additional information required in the Percentage of Labor/Parts and the Systems Covered/Duration sections of the Buyers Guide, will depend on whether the dealer uses a manual or automated process or Buyers Guides that are pre-printed with the dealer's standard warranty terms. Staff estimates that these tasks will take an average of one additional minute, *i.e.,* cumulatively, an average total time of three minutes for each used car sold under warranty.

Staff estimates that approximately fifty percent of used cars sold by dealers are sold "as is," with the other half sold under warranty. Therefore, staff estimates that the overall time required to enter data on Buyers Guides consists of 408,856 hours for used cars sold without a warranty (24,531,374 vehicles × 50% × 2 minutes per vehicle) and 613,284 hours for used cars sold under warranty (24,531,374 vehicles × 50% × 3 minutes per vehicle) for a cumulative estimated total of 1,022,140 hours.

3. Displaying Buyers Guides on Vehicles: Although the time required to display the Buyers Guides on each used car may vary substantially, FTC staff estimates that dealers will spend an average of 1.75 minutes per vehicle to match the correct Buyers Guide to the vehicle and to display it on the vehicle. The estimated burden associated with this task is approximately 715,498 hours for the 24,531,374 vehicles sold in 2009 (24,531,374 vehicles × 1.75 minutes per vehicle).

4. Revising Buyers Guides as Necessary: If negotiations between the buyer and seller over warranty coverage produce a sale on terms other than those originally entered on the Buyers Guide, the dealer must revise the Buyers Guide to reflect the actual terms of sale. According to the original rulemaking record, bargaining over warranty coverage rarely occurs. Staff notes that consumers often do not need to negotiate over warranty coverage because they can find vehicles that are offered with the desired warranty coverage online or in other ways before ever contacting a dealer. Accordingly, staff assumes that the Buyers Guide will be revised in no more than two percent of sales, with an average time of two minutes per revision. Therefore, staff estimates that dealers annually will spend approximately 16,354 hours revising Buyers Guides (24,531,374 vehicles × 2% × 2 minutes per vehicle).

5. Spanish Language Sales: The Rule requires that contract disclosures be made in Spanish if a sale is conducted in Spanish.[6] The Rule permits displaying both an English and a Spanish language Buyers Guide to comply with this requirement.[7] Many dealers with large numbers of Spanish-speaking customers likely will post both English and Spanish Buyers Guides to avoid potential compliance violations.

Calculations from United States Census Bureau surveys indicate that approximately 6.5 percent of the United States population speaks Spanish at home, without also speaking fluent English.[8] Staff therefore projects that approximately 6.5 percent of used car sales will be conducted in Spanish. Dealers will incur the additional burden of completing and displaying a second Buyers Guide in 6.5 percent of sales assuming that dealers choose to comply with the Rule by posting both English and Spanish Buyers Guides. The annual hours burden associated with completing and posting Buyers Guides is 1,737,638 hours (1,022,140 hours for entering data on Buyers Guides plus 715,498 hours for displaying Buyers Guides). Therefore, staff estimates that the additional burden caused by the Rule's requirement that dealers display Spanish language Buyers Guides when conducting sales in Spanish is 112,947 hours (1,737,638 hours × 6.5%). The other components of the annual hours burden, *i.e.,* purchasing Buyers Guides and revising them for changes in warranty coverage, remain unchanged.

Estimated annual cost burden: $26,301,525 in labor costs and $4,906,275 in non-labor costs.

1. Labor costs: Labor costs are derived by applying appropriate hourly cost figures to the burden hours described above. Staff has determined that all of the tasks associated with ordering forms, entering data on Buyers Guides, posting Buyers Guides on vehicles, and revising them as needed, including the corresponding tasks associated with Spanish Buyers Guides, are typically done by clerical or low-level administrative personnel. Using a clerical cost rate of $13.32 per hour[9] and an estimated burden of 1,974,589 hours for disclosure requirements, the total labor cost burden would be approximately $26,301,525.

2. Capital or other non-labor costs: Although the cost of Buyers Guides can vary considerably, based on industry input staff estimates that the average cost of each Buyers Guide is twenty cents. The estimated cost of Buyers Guides for the 24,531,374 used cars sold by dealers in 2009 is approximately $4,906,275. In making this estimate, staff conservatively assumes that all dealers will purchase preprinted forms instead of producing them internally, although dealers may produce them at minimal expense using current office automation technology. Capital and start-up costs associated with the Rule are minimal.

David C. Shonka,

Acting General Counsel.

[FR Doc. 2010–33110 Filed 12–30–10; 8:45 am]

BILLING CODE 6750–01–P

[6] 16 CFR 455.5.

[7] *Id.*

[8] U.S. Census Bureau, Table S1601. Language Spoken at Home. 2008 American Community Survey 1-Year Estimates, available at: *http://factfinder.census.gov/servlet/STTable?_bm=y&-qr_name=ACS_2008_1YR_G00_S1601&-geo_id=01000US&-ds_name=ACS_2008_1YR_G00_&-_lang=en&-redoLog=false&-CONTEXT'st.* The table indicates that 12.2% of the United States population 5 years or older speaks Spanish or Spanish Creole in the home and 46.7% of these in-home Spanish speakers speak English less than "very well."

