The Prevention Research Center Information System will collect in electronic format: (a) Data needed to measure progress toward, or achievement of, newly developed performance indicators, (b) information on Prevention Research Centers that is currently being reported in hard-copy documents, and (c) data on research projects that are currently submitted electronically via a spreadsheet.

In 1984, Congress passed Public Law 98–551 directing the Department of Health and Human Services (DHHS) to establish Centers for Research and Development of Health Promotion and Disease Prevention. In 1986, CDC was given lead responsibility for this program, referred to now as the Prevention Research Centers program. Currently, CDC provides funding to 28 Prevention Research Centers (PRCs) selected through competitive peer review process and managed as CDC cooperative agreements. Awards are made for five (5) years and may be renewed through a competitive RFA process. PRCs (which can be housed in a school of public health, medicine, or osteopathy) conduct multi-disciplinary, community-based, outcomes-oriented research on a broad range of topics related to health promotion and disease prevention.

In spring 2003, CDC published RFA #04003 (FY20004–20009) for the Prevention Research Centers program. The RFA introduces a set of performance indicators that have developed collaboratively with the PRCs and other program stakeholders and are consistent with federal requirements that all agencies, in response to the Government Performance and Results Act of 1993, prepare performance plans and collect program-specific performance measures.

An Internet-based information system will allow CDC to monitor, and report on, PRC activities more efficiently. Data reported to CDC through the PRC information system will be used by CDC to identify training and technical assistance needs, monitor compliance with cooperative agreement requirements, evaluate the progress made in achieving center-specific goals, and obtain information needed to respond to Congressional and other inquiries regarding program activities and effectiveness.

There are no costs to respondents.

Respondents	No. of respondents	No. of responses per respondent	Average burden per response (in hrs.)	Total burden (in hrs.)
Clerical	28	2	164/60	153
Directors	28	2	90/60	84
Total				237

Dated: August 18, 2003.

Nancy E. Cheal,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–61–03]

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

School Associated Violent Death Surveillance System—New—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

The Division of Violence Prevention (DVP), National Center for Injury Prevention and Control (NCIPC) proposes to develop a system for the surveillance of school-associated homicides and suicides. The system will rely on existing public records and interviews with law enforcement officials and school officials. The purpose of the system is to (1) estimate the rate of school-associated violent death in the United States and (2) identify common features of school-associated violent deaths. The proposed system will contribute to the understanding of fatal violence associated with schools, guide further research in the area, and help direct ongoing and future prevention programs.

Violence is the leading cause of death among young people, and increasingly recognized as an important public health and social issue. In 1998, over 3,500 school aged children (5 to 18 years old) in the United States died violent deaths due to suicide, homicide, and unintentional firearm injuries. The vast majority of these fatal injuries were not school associated. However, whenever a homicide or suicide occurs in or around school, it becomes a matter of particularly intense public interest and concern. NCIPC conducted the first scientific study of school-associated violent deaths during the 1992–99 academic years to establish the true extent of this highly visible problem.

Despite the important role of schools as a setting for violence research and prevention interventions, relatively little scientific or systematic work has been done to describe the nature and level of fatal violence associated with schools. Until NCIPC conducted the first nationwide investigation of violent deaths associated with schools, public health and education officials had to rely on limited local studies and estimated numbers to describe the extent of school-associated violent death.

The proposed system will draw cases from the entire United States in attempting to capture all cases of school-associated violent deaths that have occurred. Investigators will review public records and published press reports concerning each school-associated violent death. For each identified case, investigators will also interview an investigating law enforcement official (defined as a police officer, police chief, or district attorney), and a school official (defined as a school principal, school superintendent, school counselor, school teacher, or school

support staff) who are knowledgeable about the case in question. Researchers will request information on both the victim and alleged offender(s)—including demographic data, their academic and criminal records, and their relationship to one another. They will also collect data on the time and location of the death; the circumstances, motive, and method of the fatal injury; and the security and violence prevention activities in the school and community where the death occurred, before and after the fatal injury event. The total burden hours are estimated to be 70.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hrs.)
School Officials	35	1	1
Police Officials	35	1	1

Dated: August 18, 2003.

Nancy E. Cheal,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day–65–03]

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: Levels of Selected Drinking Water Disinfection By-products in Whole Blood after Showering: The Effect of Genetic Polymorphisms—NEW—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Chlorine is the most commonly used chemical for disinfecting U.S. water supplies; however, chlorine reacts with organic compounds in the water to produce halogenated hydrocarbon by-products. Exposure to these disinfection by-products(DBPs) has been associated with liver and bladder cancer in humans and is suspected of other adverse health outcomes. We recently completed a study of household exposure to one class of DBPs in tap water, trihalomethanes (THMs) (Backer *et al.*, 2000). We found an increase in whole blood levels of one class of (THMs) after people showered or bathed in tap water. We also found that the increases fell roughly into two groups; one group was clustered around a higher level, the other a lower level. It is possible that this clustering is the result of individual variations in physiological characteristics or it could be the result of differences in the ability to metabolize THMs.

Since several polymorphically expressed enzymes are linked to the metabolism of DBPs, these physiologic and genetic differences may be important in determining an individual's risk for cancer and other health risks associated with exposure to these compounds. We plan to measure the change in blood concentration of DBPs after showering. We will then examine the association between people with different enzyme variants and post-exposure blood THM levels. The study will be conducted in two parts. Part 1 will involve recruiting 250 volunteers who do not have a history of lung problems and who are willing to participate in all aspects of the study. These 250 will be asked to provide some demographic information. They will also provide a buccal cell sample that will be analyzed in order to find a pool of 100 volunteers who have the genetic polymorphisms of interest. Part 2 will involve the 100 study subjects giving three blood samples before and three blood samples after taking a shower. A urine sample will be collected and stored for future use in evaluating urine levels of haloacetic acids (HAAs), another important class of drinking water DBPs. Air and water samples will also be collected.

Subjects will complete a brief questionnaire in order to obtain personal information that might impact the dose of volatized DBPs they receive. This data will be analyzed to determine whether the physiologic and genetic differences among individuals result in differences in blood THM levels after similar exposure. There are no costs to respondents.

Respondents	No. of respondents	No. of responses/respondent	Avg. burden/response (in hours)
Screening Interview	250	1	20/60
Consent Form	100	1	20/60
Questionnaire	100	1	20/60
Blood Samples	100	6	5/60
Shower	100	1	20/60
Urine Sample	100	2	10/60
Tap Water Sample	100	1	10/60
Misc. Study Activities	100	1	40/60
Remain at Study Site	100	1	2