the study of culture and tradition is a valuable tool in understanding the underlying motives for health behavior.[2] The clients' understanding of the Western health care model and their cultural beliefs, influence their access to health care services, the acceptance of health education, and their compliance with health care advice.

Rural populations must contend with several characteristics that further exacerbate their health care needs. These include an uneven pattern of disease burden and an acute lack of health care resources compared to urban places. A little over 62 percent of all non-metropolitan counties are designated by DHHS as Primary Care Health Professional Shortage Areas.[3]

In FY 1993, the Office of Minority Health (OMH) launched the Bilingual/Bicultural Service Demonstration Grant Program to address the linguistic, cultural and social barriers the LEP minority populations encounter when accessing health services. In addition, the program recognized other factors which contribute to the poor health status of LEP minorities including:

- Inadequate number of health care providers and other health care professionals skilled in culturally competent and linguistically appropriate delivery of services;
- Scarcity of trained interpreters at the community level;
- Deficiency of knowledge about appropriate mechanisms to address language barriers in health care settings;
- Absence of effective partnerships between major mainstream provider organizations and LEP minority communities;
- Geographic isolation;
- Low economic status;
- Lack of health insurance, and
- Organizational barriers.

These barriers continue to impede the LEP populations' ability to access and attain quality health care. Therefore it is essential that care providers, health care professionals and other staff become informed about the diverse linguistic, cultural and medical perspectives of their clientele. Enhancement of cultural competency among these individuals should increase LEP minority populations' knowledge of the Western health care model, and increase their access to and willingness to accept appropriate health care. In FY 2000, the Bilingual/Bicultural program will concentrate on the Health People 2010 Focus Areas, six of which the Surgeon General has identified as priorities: cardiovascular disease, child and adult immunizations, HIV/AIDS, infant mortality, cancer screening and management, and diabetes.

Eligible Applicants

Public and private, nonprofit minority community-based organizations. The minority community-based organization must serve a targeted LEP minority community and have an established linkage with a health care facility. The linkage between the community-based organization and the health care facility must be documented in writing as specified under the project requirements described in this announcement. Local affiliates of national organizations which have an established link with a health care facility are eligible to apply.

National organizations are not eligible to apply. Other non-eligible entities are for-profit hospitals, universities and schools of higher learning. Organizations are not eligible to receive funding from more than one OMH grant program concurrently.

Funding Preference

There are rural areas which have much higher rates of illness and disease than non-rural areas. For instance, infant mortality rates (mirrored by birth weight rates) show a distinct regional distribution with up to 74.1 infant deaths per 1,000 births in rural and frontier counties.[4] Morbidity rates for Hepatitis A and tuberculosis in the Border are much higher than the respective national rates.[5] The OMH recognizes the special needs of minority LEP populations in certain geographic areas. To address these special needs, a preference in funding will be given to applications submitted by minority community-based organizations located in border areas, frontier areas, and rural areas (see the definitions of these areas in this announcement). This preference will only be applies to applications that rank above the 50th percentile of applications recommended for approval by the objective review committee.

Deadline

To receive consideration, grant applications must be received by the OMH Grants Management Office by May 22, 2000. Applications will be considered as meeting the deadline if they are: (1) Received on or before the deadline date, or (2) postmarked on or before the deadline date and received in time for orderly processing. A legibly

[1] Evans, P.E. (1988) Minorities and AIDS. Health Education Research, Vol 3, No. 1, pp 113–115

[2] Toumishey, H. (1993), Multicultural Health Care: An Introductory Course. In R. Masi, L. Mensah, & K. McLeod (eds.), Health and Cultures: Exploring the Relationships, pp 113–138. Mosaic Press, Ontario, Canada

[3] North Carolina Rural Health Research and Policy Analysis Center (1998), The University of North Carolina at Chapel Hill in Mapping Rural Health: The Geography of Health Care and Health Resources in Rural America.

[4] *Ibid.*

[5] Border Issues (updated April 1997); United States-Mexico Chamber of Commerce web site *http://www.usmcoc.org/borderl.html.*

dated receipt from a commercial carrier or U.S. Postal Service will be accepted in lieu of a postmark. Private metered postmarks will be accepted as proof of timely mailing. Applications submitted by facsimile transmission (FAX) or any other electronic format will not be accepted. Applications which do not meet the deadline will be considered late and will be returned to the applicant unread.

Addresses/Contacts

Applications must be prepared using Form PHS 5161–1 (Revised June 1999). Application kits and technical assistance on budget and business aspects of the application may be obtained from Ms. Carolyn A. Williams, Grants Management Officer, Division of Management Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, Maryland 20852, telephone (301) 594–0758. Completed applications are to be submitted to the same address.

