are members of tribes, and have a good sense of cultural health beliefs.

The healthcare provider group will consist of nomination by the Indian Health Service Chief Medical Officer (IHSCMO), who will nominate 3 MD/NP's or PA's and 3 nurses in each region. The participating emergency care providers will each be asked to nominate 2 providers from a cardiology clinic (cardiologists or cardiac nurses) and/or a pre-hospital (EMT/Paramedic) provider. The 6 original from each region will subtotal to 18 emergency care providers plus the 2 individuals they each nominate will subtotal to 36 from each region, a total of 54 pre-hospital and cardiology providers (medical providers) key informant interviews covering all three regions.

The community key informants will consist of 3 tribal health directors who will nominate 3 community key informants from each region, who will then each nominate 2 additional community members to be interviewed for a sample of 30 community key informants.

The individual key informant interviews of the group of patients who have had an MI or have a high risk of MI, nominated by the physicians, nurses and community members will be asked to nominate individuals whom they know have had or are at risk for a heart attack. The medical providers and community members asked to participate in the key informant interviews will equal a *minimum* of approximately 27 health providers, 15 community members or 42 key informant interview, each contacts 2 individuals, a minimum of 168 respondents to the survey.

After the key informant interviews have been completed and analyzed there will be two community focus groups each comprised of 8 to 10 participants from all three regions held. The first involving patients who have had an MI and the second focus group will involve community members at risk for MIs.

There are no costs to the respondent except their time to participate in the survey.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	No. of responses per respondent	Average burden per response (in hrs.)	Total burden (in hours)
Healthcare providers	54	1	1	54
Community leaders	30	1	1	30
Community members interviews	168	1	1	168
(2) Community member focus group retreats	20	1	8	160
Total				412

Dated: July 25, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–14703 Filed 7–30–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–07–06BN]

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 Seleda Perryman, CDC Assistant 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

Conduct a Chronic Fatigue Syndrome Registry Pilot Test (Bibb County, Georgia)—New—National Center for Infectious Diseases (NCID) Centers for Disease Control and Prevention (CDC).

Background and Brief Description

CDC is tasked with establishing a registry of chronic fatigue syndrome (CFS) and other fatiguing illnesses. The objective of the registry is to identify persons with unexplained fatiguing illnesses, including CFS, who access the healthcare system because of their symptoms. Patients will be between the ages of 12 and 59, inclusive.

Specific aims of the registry are; (1) Identify and enroll patients with CFS and other unexplained fatiguing illnesses who are receiving medical and ancillary medical care and describe their epidemiologic and clinical characteristics; (2) follow CFS patients and patients with other fatiguing illnesses over time to characterize the natural history of CFS and other unexplained fatiguing illnesses; (3) assess and monitor health care providers' knowledge, attitudes, and beliefs concerning CFS; (4) and to identify well-characterized CFS patients for clinical studies and intervention trials. These specific aims require inclusion of subjects in early stages of CFS (i.e., ill less than one year duration) who can be followed longitudinally to assess changes in their CFS symptoms. Data on persons with CFS in the general population has been collected in a separate study and is not an objective of this Registry.

In order to determine the most effective and cost-efficient design for achieving the objective and specific aims, CDC will conduct a pilot test of the Registry of CFS and other fatiguing illnesses in Bibb County, Georgia. The CFS Registry Pilot Test will assess two Registry designs for efficacy and efficiency in identifying adult and adolescent subjects with CFS who are

receiving medical and ancillary medical care. Specifically, the CFS Registry Pilot Test will evaluate surveillance of patients with CFS identified through physician practices and a surveillance of CFS patients identified by physicians and other health care providers.

The proposed study will begin when a provider refers a patient to the registry. Patients who consent to be contacted for the registry will be asked to complete a detailed telephone interview that screens for medical and psychiatric eligibility. Eligible subjects will be invited to have a clinical evaluation that comprises a physical examination; collection of blood, urine, and saliva specimens; a mental health interview; and self-administered questionnaires.

There is no cost to respondents other than their time. Patients who are clinically evaluated will be reimbursed for their time and effort. The total annualized burden hours are 2,557.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondent	Number of respondents	Number of responses per respondent	Average burden per response (hours)	Total burden (hours)
Referring Providers	400	2	5/60	67
Patient Consent to be Contacted	677	1	10/60	113
Patient Telephone Interview	541	1	30/60	271
Patient Clinical Evaluation	234	1	540/60	2,106
Total Burden				2,557

Dated: July 24, 2007.

Maryam I. Daneshvar,

Acting Reports Clearance Officer, Centers for Disease Control and Prevention.

[FR Doc. E7–14704 Filed 7–30–07; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

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

Periodically, the Health Resources and Services Administration (HRSA) publishes abstracts of information collection requests under review by the Office of Management and Budget (OMB), in compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). To request a copy of the clearance requests submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: Bureau of Primary Health Care (BPHC) Uniform Data System (OMB No. 0915–0193) Revision

The Uniform Data System (UDS) contains the annual reporting requirements for the cluster of primary care grantees funded by the HRSA. The UDS includes reporting requirements for grantees of the following primary care programs: Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care, and other grantees under section 330. The authorizing statute is section 330 of the Public Health Service Act, as amended.

HRSA collects data in the UDS which is used to ensure compliance with legislative mandates and to report to Congress and policy makers on program accomplishments. To meet these objectives, BPHC requires a core set of data collected annually that is appropriate for monitoring and evaluating performance and reporting on annual trends.

The 2008 calendar year UDS will be revised in several ways. Certain UDS tables are being proposed for elimination or modification to streamline data collection and reporting. A limited number of clinical measures will be added for reporting quality of care, health outcomes, and disparities data. In addition, the tool used to report calendar year UDS data will be changed to a Web based tool.

Estimates of annualized reporting burden are as follows:

Type of report	Number of respondents	Responses per respondent	Total responses	Hours per response	Total burden hours
Universal report	1,076	1	1,076	54	32,280
Grant report	150	1	150	18	2,700
Total	1,076		1,076		34,980

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to the desk officer for HRSA, either by e-mail to: *OIRA_submission@omb.eop.gov* or by fax to 202–395–6974. Please direct all correspondence to the ''attention of the desk officer for HRSA.''

Dated: July 20, 2007.

Alexandra Huttinger,

Acting Director, Division of Policy Review and Coordination.

[FR Doc. E7–14680 Filed 7–30–07; 8:45 am]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as