

cycles; select external AAMC reviewers for the competitive sub-awards review process; select an internal AAMC staff member (who is experienced in working with RCR activities and academic societies) to participate in the review of proposals; make sub-award selections; announce the results of the sub-awards competitive review; disperse sub-award funds; and review reports from the sub-awardees. The AAMC will also prepare and submit a final report to ORI evaluating the short-term implementation of the program. As it has done this during the current project period, the AAMC will assist the ORI in efforts to nurture the process of institutionalization of RCR into the infrastructure of biomedical and behavioral academic societies as part of its commitment to educating researchers which is central to the educational mission of the AAMC.

FOR FURTHER INFORMATION CONTACT: Carolyn R. Fassi, MPH, DPA, Director, ORI RCR Program for Academic Societies, Division of Education and Integrity, Office of Research Integrity, Suite 750, 1101 Wootton Parkway, Rockville, MD 20852; or call Dr. Carolyn Fassi at (301) 443-5300.

Dated: August 26, 2003.
Chris B. Pascal,
Director, Office of Research Integrity.
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-02-112]

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 the CDC Reports Clearance Officer at (404) 639-7090.

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. Send comments to Seleda Perryman, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: Weekly Morbidity and Mortality Reports and Annual Morbidity Series—OMB #0920-0007—Extension—Epidemiology Program Office (EPO), Centers for Disease Control and Prevention (CDC). In 1878, Congress authorized the U. S. Marine Hospital Service (later renamed the U.S. Public Health Service (PHS) to collect morbidity reports on cholera, smallpox, plague, and yellow fever from U.S. consuls overseas; this information was to be used for instituting quarantine measures to prevent the introduction and spread of these diseases into the United States. In 1879, a specific Congressional appropriation was made for the collection and publication of reports of these notifiable diseases. Congress expanded the authority for weekly reporting and publication in 1893 to include data from state and municipal authorities throughout the United States. To increase the uniformity of the data, Congress enacted a law in 1902 directing the Surgeon General of the Public Health Service (PHS) to provide forms for the collection and compilation of data and for the publication of reports at the national level.

Reports on notifiable diseases were received from very few states and cities prior to 1900, but gradually more states submitted monthly and annual summaries. In 1912, state and territorial health authorities—in conjunction with PHS—recommended immediate telegraphic reports of five diseases and monthly reporting by letter of 10 additional diseases, but it was not until after 1925 that all states reported

regularly. In 1942, the collection, compilation, and publication of morbidity statistics, under the direction of the Division of Sanitary Reports and Statistics, PHS, was transferred to the Division of Public Health Methods, PHS.

A PHS study in 1948 led to a revision of the morbidity reporting procedures, and in 1949 morbidity reporting activities were transferred to the National Office of Vital Statistics. Another committee in PHS presented a revised plan to the Association of State and Territorial Health Officers (ASTHO) at its meeting in Washington, DC, October 1950. ASTHO authorized a Conference of State and Territorial Epidemiologists (CSTE) for the purpose of determining the diseases that should be reported by the states to PHS. Beginning in 1951, national meetings of CSTE were held every two years until 1974, then annually thereafter.

In 1961, responsibility for the collection of data on nationally notifiable diseases and deaths in 122 U.S. cities was transferred from the National Office of Vital Statistics to CDC. For 37 years the Morbidity and Mortality Weekly Report (MMWR) has consistently served as CDC premier communication channel for disease outbreaks and trends in health and health behavior. In collaboration with the Council of State and Territorial Epidemiologists (CSTE), CDC has demonstrated the efficiency and effectiveness of computer transmission of data. The data collected electronically for publication in the MMWR provides information which CDC and State epidemiologists use to detail and more effectively interrupt outbreaks. Reporting also provides the timely information needed to measure and demonstrate the impact of changed immunization laws or a new therapeutic measure. Users of data include, but are not limited to, congressional offices, state and local health agencies, health care providers, and other health related groups.

The dissemination of public health information is accomplished through the MMWR series of publications. The publications consist of the MMWR, the CDC Surveillance Summaries, the Recommendations and Reports, and the Annual Summary of Notifiable Diseases. There are no costs to respondents.