Questions regarding programmatic information and/or requests for technical assistance in the preparation of grant applications should be directed to Ms. Cynthia H. Amis, Director, Division of Program Operations, Office of Minority Health, Rockwall II Building, Suite 1000, 5515 Security Lane, Rockville, Maryland 20852, telephone number (301) 594–0769.

Technical assistance is also available through the OMH Regional Minority Health Consultants (RMHCs). A listing of the RMHCs and how they may be contacted will be provided in the grant application kit. Additionally, applicants can contact the OMH Resource Center (OMHRC) at 1–800–444–6472 for health information.

Availability of Funds

Approximately $1.5 million is available for award in FY 2000. It is projected that awards of up to $150,000 total costs (direct and indirect) for a 12-month period will be made to approximately 10 to 12 competing applicants.

Period of Support

The start date for the Bilingual/Bicultural Service Demonstration Program grants is September 30, 2000. Support may be requested for a total project period not to exceed 3 years. Noncompeting continuation awards of up to $150,000 will be made subject to satisfactory performance and availability of funds.

Definitions

For purposes of this grant announcement, the following definitions apply:

Border Area—The area lying 100 kilometers (62 miles) to the north of the 3,141 kilometer (1,952 mile) U.S.-Mexico boundary (as defined in Article 4 of the La Paz Agreement between the U.S. and the United Mexican States, entered into force February 16, 1984).

Community-Based Organization—Public and private, nonprofit organizations which are representative of communities or significant segments of communities, and which address health and human services.

Cultural Competency—a set interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs, and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other supports. (Orlandi, Mario A., 1992.)

Health Care Facility—a public nonprofit facility that has an established record for providing comprehensive health care services to a targeted, LEP racial/ethnic minority community. Facilities providing only screening and referral activities are not included in this definition. A health care facility may be a hospital, outpatient medical facility, community health center, migrant health center, or a mental health center.

Frontier Area—an area (borough, county or parish) with 6 or fewer persons per square mile.

Limited-English-Proficient Populations (LEP)—individuals (as defined in Minority Populations below) with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in and benefit from any aid, service or benefit provided by the health provider.

Minority Community-Based Organization—a public or private nonprofit community-based minority organization or a local affiliate of a national minority organization that has: a governing board composed of 51 percent or more racial/ethnic minority members, a significant number of minorities employed in key program positions, and an established record of service to a racial/ethnic minority community.

Minority Populations—American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, and Native Hawaiian or other Pacific Islander. (Revision to the Standards for the Classification of Federal Data on Race and Ethnicity, Federal Register, Vol. 62, No. 210, pg. 58782, October 30, 1997)

Rural Area—a borough, county or parish with a population less than 50,000 that is not included in a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget.

Project Requirements

Each project funded under this demonstration grant must address all of the following requirements.

1. Address at least one, but no more than three of the health focus areas referenced in the Background section of this announcement.

2. Carry out activities to improve and expand the capacity of health care providers and other health care professionals to deliver linguistically and culturally competent health care services to the target population. Potential activities may include: language and cultural competency training and curricula development; health promotion or health service access information in the native language of the target population; on-site interpretation services; or training products such as CD–ROMs, video tapes, or on-line distance based learning formats for continuing education.

3. Carry out activities to improve access to health care for the LEP population. Potential activities may include those that will: Educate the target population on the importance of health promotion and disease prevention; enhance the ability of the target population to communicate their health care concerns to health care providers; increase their understanding of health education information; and improve compliance with health care treatments. The applicant may utilize culturally and/or linguistically appropriate information or methods of communication, such as printed materials with pictorial messages, mass media, public service announcements and neighborhood outreach as educational tools. Forums, seminars or workshops to promote information exchange among the targeted LEP population and the health care professionals may also be considered activities for the education of both groups.

4. Have an established, formal linkage between the minority community-based organization and a health care facility,

prior to submission of an application. The linkage must be confirmed by a signed agreement between the applicant organization and the health care facility which specifies in detail the roles and resources that each entity will bring to the project, and state the duration and terms of the linkage. The document must be signed by individuals with the authority to represent the organization (*e.g.,* president, chief executive officer, executive director).

Use of Grant Funds

Budgets of up to $150,000 total cost (direct and indirect) per year may be requested to cover costs of: personnel, consultants, supplies (including screening and outreach supplies), equipment, and grant-related travel. Funds may not be used for medical treatment, construction, building alterations, or renovations. All budget requests must be fully justified in terms of the proposed goals and objectives and include a computational explanation of how costs were determined.

