transport passengers and cargo on U.S. Government procured transportation for both scheduled and charter flights, subject to certain conditions. Specifically, community airlines may transport passengers and cargo on scheduled and charter flights for which a U.S. Government civilian department, agency, or instrumentality:

(1) Obtains the transportation for itself or in carrying out an arrangement under which payment is made by the U.S. Government or payment is made from amounts provided for the use of the U.S. Government, or

(2) Provides the transportation to or for a foreign country or international or other organization without reimbursement, and the transportation is:

(a) between any point in the United States and any point in a Member State, except—with respect to passengers only—between points for which there is a city-pair contract fare in effect, or

(b) between any two points outside the United States.

This provision described above does not apply to transportation funded by the Secretary of Defense or the Secretary of a military department.

The Federal Travel Regulation (FTR), section 301–10.135 (b) (41 CFR 301–10.135(b)) includes an exception to the use of U.S. flag air carrier service when the transportation is provided under a bilateral or multilateral air transportation agreement to which the U.S. Government and the government of a foreign country are parties, and which the Department of Transportation has determined meets the requirements of the Fly America Act. As the U.S.–EU Open Skies agreement is such an air transportation agreement, the General Services Administration (GSA) intends to issue regulations addressing the content of the provision on U.S. Government procured transportation included in the agreement to ensure that all are aware of the change made by the agreement. Regulations addressing air passenger transportation will be included in the FTR.

GSA is in the process of drafting a proposed rule with request for comments on proposed revisions to the FTR that will be published in the **Federal Register**.

Dated: July 17, 2007.

Becky Rhodes,

Deputy Associate Administrator.

[FR Doc. E7–14900 Filed 7–31–07; 8:45 am]

BILLING CODE 6820–14–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-07–0026]

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 Maryam I. Daneshvar, CDC Acting 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

Report of Verified Case of Tuberculosis (RVCT), (OMB No. 0920–0026)—Revision—National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

In the United States, an estimated 10 to 15 million people are infected with *Mycobacterium tuberculosis* and about 10% of these persons will develop tuberculosis (TB) disease at some point in their lives. The purpose of this project is to conduct the first major revision since 1993 of the national tuberculosis surveillance form, the Report of Verified Case of Tuberculosis (RVCT), to capture changes in the diagnosis and treatment of TB, and to better monitor trends in TB epidemiology and outbreaks, in order to develop strategies to meet the national goal of TB elimination.

CDC currently conducts and maintains the national surveillance system pursuant to the provisions of section 301(a) of the Public Service Act [42 U.S.C. 241] and section 306 of the Public Service Act [42 U.S.C. 241(a)]. Data are collected by 60 reporting areas (the 50 states, the District of Columbia, New York City, Puerto Rico, and 7 jurisdictions in the Pacific and Caribbean). In 2001, CDC's Division of Tuberculosis Elimination (DTBE) initiated a comprehensive review of the RVCT. A work group with nearly 30 members from 15 TB programs, CDC, and the National TB Controllers Association (NTCA) convened 26 conference calls to consider variable revisions based on surveillance significance, ease of data collection, and ability to yield meaningful and useful data. The proposed revision further benefited from review by TB experts active in research and field services and was pilot-tested in two phases. Revisions resulting from stakeholder input include the capture of data on verified TB cases who do not meet the national surveillance definition since counted by another U.S. area, TB treatment was initiated in another country, or TB recurred less than 12 months after completion of therapy. The year the case was reported and the reporting jurisdiction were incorporated into state case identification number with fields for linking state case numbers to allow better tracking of such cases. New variables reflecting diagnostic updates since 1993 include nucleic acid amplification, interferon gamma release assay, computerized tomography, and genotyping. The dates of tuberculin skin test and of specimen collection for other diagnostic tests, along with result dates by laboratory type, were added. The primary reason the patient was evaluated for TB disease, and reasons for extending TB therapy beyond one year were added. Risk characteristics such as diabetes, end-stage renal disease, post-organ transplantation, other immunosuppression, anti-tumor necrosis factor-alpha therapy, contact with a drug-resistant case, contact with an infectious case, missed contacts, incomplete treatment for latent TB infection, immigration status for TB screening, and parental origin and international background for pediatric cases will also be collected. A variable was added to capture whether the TB patient moved during treatment and if so, where, with a check box to indicate

transnational referral. Modifications include updates to drug regimens and drug susceptibility tests. Date of death and whether TB was a cause of death were added to status at diagnosis. Major site and additional sites of TB disease were combined to a single question. Smear, pathology, or cytology now capture histology results in addition to microbiology, and a single field for anatomic specimen code replaced two codes for positive specimens. Initial chest radiograph or other chest imaging was updated to capture whether an abnormal chest image shows a cavity or miliary TB, replacing miliary as a site of disease and simplifying check boxes for radiograph as cavitary, consistent with TB, stable, worsening, improving, or unknown. Whether patients were under custody of Immigration and Customs Enforcement was added to the correctional facility variable, and occupation was modified to capture the past year, with check boxes to differentiate persons not eligible for employment from the unemployed. Type of health care provider was clarified with categories of outpatient care. Reasons for culture conversion not being documented were incorporated, and adverse treatment event and death were added as reasons TB therapy stopped or never started. Deletions include removal of: (1) Soundex, a software code; (2) a text field to indicate who submitted the RVCT; (3) a check box asking whether the case was anergic; (4) CDC AIDS patient number; (5) how HIV positive status was determined; (6) a check box for more than one additional site of TB disease; and (7) site of directly observed therapy. DTBE is currently working with stakeholders and software team members towards development and implementation of an updated software module for the transition from the current software for RVCT data entry and electronic transmission of reports to CDC to collection and reporting of revised RVCT data. Following the transition, respondents will be able to use either the CDC associated TB module or their own TB surveillance application to collect and report RVCT data to CDC. CDC publishes an annual report using RVCT data to summarize national TB statistics and also periodically conducts special analyses for publication to further describe and interpret national TB data. These data assist in public health planning, evaluation, and resource allocation. Reporting areas also review and analyze their RVCT data to monitor local TB trends, evaluate program success, and focus resources to eliminate TB. No other Federal agency collects this type of national TB data. In addition to providing technical assistance on the use of RVCT, CDC provides technical support for reporting software. In this request, CDC is requesting approval for approximately 8050 burden hours, an estimated increase of 490 hours. This increase is due to the addition of information on new clinical diagnostic tests and factors to identify high-risk patients. There is no cost to respondents other than their time to participate in the survey.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Types of respondents	Number of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Local, state, and territorial health departments	60	230	35/60	8050

Dated: July 26, 2007.

Maryam I. Daneshvar,

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

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–07–07BI]

Proposed Data Collections Submitted for Public Comment and Recommendations

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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

Rapid HIV Testing in Community Mental Health Settings Serving African Americans—New—National Center for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

People with chronic mental illness, including those with substance use disorders, are at increased risk of HIV infection compared with the general population. However, not enough is known about the risk behaviors, willingness to be tested for HIV, and HIV prevalence among persons with chronic mental illness. In addition, the interrelations among diagnosis of HIV infection, compliance with medical care, subsequent risk behaviors, and the course of mental illness have not been well-described. Mental health clinics are an important setting for HIV rapid testing and promoting prevention efforts against the transmission of HIV infection.

The objectives of this project are to (1) increase the number of mental health providers who routinely provide HIV counseling, testing, and linkage to care in settings that provide mental health care, especially those serving African American communities; and (2) describe the relationship between mental illness,