

at work for all people through research and prevention. Working youth have long been a priority area for NIOSH. Approximately 17.5 million workers were less than 24 years of age in 2010, representing 13% of the workforce [NIOSH 2014]. For the period 1997 through 2003, nearly 80% of high school students reported working while still in high school [BLS 2005; NIOSH 2013]. During the 10-year period 1998–2007, an estimated 7.9 million nonfatal injuries to younger workers were treated in U.S. hospital emergency departments (EDs) [CDC 2010]. The nonfatal injury rate was 5.0 ED-treated injuries per 100 full-time equivalent (FTE) workers, approximately two times higher than among workers age 25 or over [CDC 2010]. One study estimates that work-related injuries for youths up to age 19 account for an annual cost of \$5 billion, or 3.9% of all workplace injury costs in the United States [Miller and Waehrer 1998].

Given the disproportionate number of workplace injuries and illnesses suffered by young workers, occupational safety education is a critical and urgent concern [Chin et al. 2010]. Although the Occupational Safety and Health (OSH) Act of 1970 regulates that employers have the primary responsibility for providing a safe and healthy workplace, future working generations should be equipped with a foundation of workplace safety and health knowledge and skills. A mastery of general occupational safety and health competencies that protect workers from

injury or illness are key to any work-readiness effort and to every job. NIOSH has developed fundamental workplace safety and health competencies that apply to all workplaces [NIOSH 2013; Schulte et al. 2014]. The eight core workplace safety and health competencies are general transferable skills that can apply across all industries. They can be used with the job-specific skills that workers gain through apprenticeship and career technical or vocational training programs. These core competencies/skills can be used to improve the health and safety of individuals in other places as well, such as in homes, schools, or communities.

The purpose of this study is, therefore, to conduct key informant interviews with a limited number of assistant superintendents and/or curriculum coordinators in school districts across the country to assess their openness to incorporating workplace safety and health skills for young workers into their programs as a vital component of their curricula in both academic and vocational education programs at the middle and high school level. The information will inform NIOSH on incentives barriers for the inclusion of work place safety and health competencies as the “missing life skill” in the curricula and programs of U.S. middle schools and high schools. Providing youth with foundational workplace health and safety skills enables young workers to better protect

themselves and others and to contribute to safe and healthy working conditions.

For this project, twenty-eight (28) key informant interviews will be conducted. They will consist of seven (7) respondents from each of the four (4) regions of the United States (Northeast, Midwest, West, South) as defined by the U.S. Census Bureau. In each region, a sample of districts will be selected based on jurisdictional density, as defined by the National Center for Education Statistics (NCES). The participants for this data collection will be recruited with the assistance of a contractor who has successfully performed similar tasks for NIOSH in the past. The sample size is based on recommendations related to qualitative interview methods and the research team’s prior experience. The interview discussion guide will be administered verbally by phone to participants in English. Once this study is complete, results will be made available via various means including print publications and the agency internet site. The information gathered by this project will inform NIOSH of the receptivity and barriers faced by these school districts for incorporating workplace safety and health competencies for young workers as a vital component of their curricula within academic and vocational education programs at the middle and high school level. There is no cost to respondents other than their time.

The total estimated annual burden hours are 14.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden hours
Public School Officials	Interview discussion guide	28	1	30/60	14
Total	14

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Chief, Information Collection Review Office,
Office of Scientific Integrity, Office of the
Associate Director for Science, Office of the
Director, Centers for Disease Control and
Prevention.

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**DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

**Centers for Disease Control and
Prevention**

[60 Day–14–14A00]

**Proposed Data Collections Submitted
for Public Comment and
Recommendations**

The Centers for Disease Control and Prevention (CDC), as part of its continuing effort to reduce public burden, invites the general public and other Federal agencies to take this

opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995. To request more information on the below proposed project or to obtain a copy of the information collection plan and instruments, call 404–639–7570 or send comments to Leroy Richardson, 1600 Clifton Road, MS–D74, Atlanta, GA 30333 or send an email to omb@cdc.gov.