Criteria for Evaluating Applications

Review of Applications: Applications will be screened upon receipt. Those that are judged to be incomplete, non-responsive to the announcement or nonconforming will be returned without comment. Each organization may submit no more than one proposal under this announcement. If an organization submits more than one proposal, all will be deemed ineligible and returned without comment. Accepted applications will be reviewed for technical merit in accordance with PHS policies. Applications will be evaluated by an Objective Review Panel chosen for their expertise in minority health and their understanding of the unique health problems and related issues confronted by the racial/ethnic minority populations in the United States.

Applicants are advised to pay close attention to the specific program guidelines and general and supplemental instructions provided in the application kit.

Application Review Criteria: The technical review of applications will consider the following generic factors:

Factor 1: Background (15%)

Adequacy of: Demonstrated knowledge of the problem at the local level; demonstrated need within the proposed community and target population; demonstrated support and established linkage(s) in order to conduct the proposed model; and extent and documented outcome of past efforts and activities with the target population.

Factor 2: Objectives (15%)

Merit of the objectives, their relevance to the program purpose and stated problem, and their attainability in the stated time frames.

Factor 3: Methodology (35%)

Appropriateness of proposed approach and specific activities for each objective. Logic and sequencing of the planned approaches in relation to the objectives and program evaluation. Soundness of the established linkages.

Factor 4: Evaluation (20%)

Thoroughness, feasibility and appropriateness of the evaluation design, and data collection and analysis procedures. Potential for replication of the project for similar target populations and communities.

Factor 5: Management Plan (15%)

Applicant organization's capability to manage and evaluate the project as determined by: the qualification of proposed staff or requirements for ''to be hired'' staff; proposed staff level of effort; management experience of the lead agency; and experience of each member of the linkage as it relates to its defined roles and the project.

Award Criteria

Funding decisions will be determined by the Deputy Assistant Secretary of Minority Health, Office of Minority Health, and will take under consideration: the recommendations and ratings of the review panel; the funding preference; geographic and racial/ethnic distribution; and health problem areas having the greatest impact on minority health. Consideration will be given to projects proposed to be implemented in Empowerment Zones and Enterprise Communities.

Reporting and Other Requirements

General Reporting Requirements

A successful applicant under this notice will submit: (1) Bi-annual progress reports; (2) an annual Financial Status Report, and (3) a final progress report and final Financial Status Report in the format established by the Office of Minority Health, in accordance with provisions of the general regulations which apply under ''Monitoring and Reporting Program Performance,'' 45 CFR Part 74, Subpart J.

Provision of Smoke-Free Workplace and Nonuse of Tobacco Products by Recipients of PHS Grants

The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and to promote the nonuse of all tobacco products. In addition, Public Law 103–227, the Pro-Children Act of 1994, prohibits smoking in certain facilities (or in some cases, any portion of a facility) in which regular or routine education, library, day care, health care or early childhood development services are provided to children.

Public Health System Reporting Requirements

This program is subject to Public Health Systems Reporting Requirements. Under these requirements, a community-based nongovernmental applicant must prepare and submit a Public Health System Impact Statement (PHSIS). The PHSIS is intended to provide information to State and local health officials to keep them apprised of proposed health services grant applications submitted by community-based nongovernmental organizations within their jurisdictions.

Community-based, nongovernmental applicants are required to submit, no later than the Federal due date for receipt of the application, the following information to the head of the appropriate state and local health agencies in the area(s) to be impacted: (a) a copy of the face page of the applications (SF 424), (b) a summary of the project (PHSIS), not to exceed one page, which provides: (1) A description of the population to be served, (2) a summary of the services to be provided, (3) a description of the coordination planned with the appropriate State or local health agencies. Copies of the letters forwarding the PHSIS to these authorities must be contained in the application materials submitted to the Office of Minority Health.

State Reviews

This program is subject to the requirements of Executive Order 12372 which allows States the option of setting up a system for reviewing applications from within their States for assistance under certain Federal programs. The application kit to be made available under this notice will contain a listing of States which have chosen to set up a review system and will include a State Single Point of Contact (SPOC) in the State for review. Applicants (other than federally recognized Indian tribes) should contact their SPOCs as early as

possible to alert them to the prospective applications and receive any necessary instructions on the State process. For proposed projects serving more than one State, the applicant is advised to contact the SPOC of each affected State. The due date for State process recommendations is 60 days after the application deadline by the Office of Minority Health's Grants Management Officer. The Office of Minority Health does not guarantee that it will accommodate or explain its responses to State process recommendations received after that date. (See ''Intergovernmental Review of Federal Programs,'' Executive Order 12372, and 45 CFR Part 100 for a description of the review process and requirements.)