Type of respondents	Number of respondents	Frequency of response	Average time of response	Annual hour burden
State and Local Health Departments	179	52	30/60	4,654

Type of respondents	Number of respondents	Frequency of response	Average time of response	Annual hour burden
Total				4, 654

Dated: August 25, 2003.

Nancy E. Cheal,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention.

[FR Doc. 03-22101 Filed 8-28-03; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Government-Owned Inventions; Availability for Licensing and Cooperative Research and Development Agreements (CRADAs)

AGENCY: Centers for Disease Control and Prevention (CDC), Technology Transfer Office, Department of Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The invention named in this notice is owned by agencies of the United States Government and is available for licensing in the United States (U.S.) in accordance with 35 U.S.C. 207, and is available for cooperative research and development agreements (CRADAs) in accordance with 15 U.S.C. 3710, to achieve expeditious commercialization of results of federally funded research and development. U.S. and foreign patent applications are expected to be filed in the near future to extend market coverage for U.S. companies and may also be available for licensing.

ADDRESSES: Licensing and CRADA information, and information related to the technology listed below, may be obtained by writing to Suzanne Seavello Shope, J.D., Technology Licensing and Marketing Scientist, Technology Transfer Office, Centers for Disease Control and Prevention (CDC), Mailstop K-79, 4770 Buford Highway, Atlanta, GA 30341, telephone (770) 488-8613; facsimile (770) 488-8615; or e-mail sshlope@cdc.gov. A signed Confidential Disclosure Agreement (available under Forms at <http://www.cdc.gov/tto>) will be required to receive copies of unpublished patent applications and other information.

Occupational Safety

Air Sampler for Collecting Airborne Pollutants in a Micro Centrifuge Tube for Molecular Analysis

Occupational exposure to small particles, such as fungal spores, bacteria, dust, *etc.*, is of concern in a number of places that exhibit air quality problems, for example, school buildings and agricultural settings. The conventional approach for assessing human exposure to bioaerosols has been to take samples using filters, impingers, or impactors and then perform laboratory analyses, which could be directly counting the organisms or indirectly counting their colony-forming units. While these methods provide reasonably adequate assessment in bioaerosol concentration, they are time-consuming and sometimes take days or even weeks to conduct the analysis. In addition, although the health consequence is evident, there has been difficulty in establishing exposure-response relationship because of the poor correlation between measured biomass and recorded health effect. Recent attention paid to indoor air quality, biological warfare and terrorist attacks has revealed a need for highly specific and sensitive techniques, such as immunoassays and polymerase chain reactions (PCR), for detecting a variety of air pollutants. However, there is a lack of sampling devices that could provide adequate sampling of airborne pollutants and match these advanced analytical techniques.

Researchers at NIOSH have evaluated sampling techniques matched to the analytical procedures used in PCR, immunoassays, and other procedures, and developed a personal sampler for collecting airborne pollutants. Preliminary data have demonstrated an excellent aspiration and collection efficiency for the sampler. It is the intent that use of this sampler would solve the technical compatibility problem between sampling and analyzing as well as allow sample analysis without the need for sample extraction which is required by most current air sampling methods. In turn, the whole scheme of sampling and analysis would help enhance the assessment of exposure to airborne pollutants.

Inventors: The-hsun "Bean" Chen *et al.*

U.S. Patent Application SN: Not yet filed.

(CDC Ref. #: I-020-03).

Dated: August 25, 2003.

Joseph R. Carter,

Deputy Chief Operating Officer, Centers for Disease Control and Prevention (CDC).

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS-1537, CMS-R-200, CMS-10094 and CMS-R-247]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare and Medicaid Services.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration (CMS)), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Reinstatement, with change, of a previously approved collection for which approval has expired; *Title of Information Collection:* Medicare/Medicaid Hospital Surveyor's Worksheet Form and Supporting Regulations in 42 CFR 488.26 and 442.30; *Form No.:* CMS-1537 (OMB #0938-0382); *Use:* Section 1861(e) of the Social Security Act (the Act) provides that hospitals participating in