them to be critical users in their approach and application of the data.

Similar methodology has been adopted by other federal agencies, as well as by academic and commercial survey organizations. There are no costs to respondents other than their time. The total estimated annual burden hours are 9450.

ESTIMATED ANNUALIZED BURDEN HOURS

Projects	Number of respondents	Responses per respondent	Average burden per response (in hours)
QDRL Interviews	9000	1	1
Focus groups	300	1	1.5

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Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–12–0828]

Agency Forms Undergoing Paperwork Reduction Act Review

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) 639–7570 or send an email to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

National Adult Tobacco Survey (NATS)—Reinstatement with Changes—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC) and the Center for Tobacco Products (CTP), Food and Drug Administration (FDA).

Background and Brief Description

Tobacco use remains the leading preventable cause of disease and death in the United States, resulting in approximately 440,000 deaths annually. Smokers die an average of 14 years earlier than nonsmokers. Moreover, cigarette smoking costs more than $193 billion; $97 billion in lost productivity plus $96 billion in health care expenditures.

With passage of the Family Smoking Prevention and Tobacco Control Act (Tobacco Control Act) in 2009, the FDA is legally mandated to regulate tobacco products for the protection of public health. Such authority involves considering whether the marketing of tobacco products might encourage people who don't use tobacco products to begin using them, to encourage people who might otherwise quit to continue using tobacco, or to encourage former users to relapse.

In order to ensure that FDA is in compliance with the Tobacco Control Act's mandate to protect the public health, annual data collection is needed at least initially to monitor the benefits and potential adverse consequences of FDA's regulatory actions, as the regulatory framework is being established. As novel tobacco products are introduced onto the market, the FDA must regularly monitor patterns of all tobacco product usage—not just cigarettes—to identify changes in susceptibility and rates of tobacco use initiation, perceptions regarding tobacco use, and rates of tobacco use cessation.

Rather than develop a completely new system to monitor measures critical to FDA, and thereby increasing burden to the population, FDA has partnered with CDC to leverage the existing NATS system. While NATS has been re-designed to meet the critical data needs of the FDA, many of the measures are relevant to CDC's National Tobacco Control Program (NTCP), and CDC also will use the NATS data to evaluate the NTCP. Many of the NATS questions reflect CDC's key outcome indicators for evaluating tobacco control programs.

CDC proposes to conduct three annual cycles of the NATS to collect data necessary to evaluate the effectiveness of FDA's initial regulatory actions. The NATS will be a stratified, random-digit dialed telephone survey of non-institutionalized adults 18 years of age and older. To yield results that are representative nationally, information will be collected from 56,250 landline respondents and 18,750 cell phone respondents who do not have a landline to include the growing population of households that exclusively use cell phones and would be missed in a survey relying only on land-lines. To obtain the target number of completed telephone interviews, approximately 166,000 respondents will be contacted for initial eligibility screening and consent.

The burden per response for the proposed NATS remains the same by design as the 2009/2010 NATS. However, the number of respondents is smaller because the current NATS seeks to develop national estimates, whereas the 2009/2010 NATS sought to develop state-level estimates. Therefore, the total respondent burden for the new NATS cycle is substantially lower than the prior NATS. The 2009/2010 NATS involved a total respondent burden of 38,303 hours. The revised 2012/2013 NATS involves a total respondent burden of 29,850 hours, which amounts to 8,453 fewer hours, or 22.1% fewer hours, than the 2009/2010 NATS.

Results will have significant implications for the development and periodic adjustment of policies and programs aimed at preventing and reducing tobacco use in the United States.

Participation in the NATS is voluntary. There are no costs to respondents except their time. The total estimated annualized burden hours are 29,850.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Adults ages 18 or older	Screener for land-line users (pp. 3–8 of the NATS)	125,000	1	2/60
	Screener for cell phone users (pp. 9–11 of the NATS)	41,000	1	1/60
	National Adult Tobacco Survey for landline users (pp. 12–end of the NATS).	56,250	1	20/60
	National Adult Tobacco Survey for cell phone users (pp. 12–end of the NATS).	18,750	1	20/60

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Deputy Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–12JF]

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 404–639–7570 and send comments to Kimberly Lane, at CDC, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email 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

Returning our Veterans to Employment and Reintegration (ROVER)-New-National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

NIOSH, under Public Law 91–596, Sections 20 and 22 (Section 20–22, Occupational Safety and Health Act of 1970) has the responsibility to conduct research relating to innovative methods, techniques, and approaches dealing with occupational safety and health problems.

Reintegrating Post-9/11 Veterans into civilian life and employment is complicated by recent exposure to war zone stressors (e.g., combat, bombs, improvised explosive devices, injury and death of military personnel and civilians) and development of clinical disorders, such as posttraumatic stress disorder (PTSD) and depression. PTSD, for example, is typified by such symptoms as re-experiencing war zone stressors (*e.g.,* distracting intrusive thoughts and images, disturbing nightmares); hyper-arousal (*e.g.,* intense startle response, poor concentration and memory, constantly being on-guard, disturbed sleep, high irritability); and avoidance of people (family, friends, co-workers), places (such as enclosed areas, crowds), and things (e.g., loud noises, certain sights and smells) that remind one of war zone stressors. Such symptoms can have a significant impact on the ability of a Veteran to work in a setting with features such as other people, enclosed work areas, constant movement and noise, tasks that require concentration to details or safety issues, and stress related to requests and feedback of supervisors or task speed and accuracy. An approach for helping Veterans with PTSD and other psychiatric impairments is that of using service dogs for assistance and support.

Although there is significant interest in service dogs for Veterans to aid in readjustment, the focus has not been on employment. Although a service-dog program ''feels good'' and has face validity, there is a resounding lack of empirical evidence documenting whether the provision of service dogs is of therapeutic benefit for persons with PTSD—other than the generally accepted positive effects of human-animal companionship. For example, a descriptive review of the pet-facilitated therapy (PFT) literature by Brodie and Biley (1999) presages a more substantive review by Nimer and Lundahl (2007) in finding multiple studies with poor research designs and other methodological problems that made it hard for those authors to draw firm conclusions. Even where studies focused on ''psychological'' outcomes, these tended to be self-report measures of such constructs as stress, relaxation, loneliness, and morale. Some impact on the behavior of children was noted; standard measures of clinical disorders (e.g., depression, anxiety) were not noted.

Nimar and Lundahl (2007) conducted a meta-analysis of the animal-assisted therapy (AAT) literature; that is, studies examining the incorporation of animals in treatment plans. Over 250 studies were located, but only 49 (20%) met the criteria of sufficient statistical information to estimate effect sizes. Most of the studies utilized dogs with children with behavior problems or developmental disorders, or adults with chronic mental disorders, such as dementia or schizophrenia. None of the studies specifically included Veterans, and none focused on the work setting (although several looked at animals as an adjunct to occupational therapy). The overall effect size for the impact of AAT was considered to be ''moderate,'' with no differential effects related to the population receiving AAT—a positive point when considering extending this work to Veterans. Most of the outcomes were focused on emotional well-being, but there were positive findings for an impact on behavioral problems (mostly with children). In general, the literature is problematic for the lack of