OMB Catalog of Federal Domestic Assistance

The OMB Catalog of Federal Domestic Assistance Number for the Bilingual and Bicultural Service Demonstration Program is 93.105.

Dated: March 14, 2000.

Nathan Stinson, Jr.,

Deputy Assistant Secretary for Minority Health.

[FR Doc. 00–6897 Filed 3–20–00; 8:45 am]

BILLING CODE 4160–17–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Notice of Meeting

In accordance with section 10(d) of the Federal Advisory Committee Act as amended (5 U.S.C., Appendix 2), the Agency for Healthcare Research and Quality (AHRQ) announces a meeting of a scientific peer review group. The subcommittee listed below is part of the Agency's Health Services Research Initial Review Group.

The subcommittee meeting will be closed to the public in accordance with the Federal Advisory Committee Act, section 10(d) of 5 U.S.C., Appendix 2 and 5 U.S.C., 552b(c)(6). Grant applications are to be reviewed and discussed at this meeting. These discussions are likely to reveal personal information concerning individuals associated with the applications. This information is exempt from mandatory disclosure under the above-cited statutes.

1. *Name of Subcommittee:* Health Care Research Training

Date: April 13, 2000 (Open from 10 a.m. to 10:15 a.m. and closed for remainder of the meeting)

Place: AHRQ, Executive Office Center, 6010 Executive Boulevard, 4th Floor Conference Center, Rockville, Maryland 20852

Contact Person: Anyone wishing to obtain a roster of members or minutes of the meetings should contact Ms. Jenny Griffith, Committee Management Officer, Office of Research Review, Education and Policy, AHRQ, 2101 East Jefferson Street, Suite 400, Rockville, Maryland 20852, Telephone (301) 594–1847.

Agenda items for these meetings are subject to change as priorities dictate.

Dated: March 13, 2000.

John M. Eisenberg,

Director.

[FR Doc. 00–6964 Filed 3–20–00; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Toxic Substances and Disease Registry

[ATSDR–157]

Public Health Assessments Completed

AGENCY: Agency for Toxic Substances and Disease Registry (ATSDR), Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: This notice announces those sites for which ATSDR has completed public health assessments during the period from October through December 1999. This list includes sites that are on or proposed for inclusion on the National Priorities List (NPL), and also includes sites for which assessments were prepared in response to requests from the public.

FOR FURTHER INFORMATION CONTACT: Robert C. Williams, P.E., DEE, Assistant Surgeon General, Director, Division of Health Assessment and Consultation, Agency for Toxic Substances and Disease Registry, 1600 Clifton Road, NE., Mailstop E–32, Atlanta, Georgia 30333, telephone (404) 639–0610.

SUPPLEMENTARY INFORMATION: The most recent list of completed public health assessments was published in the **Federal Register** on January 11, 2000, (65 FR1637). This announcement is the responsibility of ATSDR under the regulation, Public Health Assessments and Health Effects Studies of Hazardous Substances Releases and Facilities (42 CFR Part 90). This rule sets forth ATSDR's procedures for conducting public health assessments under section 104(i) of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), as amended by the Superfund Amendments and Reauthorization Act (SARA) (42 U.S.C. 9604(i)).

Availability

The completed public health assessments and addenda are available for public inspection at the Division of Health Assessment and Consultation, Agency for Toxic Substances and Disease Registry, Building 33, Executive Park Drive, Atlanta, Georgia (not a mailing address), between 8 am and 4:30 pm, Monday through Friday except legal holidays. The completed public health assessments are also available by mail through the U.S. Department of Commerce, National Technical Information Service (NTIS), 5285 Port Royal Road, Springfield, Virginia 22161, or by telephone at (703) 605–6000. NTIS charges for copies of public health assessments and addenda. The NTIS order numbers are listed in parentheses following the site names.

Public Health Assessments Completed or Issued

Between, October 1 and December 31 1999, public health assessments were issued for the sites listed below:

NPL Sites

Georgia

Camilla Wood Preserving Company—(a/k/a Escambia Treating Company Incorporated)—Camilla—(PB20–103266).

Illinois

Depue/Jersey Zinc/Mobil Chemical Corporation—Depue—(PB20–102450). Evergreen Manor Groundwater Contamination Plume—Roscoe—(PB20–102849). Savanna Army Depot Activity—Savanna—(PB20–102850).

Iowa

Iowa Army Ammunition Plant—Middletown—(PB20–102851).

Maryland

Fort George G. Meade—Fort Meade—(PB20–101390).

Michigan

West Beitz Creek Fill Area—(a/k/a Marshall Elementry School)—Livonia—(PB20–101391).

New Jersey

Fort Dix (Landfill Site)—Wrightstown—(PB20–100618).