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget (OMB) approval. 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; (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; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; to develop, acquire, install and utilize technology and systems for the purpose of collecting, validating and verifying information, processing and maintaining information, and disclosing and providing information; to train personnel and to be able to respond to a collection of information, to search data sources, to complete and review the collection of information; and to transmit or otherwise disclose the information. Written comments should be received within 60 days of this notice.

Proposed Project

Monitoring and Reporting System for the Division of Community Health's Cooperative Agreement Programs—New—National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Centers for Disease Control and Prevention (CDC) established the

Division of Community Health (DCH) to support multi-sectorial, community-based programs that promote healthy living. In 2014, DCH announced three new cooperative agreement programs authorized by the Public Health Service Act and the Prevention and Public Health Fund of the Affordable Care Act (Funding Opportunity Announcement (FOA) DP14-1417, FOA DP14-1418, and FOA DP14-1419PPHF14). The new programs are designed to address chronic diseases and risk factors for chronic diseases, including physical inactivity, poor diet, obesity, and tobacco use. The programs will provide support for implementation of broad, evidence- and practice-based policy and environmental improvements in large and small cities, urban rural areas, tribes, multi-sectorial community coalitions, and racial and ethnic communities experiencing chronic disease disparities. DCH programs align with the *National Prevention Strategy* and "Healthy People 2020" focus areas.

Awards under the new FOAs will be announced in the Fall of 2014. Awardees are expected to include a mix of approximately 57 state, local, and tribal government entities, and approximately 51 private sector entities including national organizations. CDC will seek OMB approval to collect information from these awardees.

Information collection will be conducted primarily via an electronic management information system (MIS) which will enable the accurate, reliable, uniform and timely submission to CDC of each awardee's work plans and progress reports, including objectives and milestones. The electronic MIS will also generate a variety of routine and customizable reports. Local level reports will allow each awardee to summarize its activities and progress towards meeting work plan objectives. CDC will use the information collected in the MIS to monitor each awardee's progress and to identify its strengths and weaknesses.

Monitoring allows CDC to determine whether an awardee is meeting performance goals and to make adjustments in the type and level of technical assistance provided to them to support attainment of their objectives. CDC's monitoring and evaluation activities also allow CDC to provide oversight of the use of federal funds, and to identify and disseminate information about successful prevention and control strategies implemented by awardees. Finally, the information collection will allow CDC to monitor the increased emphasis on partnerships and programmatic collaboration, and is expected to reduce duplication of effort, enhance program impact and maximize the use of federal funds. The estimated burden of initial population of the MIS is 15 hours per awardee. Thereafter, the estimated burden of producing each semi-annual report is 3 hours.

Due to substantial interest in the new DCH programs from a variety of stakeholders, CDC may also seek OMB approval to conduct targeted, special-purpose information collections on an as-needed basis. CDC estimates that each DCH awardee could be asked to participate in one special purpose information collection per year. Methods for these data collections could include telephone interviews, in-person interviews, Web-based surveys, or paper-and-pencil surveys. Each special-purpose information collection request will be submitted to OMB for approval through the Change Request mechanism, and will include the data collection instrument(s) and a description of purpose and methods.

OMB approval is requested for three years. Participation in semi-annual progress reporting is required for cooperative agreement awardees, but could be voluntary for some special-purpose data collections. There are no costs to respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
DCH Program Awardees (state, local and tribal government sector).	DCH MIS: Initial population	19	1	15	285
	DCH MIS: Semi-annual reporting	57	2	3	342
	Special Data Request	19	1	17	323
DCH Program Awardees (private sector).	DCH MIS: Initial population	17	1	15	255
	DCH MIS: Semi-annual reporting	51	2	3	306
	Special Data Request	17	1	17	289
Total	1,800

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Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day-14-0975]

Agency Forms Undergoing Paperwork Reduction Act Review

The Centers for Disease Control and Prevention (CDC) has submitted the following information collection request to the Office of Management and Budget (OMB) for review and approval in accordance with the Paperwork Reduction Act of 1995. The notice for the proposed information collection is published to obtain comments from the public and affected agencies.