[9] The hourly rate is based on Bureau of Labor Statistics estimate of the mean hourly wage for office clerks, general. Occupational Employment and Wages, May 2009, available at *http://www.bls.gov/oes/current/oes439061.htm#nat.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the Advisory Committee on Minority Health; Correction

AGENCY: Office of Minority Health, Office of the Assistant Secretary for Health, Office of the Secretary, Department of Health and Human Services.

ACTION: Notice: Correction.

SUMMARY: The Department of Health and Human Services published a notice in the **Federal Register** of December 21, 2010 announcing a meeting of the Advisory Committee on Minority Health. It was announced that this meeting would be held on Monday, January 10, 2011 from 9 a.m. to 5 p.m. and Tuesday, January 11, 2011 from 9 a.m. to 1 p.m. Due to unforseen circumstances the meeting date has been changed.

FOR FURTHER INFORMATION CONTACT: Ms. Monica A. Baltimore, Phone: 240–453–2882 Fax: 240–453–2883.

Correction

In the **Federal Register** of December 21, 2010, Vol. 75, No. 244, on page 80055, in the 2nd column, correct the **DATES** caption to read:

The meeting will be held on Monday, February 21, 2011 from 9 a.m. to 5 p.m. and Tuesday, February 22, 2011 from 9 a.m. to 1 p.m.

Dated: December 28, 2010.

Mirtha Beadle,

Deputy Director, Office of Minority Health, Office of the Assistant Secretary for Health, Office of the Secretary, U.S. Department of Health and Human Services.

[FR Doc. 2010–33084 Filed 12–30–10; 8:45 am]

BILLING CODE 4150–29–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–11–11BM]

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 Carol E. Walker, Acting CDC 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

Healthcare System Surge Capacity at the Community Level—New—National Center for Emerging and Zoonotic Infectious Diseases, (NCEZID), Centers for Disease Control and Prevention, (CDC).

Background and Brief Description

The Healthcare Preparedness Activity, Division of Healthcare Quality Promotion (DHQP) at the Centers for Disease Control and Prevention (CDC) works with other Federal agencies, State governments, medical societies and other public and private organizations to promote collaboration amongst healthcare partners, and to integrate healthcare preparedness into Federal, State and local public health preparedness planning. The goal of the Activity is to help local communities' healthcare delivery and public health sectors effectively and efficiently prepare for and respond to urgent and emergent threats.

Surge is defined as a marked increase in demand for resources such as personnel, space and material. Health care providers manage both routine surge (predictable fluctuations in demand associated with the weekly calendar, for example) as well as unusual surge (larger fluctuations in demand caused by rarer events such as pandemic influenza). Except in extraordinary cases, providers are expected to manage surge while adhering to their existing standards for quality and patient safety. Currently, health care organizations are expected to prepare for and respond to surges in demand ranging from a severe catastrophe (for example, a nuclear detonation) to more common, less severe events (for example, a worse-than-usual influenza season). The Centers for Disease Control and Prevention (CDC) and Federal agencies have dedicated considerable funding and technical assistance towards developing and coordinating community-level responses to surges in demand, but it remains a difficult task.

While there is extensive research on managing collaborations during times of extraordinary pressure where response to surge takes precedence over other activities, less is known about developing and maintaining integrated collaborations during periods where the system must respond to unusual surge but also continue the routine provision of health care. In particular, studies have not explored how these collaborations can build on sustainable relationships between a broad range of stakeholders (including primary care providers) in communities with different market structures and different degrees of investment in public health.

This study aims to generate information about the role of community-based collaborations in disaster preparedness that the CDC can use to develop its programs guiding and supporting these collaborations. This project will explore barriers and facilitators to coordination on surge response in ten communities, eight of which have been studied longitudinally since the mid-1990s as part of the Center for Studying Health System Change's (HSC's) Community Tracking Study (CTS). Interviews of local healthcare stakeholders will be conducted at 10 sites.

Interviews will be conducted at a total of 63 organizations over the two years of this project. Within each of the ten communities studied, two emergency practitioner respondents (one from a safety-net hospital and one from a non-safety-net hospital), two primary care providers (one from a large practice and one from a small practice) and two local preparedness experts (one from the County or local public health agency, and one coordinator or collaboration leader) will be interviewed. In three sites (Phoenix, Greenville and Seattle) an additional respondent will be identified from an outlying rural area to offer the perspective of providers in those communities. There is no cost to respondents except their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondent category	Number of respondents	Number of responses per respondent	Average burden response (in hours)	Total burden (in hours)
Emergency Department: Private, non-safety net	10	1	1	10
Emergency Department: Public/safety net	10	1	1	10
Primary Care: Larger practice	10	1	1	10
Primary Care: Solo/2 physician practice	10	1	1	10
Preparedness: Public/Department of Health	10	1	1	10
Preparedness: Health care preparedness coordinator/collaboration leader	10	1	1	10
Rural (Greenville, Phoenix, Seattle only: Clinician-leader at rural site (ED or PC)	3	1	1	3