circumstances in which the three-part test heretofore utilized under the Statement is not met, such as where the alleged antitrust violation is not clear or where other remedies would be sufficient to address the violation. I have significant concerns about sending such a signal and seeking disgorgement in such situations.

In withdrawing the Policy Statement, the majority makes the vague assertion that ''[i]t has been our experience that the Policy Statement has chilled the pursuit of monetary remedies in the years since the statement's issuance.'' [5] I have not been presented with any evidence that the Policy Statement has inappropriately constrained the Commission in the nine years it has been in effect. This begs the questions why the agency needs to rescind the Policy Statement now and why it should not perhaps be revised rather than rescinded altogether.

The guidance in the Policy Statement will be replaced by this view: ''[T]he Commission withdraws the Policy Statement and will rely instead upon existing law, which provides sufficient guidance on the use of monetary equitable remedies.'' [6] This position could be used to justify a decision to refrain from issuing any guidance whatsoever about how this agency will interpret and exercise its statutory authority on any issue. It also runs counter to the goal of transparency, which is an important factor in ensuring ongoing support for the agency's mission and activities. In essence, we are moving from clear guidance on disgorgement to virtually no guidance on this important policy issue.

Finally, I am troubled by the seeming lack of deliberation that has accompanied the withdrawal of the Policy Statement. Notably, the Commission sought public comment on a draft of the Policy Statement before it was adopted. That public comment process was not pursued in connection with the withdrawal of the statement. I believe there should have been more internal deliberation and likely public input before the Commission withdrew a policy statement that appears to have served this agency well over the past nine years.

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BILLING CODE 6750–01–P

[5] Fed. Trade Comm'n, Withdrawal of the Commission's Policy Statement on Monetary Equitable Remedies in Competition Cases, at 2 (July 31, 2012).

[6] *Id.* at 1.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day–12–0128]

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 S. Lane, 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

Congenital Syphilis (CS) Case investigation and Report Form (CDC73.126), (OMB) No.0920–0128, Expiration (03/31/2013)—Revision—Division of STD Prevention (DSTDP), National Center for HIV, Viral Hepatitis, STD and TB Prevention (NCHHSTP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Congenital syphilis (CS) is an important sentinel health event that marks potential problems in both prenatal care and syphilis prevention programs. Congenital syphilis (CS) is nearly 100% preventable by early detection and treatment of syphilis in pregnant women before or during pregnancy.

Reducing congenital syphilis is a national objective in the U.S. Department of Health and Human Services report entitled, ''Healthy People 2020''.

The CDC continues to collect and report information on congenital syphilis morbidity as part of its ongoing Sexually Transmitted Disease (STD) surveillance efforts. A reporting form for congenital syphilis (CDC Form 73.126) was initiated in 1983 to improve detection, case management, and treatment of congenital syphilis cases. Continued data collection will assist in identifying needs for congenital syphilis prevention efforts nationwide.

The current CS reporting form was revised and approved by OMB in 2009 to collect information based on the surveillance case definition and removal of Reporting city information. It is being used by all health jurisdictions reporting CS to CDC as part of the National Notifiable Diseases Surveillance. For the new approval period, CDC requests elimination of the field ''Did the infant/child have an IgM-specific treponemal test?'' This data element is no longer required because treponemal IgM technologies, for the purpose of identifying CS in an infant, are highly insensitive. The following fields have been added: ''Mothers obstetric history'', ''Did mother have treponemal test result: If so, when was the test performed?'' ''What stage of syphilis did mother have?'', ''Date of Mother's treatment'', ''What was mother's treatment?'' ''Congenital Syphilis Case Classification—Presumptive has been replaced with probable,'' as there is no case definition for presumptive congenital syphilis.

This information collection is authorized under Sections 301 and 318 of the Public Health Service Act (42 U.S.C. 241 and 247c).

The congenital syphilis data will continue to be used to develop intervention strategies and to evaluate ongoing control efforts. There is no cost to respondents other than their time.

