testimony (no more than 1–2 pages in length) can be submitted to Marietta Squire at *marietta.squire@cdc.hhs.gov,* phone: 301–458–4524. In order for written testimony to be included in the meeting summary, it must be submitted by April 30, 2009.

Additional program information as well as summaries of meetings and a roster of Committee members may be obtained from Marjorie S. Greenberg, Executive Secretary, NCVHS, National Center for Health Statistics, Centers for Disease Control and Prevention, 3311 Toledo Road, Room 2402, Hyattsville, Maryland 20782, telephone (301) 458–4245.

Should you require reasonable accommodation, please contact the CDC Office of Equal Employment Opportunity on (301) 458–4EEO (4336) as soon as possible.

Dated: April 16, 2009.

James Scanlon,

Acting Assistant Secretary for Planning and Evaluation, Office of the Assistant Secretary for Planning and Evaluation.

[FR Doc. E9–9219 Filed 4–21–09; 8:45 am]

BILLING CODE 4151–05–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60-Day–09–09BL]

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 404–639–5960 and send comments to Maryam I. Daneshvar PhD, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an e-mail 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

The Epidemiology and Impact of Workplace Violence in Pennsylvania Teachers and Paraprofessionals—NEW—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Workplace violence (WPV) is a significant concern for employers and employees alike; every year in the U.S., WPV results in hundreds of deaths, nearly two million nonfatal injuries, and billions of dollars in costs. Historically, the education field has not been the focus of WPV research; however, the classroom is a workplace too. From 1999 to 2003, teachers were the victims of approximately 183,000 nonfatal crimes including 119,000 thefts and 65,000 violent crimes such as rape and assault.

Workplace violence is not limited to physical attacks; verbal threats, bullying, and harassment also produce psychological harm to teachers and school staff. A newer form of such violence is that of electronic aggression. The CDC defines the problem as: ''Any type of harassment or bullying (teasing, telling lies, making fun of someone, making rude or mean comments, spreading rumors, or making threatening or aggressive comments) that occurs through e-mail, a chat room, instant messaging, a Web site (including blogs) or text messaging.'' While a recent study found that 35% of young people had been the victims of electronic aggression, the impact of this in the workplace is relatively unknown. The extant evidence indicates that working in a school environment carries an excess risk for becoming a victim of some form of WPV; however, little is known about the incidence or risk factors for such.

The Occupational Safety and Health Act, Public Law 91–596 (section 20[a][1]) authorizes the National Institute for Occupational Safety and Health (NIOSH) to conduct research to advance the health and safety of workers. NIOSH is conducting a population-based, cross-sectional survey among teachers and paraprofessionals in the state of Pennsylvania. The goals of this study are (1) Estimate the number and prevalence proportions (rates) of physical, non-physical, and electronic WPV in teachers and paraprofessionals; (2) Identify the circumstances and most common risk factors for physical, non-physical, and electronic WPV in teachers and paraprofessionals; (3) Measure the impact of WPV on job satisfaction and quality of life.

NIOSH is proposing to conduct a population-based, cross-sectional survey among teachers and paraprofessionals in the state of Pennsylvania. Paper-and-pencil surveys will be mailed to potential participants through the Pittsburgh Federation of Teachers (PFT), Philadelphia Federation of Teachers (PA–AFT), and the Pennsylvania State Education Association (PSEA). Since approximately 90% of teachers and 65% of paraprofessionals in the state of Pennsylvania hold membership in one of these three unions and no known state-wide database exists that includes both teachers and paraprofessionals, a sample of eligible participants will be drawn using state-based union records.

A stratified random sample will be drawn to ensure representativeness on important dimensions such as gender of participant and urban-rural status of the school district. In conjunction with each participating union, study packets consisting of an introduction letter, paper-and-pencil survey, and non-response form will be mailed to eligible participant's home addresses. The questionnaire is a paper-and-pencil survey and provides information on the following categories: demographics, occupation, physical assault characteristics, non-physical assault characteristics, electronic aggression characteristics, job satisfaction, and quality of life.

The sample size for the cross-sectional survey is estimated to be approximately 6,450 teachers and paraprofessionals. This estimate is based on the number of reported teachers and paraprofessionals represented by the three unions participating in this study and on an 80% response rate that is comparable to the response rate of previously conducted surveys in similar populations. Pilot test data demonstrates that respondents should take approximately 30 minutes to complete the paper-and-pencil survey, resulting in an annualized burden estimate of 3,225 hours. Participation in the study is completely voluntary.

Once the study is completed, NIOSH will provide a copy of the final report to each participating union.

There are no costs to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Teachers & Support Personnel	6,450	1	0.5	3,225
Total				3,225

Dated: April 15, 2009.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Office of the Chief Science Officer, Centers for Disease Control and Prevention.

[FR Doc. E9–9156 Filed 4–21–09; 8:45 am]

BILLING CODE P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–09–0571]

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 404–639–5960 or send comments to Maryam I. Daneshvar, CDC Acting Reports Clearance Officer, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an e-mail 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

Minimum Data Elements (MDEs) for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP)—Extension—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Many cancer-related deaths in women could be avoided by increased utilization of appropriate screening and early detection tests for breast and cervical cancer. Mammography is extremely valuable as an early detection tool because it can detect breast cancer well before the woman can feel the lump, when the cancer is still in an early and more treatable stage. Similarly, a substantial proportion of cervical cancer-related deaths could be prevented through the detection and treatment of precancerous lesions. The Papanicolaou (Pap) test is the primary method of detecting both precancerous cervical lesions as well as invasive cervical cancer. Mammography and Pap tests are underused by women who have no source or no regular source of health care and women without health insurance.

Despite the availability and increased use of effective screening and early detection tests for breast and cervical cancers, the American Cancer Society (ACS) estimated that 182,460 new cases of breast cancer would be diagnosed among women in 2008, and that 40,480 women would die of this disease. The ACS also estimated that 11,070 new cases of invasive cervical cancer would be diagnosed in 2008, and that 3,870 women would die of this disease.

The CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) provides screening services to underserved women through cooperative agreements with 50 States, the District of Columbia, 5 U.S. Territories, and 12 American Indian/Alaska Native tribal programs. The program was established in response to the Breast and Cervical Cancer Mortality Prevention Act of 1990. Screening services include clinical breast examinations, mammograms and Pap tests, as well as timely and adequate diagnostic testing for abnormal results, and referrals to treatment for cancers detected. Awardees collect patient level screening and tracking data to manage the program and clinical services. A de-identified subset of data on patient demographics, screening tests and outcomes are reported by each awardee to CDC twice per year in the Minimum Data Elements (MDE) OMB No. 0920–0571, exp. 1/31/2010). Burden to respondents was significantly reduced in 2008 when the annual requirement to report infrastructure information (System for Technical Assistance Reporting, STAR), previously associated with collection of MDE information, was discontinued.

CDC plans to request OMB approval to collect MDE information for an additional three years. Because awardees already collect and aggregate data at the state, territory and tribal level, the additional burden of submitting data to CDC will be small. CDC will use the information to monitor and evaluate NBCCEDP awardees; improve the availability and quality of screening and diagnostic services for underserved women; develop outreach strategies for women who are never or rarely screened for breast and cervical cancer, and report program results to Congress and other legislative authorities. There are no costs to respondents other than their time.