Written comments and suggestions from the public and affected agencies concerning the proposed collection of information are encouraged. Your comments should address any of the following: (a) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) Evaluate the accuracy of the agencies estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used; (c) Enhance the quality, utility, and clarity of the information to be collected; (d) Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses; and (e) Assess information collection costs.

To request additional information on the proposed project or to obtain a copy of the information collection plan and instruments, call (404) 639-7570 or send an email to omb@cdc.gov. Written comments and/or suggestions regarding the items contained in this notice should be directed to the Attention: CDC Desk Officer, Office of Management and Budget, Washington, DC 20503 or

by fax to (202) 395-5806. Written comments should be received within 30 days of this notice.

Proposed Project

Virtual Reality to Train and Assess Emergency Responders—Revision—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

NIOSH, under Public Law 91-173 as amended by Public Law 95-164 (Federal Mine Safety and Health Act of 1977), and Public Law 109-236 (Mine Improvement and New Emergency Response Act of 2006) has the responsibility to conduct research to improve working conditions and to prevent accidents and occupational diseases in underground coal and metal/nonmetal mines in the U.S.

The turn of the 21st century started with much promise for the coal mining industry. Because there was only one underground disaster in the 1990s, it seemed that emergency response in the United States no longer needed to be a top research priority. However, major coal mine disasters between 2001 and 2010 have resulted in 65 fatalities. These events highlighted the critical need to balance investments to reduce low probability/high severity events with those that focus on frequent, but less severe injuries and illnesses.

The present research project seeks to determine optimal use of virtual reality (VR) technologies for training and assessing mine emergency responders using the Mine Rescue and Escape Training Laboratory (MRET Lab). Responders include specially trained individuals, such as mine rescue or fire brigade team members, and also managers and miners who may either be called upon to respond to an emergency situation or engage in self-protective actions in response to an emergency. This project is a step toward determining how new immersive virtual reality technologies should be used for miner training and testing in the U.S.

As stated previously in the original information collection request justification, research activities involving rank-and-file underground coal miners who participate in the mine escape training may occur at either the MRET Lab or in an off-site classroom or other typical instructional setting either at an above-ground mine safety training facility, mine administration building, or a university or academic environment (hereinto referenced as the “classroom

setting”). Having these two subsamples allows us to better assess uses for VR training applications, determine the potential additive value of training provided in the MRET Lab, and the potential benefits of adapting simulation-based mine emergency training to a broader audience. To accommodate an appropriate amount of mine escape participants for both the MRET Lab modules and classroom settings, we are requesting adding 60 more participants to our 150 participant data collection cap, which would ideally leave us with 30 BG4 participants, 60 mine rescue participants (MRET Lab), 60 mine escape participants (MRET Lab), and 60 mine escape participants (classroom setting), for a new grand total of 210 participants.

The project objective will be achieved through specific aims in two related areas as illustrated below.

Training assessment:

1. Evaluate four training modules
2. Evaluate participant reactions
3. Develop guidelines

Training development:

4. Use 3D technologies to develop a prototype for a mine rescue closed-circuit breathing apparatus (e.g., Dräger BG4).

To accomplish these goals over the life of the project, researchers will utilize a variety of data collection strategies, including self-report pre- and post-test instruments for assessing trainee reaction and measuring learning. Data collection will take place with approximately 210 underground coal miners over three years. The respondents targeted for this study include rank-and-file miners, mine rescue team members, and mine safety and health professionals. All participants will be between the ages of 18 and 65, currently employed, and living in the United States. Findings will be used to improve the safety and health of underground coal miners by assessing the efficacy of immersive VR environments for teaching critical mine safety and health skills.

To assess learning as a result of training, each participant will complete a pre-training questionnaire, a post-simulation questionnaire, and a post-training questionnaire. Participants evaluating the closed-circuit breathing apparatus training will only complete a version of the pre-training questionnaire. There is no cost to respondents other than their time. The total estimated burden hours are 47.