ESTIMATE OF ANNUALIZED BURDEN TABLE

Types of respondent	Form name	Number of respondents	Number of responses per respondent	Average Burden per Response (in hours)	Total annual burden (in hours)
State Health Departments	Congenital Syphilis (CS) Case Investigation and Report.	10	11	20/60	37
Territorial Health Agencies	Congenital Syphilis (CS) Case Investigation and Report.	3	11	20/60	11
City and county health departments	Congenital Syphilis (CS) Case Investigation and Report.	4	11	20/60	15
Total		17			63

Dated: July 31, 2012.

Ron A. Otten,

Director, Office of Scientific Integrity (OSI), Office of the Associate Director for Science (OADS), Office of the Directors, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-12–12IG]

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.

Proposed Project

Targeted Surveillance and Biometric Studies for Enhanced Evaluation of Community Transformation Grants—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Prevention and Public Health Fund (PPHF) of the Patient Protection and Affordable Care Act of 2010 (ACA) provides an important opportunity for states, counties, territories and tribes to advance public health across the lifespan and to reduce health disparities. The PPHF authorizes Community Transformation Grants (CTG) for the implementation, evaluation, and dissemination of evidence-based community preventive health activities. The CTG Program emphasizes five strategic directions: (1) Tobacco-free living, (2) active lifestyles and healthy eating, (3) high impact, evidence-based clinical and other preventive services, (4) social and emotional well-being, and (5) healthy and safe physical environments.

The CTG Program is administered by the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). As required by Section 4201 of the ACA, CDC is responsible for conducting a comprehensive evaluation of the CTG Program which includes assessment over time of measures relating to each of the five strategic directions.

CDC is requesting OMB approval to collect information through two studies needed for these assessments. One study is a telephone and mailed survey (Adult Targeted Surveillance Survey) of a random sample of adults in 20 CTG communities (1000 individuals per community). Respondents will be asked to provide information about household practices and their personal behaviors specific to the five strategic directions (e.g., nutrition). Information from the targeted surveillance surveys will be compared with data from other local, state or national surveillance systems to monitor changes in relevant attitudes, risk behaviors, and other behavioral factors.

The second study for which OMB approval is requested to conduct the Youth and Adult Biometric Study (YABS), in up to 8 CTG areas that are implementing evidence-based strategies to prevent exposure to secondhand smoke and to improve nutrition and physical activity among children and adults (and are part of the targeted surveillance study described above). The YABS will examine the impact of CTG strategies on biometric markers of health status including weight, height (i.e., body mass index or BMI), waist circumference, secondhand smoke exposure, and blood pressure. Each adult respondent in the YABS will be asked to participate in an in-home visit with a trained interviewer, who will collect biometric data about the respondent such as height, weight, saliva, blood pressure, etc. The adult respondent will also be asked to provide information about his or her activity level over a one-week period. Objective measures of activity will be collected through use of an accelerometer, i.e., an electronic meter worn next to the body. In addition, the respondent will maintain a hardcopy activity diary to assist in interpreting the accelerometry data. An adult YABS respondent who is the parent or guardian of a child in the household will be asked to allow one child (age 3–17 years) to participate in the youth component of the YABS. With the child's assent, similar biometric and activity measures will be collected from the child. If the child is between 3 and 11 years of age, the parent or guardian will be asked to complete a Caregiver Survey about the child's behaviors. If the child is between 12 and 17 years of age, he or she will be asked to complete a Youth Survey.

The estimated burden per response is 30 minutes for adults participating in the first study, and up to an additional 60 minutes if the same adult agrees to participate in the YABS study. The estimated burden for youth between 12 and 17 years of age is 50 minutes, and 20 minutes for children aged 3 to 11 years. Caregivers for the younger children will have an estimated burden per response of 20 minutes to complete the Caregiver Survey. The information to be collected will allow CDC to estimate the effect of all CTG interventions on health behaviors and health outcomes in adults and children ages 3–17 years, and to estimate the independent effect of school-based interventions in youth. OMB approval is requested for the first three years of the five-year CTG project period. Participation is voluntary and there are