and third leading causes of death, respectively, in the 1–34 year old age group. Unfortunately, public health agencies don't know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, *e.g.* those in Morbidity and Mortality Weekly Report, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and Federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides. The FBI's Supplemental Homicide Report system (SHRs) does collect basic information about the victim-suspect relationship and circumstances, like death certificates, it does not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10–20 percent of police departments nationwide do not participate. The FBI's National Incident Based Reporting System (NIBRS) addresses some of these deficiencies, but it covers less of the country than SHRs, still includes only homicides, and collects only police information. Also, the Bureau of Justice Statistics Reports do not use data that is less than two years old.

CDC therefore proposes to start a state-based surveillance systems for violent deaths that will provide more detailed and timely information. It will tap into the case records held by medical examiners/coroners, police, and crime labs. Data will be collected centrally by each state in the system, stripped of identifiers, and then sent to the CDC. Information will be collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States will use standardized data elements and software designed by CDC. Ultimately, this information will guide states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.5 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

The number of state health departments to be funded may be as high as 14 once FY03 cooperative agreements are awarded. Six states were funded thru FY02 cooperative agreements, and up to 8 more may be funded in 2003. NCIPC hopes to eventually fund all 50 states. Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. There are 50,000 such deaths annually among U.S. residents, so the average state will experience approximately 1,000 such deaths each year.

Respondents	Number of respondents	Number of responses/ respondent	Average burden/response (in hours)	Total burden (in hours)
State Health Departments	14	1,000	150/60	35,000
Total				35,000

Dated: March 13, 2003.

Thomas Bartenfeld,

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

[FR Doc. 03–6871 Filed 3–21–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–03–51]

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 on (404) 498–1210.

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 Anne O'Connor, 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: Centers for Disease Control and Prevention's Performance Evaluation Program for Mycobacterium Tuberculosis and Non-Tuberculosis Mycobacterium (NTM) Drug Susceptibility Testing—New—Public Health Practice Program Office (PHPPO), Centers for Disease Control and Prevention (CDC).

As part of the continuing effort to support both domestic and global public health objectives for treatment of tuberculosis (TB), prevention of multi-drug resistance and surveillance programs, the Division of Laboratory Systems seeks to collect information from domestic private clinical and public health laboratories twice per year. Participation and information collections from international laboratories will be limited to those

which have public health responsibilities for tuberculosis drug susceptibility testing and approval by their national tuberculosis program. While the overall number of cases of TB in the U.S. has decreased, rates still remain high among foreign-born persons, prisoners, homeless populations, and individuals infected with HIV in major metropolitan areas. The rate of TB cases detected in foreign-born persons has been reported to be almost nine times higher than the rate among the U.S. born population. CDC's goal to eliminate TB will be virtually impossible without considerable effort in assisting heavy disease burden countries in the reduction of tuberculosis. The M. tuberculosis/NTM program supports this role by monitoring the level of performance and practices among laboratories performing M. tuberculosis susceptibility within the U.S. as well as internationally to ensure high-quality laboratory testing, resulting in accurate and reliable results.

Information collected in this program will include the susceptibility test results of primary and secondary drugs, concentrations, and test methods performed by laboratories on a set of challenge isolates sent twice yearly.

A portion of the response instrument will collect demographic data such as laboratory type and the number of tests performed annually. By providing an evaluation program to assess the ability of the laboratories to test for drug resistant M. tuberculosis and selected strains of NTM, laboratories will also have a self-assessment tool to aid in maximizing their skills in susceptibility testing. Information obtained from laboratories on susceptibility testing practices and procedures will assist with determining variables related to good performance, with assessing areas for training and with developing practice standards. There is no cost to respondents.

Respondents	Number of respondents	Number of responses per respondenst	Average Burden per response (in hours)	Total burden (in hours)
XXXX	165	30	30/60	82.5
YYYY	165	30	30/60	82.5
Total				165

Dated: March 12, 2003.

Thomas Bartenfeld,

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

[FR Doc. 03–6872 Filed 3–21–03; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Disease, Disability, and Injury Prevention and Control Special Emphasis Panel: Occupational Safety and Health Research, SOH Conflict Review, Program Announcement #99–143

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following meeting:

Name: Disease, Disability, and Injury Prevention and Control Special Emphasis Panel (SEP): Occupational Safety and Health Research, SOH Conflict Review, Program Announcement #99–143.

Times and Dates: 1 p.m.–1:30 p.m., April 8, 2003 (open). 1:30 p.m.–5 p.m., April 8, 2003 (closed).

Place: Executive Park, Building 24, Conference Room 1525, Atlanta, GA 30329.

Phone: 404.498.2508.

Status: Portions of the meeting will be closed to the public in accordance with provisions set forth in section 552b(c) (4) and (6), title 5 U.S.C., and the Determination of the Director, Management Analysis and Services Office, CDC, pursuant to Public Law 92–463.

Matters to be Discussed: The meeting will include the review, discussion, and evaluation of applications received in response to PA# 99–143.

Contact Person for More Information: Gwendolyn Cattledge, Ph.D., Scientific Review Administrator, National Institute Occupational for Safety and Health, CDC, 1600 Clifton Rd., NE., MS–E74, Atlanta, GA 30333, Telephone (404) 498–2586.

The Director, Management Analysis and Services Office has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Dated: March 19, 2003.

Alvin Hall,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 03–7002 Filed 3–20–03; 1:21 pm]

BILLING CODE 4163–19–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. 02E–0149]

Determination of Regulatory Review Period for Purposes of Patent Extension; GENESIS NEUROSTIMULATION SYSTEM

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

SUMMARY: The Food and Drug Administration (FDA) has determined the regulatory review period for GENESIS NEUROSTIMULATION SYSTEM and is publishing this notice of that determination as required by law. FDA has made the determination because of the submission of an application to the Director of Patents and Trademarks, Department of Commerce, for the extension of a patent which claims that medical device.

ADDRESSES: Submit written comments and petitions to the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852. Submit electronic comments to http://www.fda.gov/dockets/ecomments.

FOR FURTHER INFORMATION CONTACT: Claudia Grillo, Office of Regulatory Policy (HFD–013), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–3460.

SUPPLEMENTARY INFORMATION: The Drug Price Competition and Patent Term Restoration Act of 1984 (Public Law 98–417) and the Generic Animal Drug and Patent Term Restoration Act (Public Law 100–670) generally provide that a patent may be extended for a period of up to 5 years so long as the patented item (human drug product, animal drug product, medical device, food additive, or color additive) was subject to regulatory review by FDA before the item was marketed. Under these acts, a product's regulatory review period