annually from 1973 to 1981, again in 1985, and resumed as an annual survey in 1989. The survey is directed by CDC, National Center for Health Statistics, Division of Health Care Statistics. The purpose of NAMCS is to meet the needs and demands for statistical information about the provision of ambulatory medical care services in the United States. Ambulatory services are rendered in a wide variety of settings, including physicians' offices and hospital outpatient and emergency departments. The NAMCS target population consists of all office visits made by ambulatory patients to non-Federal office-based physicians (excluding those in the specialties of anesthesiology, radiology, and pathology) who are engaged in direct patient care. To complement these data, NCHS initiated the National Hospital Ambulatory Medical Care Survey (NHAMCS, OMB No. 0920–0278) to provide data concerning patient visits to hospital outpatient and emergency departments.

The NAMCS provides a range of baseline data on the characteristics of the users and providers of ambulatory medical care. Data collected include the patients' demographic characteristics, reason(s) for visit, physicians' diagnosis, diagnostic services, medications and visit disposition. In addition to the annual statistics normally collected, a key focus of the 2005–2006 survey will be on the prevention and treatment of selected chronic conditions. These data, together with trend data, may be used to monitor the effects of change in the health care system, provide new insights into ambulatory medical care, and stimulate further research on the use, organization, and delivery of ambulatory care.

Users of NAMCS data include, but are not limited to, congressional and other federal government agencies, state and local governments, medical schools, schools of public health, researchers, administrators, and health planners. NAMCS plans to extend its data collection into 2005 and 2006. To calculate the burden hours the number of respondents for NAMCS is based on a sample of 3,000 physicians with a 50 percent participation rate (this includes physicians who are out-of-scope as well as those who refuse). The estimated annualized burden is 5,875 hours.

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response
Physician Eligible	Induction Interview-eligible Physician	2,250	1	35/60
Physician Ineligible	Induction Interview-ineligible Physician	750	1	5/60
Physician/Non-physician Staff	Patient Record Form	2,250	30	4/60

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Bill J. Atkinson,

Acting Director, Management Analysis and Services Office Centers for Disease Control And Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–42–04]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 498–1210. Send written comments to CDC, Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project: Delayed Symptoms Associated with the Convalescent Period of a Dengue Infection—New—National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC). Dengue is a vector-borne febrile disease of the tropics transmitted most often by the mosquito Aedes aegypti. Symptoms of the acute disease include fever, headache, rash, retro-orbital pain, myalgias, arthralgias, vomiting, abdominal pain and hemorrhagic manifestations.

Many symptoms are mentioned in the medical literature as associated with the convalescent period (three-eight weeks) after dengue infection, including depression, dementia, loss of sensation, paralysis of lower and upper extremities and larynx, epilepsy, tremors, manic psychosis, amnesia, loss of visual acuity, hair loss, and peeling of skin. No epidemiologic study has been conducted to define the timing, frequency, and risk factors for these symptoms. The objective of this study is to examine the incidence and characteristics of mental health disorders and other delayed complications associated with dengue infection and convalescence. The study will be conducted in Puerto Rico, where dengue is endemic and causes severe sporadic epidemics. Laboratory positive confirmed cases of dengue, laboratory negative suspected dengue cases, and neighborhood controls will be prospectively enrolled in the study. Person-to-person interviews with adults (age 18 years or greater), will be conducted and information will be collected regarding symptoms experienced during the convalescent phase of the infection. The estimated annualized burden is 400 hours

Respondents	Number of respondents	Number of responses per respondent	Averge burden per response (in hrs.)
Laboratory positive confirmed dengue	200	2	20/60
Dengue negative control	200	2	20/60
Neighborhood control	200	2	20/60

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[30Day–45–04]

Proposed Data Collections Submitted for Public Comment and Recommendations

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Proposed Project: Coal Workers' X-ray Surveillance Program (CWXSP), OMB No. 0920–0020—Extension—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background

The CWXSP is a federally mandated program under the Federal Mine Safety and Health Act of 1977, PL–95–164. The Act provides the regulatory authority for the administration of the CWXSP, a surveillance program to protect the health and safety of underground coal miners. This Program requires the gathering of information from coal mine operators, participating miners, participating x-ray facilities, and participating physicians. The Appalachian Laboratory for Occupational Safety and Health (ALOSH), located in Morgantown, WV, is charged with administration of this Program. The estimated annualized burden is 1246 hours.

Respondents	Form name and no.	Number of respondents	Number of responses/respondent	Average burden/response (in hrs)
Physicians (B Readers)	Roentgen graphic Interpretation Form CDC/NIOSH (M)2.8.	5,000	1	3/60
Miners	Miner Identification Document CDC/NIOSH (M)2.9.	2,500	1	20/60
Coal Miners Operators	Coal Mine Operator's Plan-CDC/NIOSH (M)2.10.	200	1	30/60
Supervisors at X-ray Facilities	Facility Certifications Document-CDC/NIOSH (M)2.11.	25	1	30/60
Physicians (B Readers)	Interpreting Phisician Certification Document CDC/NIOSH (M)2.12.	300	1	10/60

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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[30Day–40–04]

Proposed Data Collections Submitted for Public Comment and Recommendations

The Centers for Disease Control and Prevention (CDC) publishes a list of information collection requests under review by the Office of Management and Budget (OMB) in compliance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). To request a copy of these requests, call the CDC Reports Clearance Officer at (404) 498–1210. Send written comments to CDC, Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project: Travelers' Health Survey, OMB No. 0920–0519—Reinstatement—National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC). Approximately 58 million Americans travel abroad each year, and over a third travel to developing countries where the risk is greater for contracting infectious diseases. Many of these diseases are preventable through vaccines, drugs, and other preventive measures. According to surveillance data from the CDC, over 99% of malaria, 72% of typhoid, and 7% of hepatitis A cases in the U.S. are acquired abroad. Information on preventing illness during travel is available free or at little cost through public health departments, a CDC toll-free fax system, and the Internet. However, many travelers may be unaware of the health risks they face when traveling because they either lack access to pre-travel health services or do not understand the measures necessary to avoid health risks. Evidence shows first- and second-generation U.S. immigrants that travel to their countries of origin to visit friends and relatives may be at a greater risk for contracting infectious diseases.

The objectives of this project are to determine: (i) Whether travelers seek pre-travel health information; (ii) where they access this information; (iii) travelers' baseline knowledge of prevention measures for diseases commonly associated with travel; and (iv) whether specific groups of travelers (*i.e.* first- and second-generation immigrants) lack information on or access to pre-travel health recommendations and services. To accomplish these objectives, in partnership with Delta Airlines, CDC proposes to conduct voluntary, self-administered, anonymous, in-flight surveys of U.S. citizens and residents traveling abroad to areas where malaria, typhoid fever, and hepatitis A are endemic.

This preliminary project will focus on first- and second-generation U.S. immigrants from India visiting friends and relatives in India, where all three diseases are endemic. A study period of 2 to 3 months is estimated. Data from this project will fulfill Healthy People