

## Request for Approval under the “Generic Clearance for the Collection of Routine Customer Feedback” (OMB Control Number: 0920-1050)

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*Instruction: This form should be completed by the primary contact person from the Program sponsoring the collection.*

### DETERMINE IF YOUR COLLECTION IS APPROPRIATE FOR THIS GENERIC CLEARANCE MECHANISM:

*Instruction: Before completing and submitting this form, determine first if the proposed collection is consistent with the scope of the Collection of Routine Customer Feedback generic clearance mechanism. To determine the appropriateness of using the Collection of Routine Customer Feedback generic clearance mechanism, complete the checklist below.*

*If you select “yes” to all criteria in Column A, the Collection of Routine Customer Feedback generic clearance mechanism can be used. If you select “yes” to any criterion in Column B, the Collection of Routine Customer Feedback generic clearance mechanism cannot be used.*

Column A	Column B
The information gathered will only be used internally to CDC. [ x ] Yes   [ ] No	Information gathered will be publicly released or published. [ ] Yes   [ x ] No
Data is qualitative in nature and not generalizable to people from whom data was not collected. [ x ] Yes   [ ] No	Employs quantitative study design (e.g. those that rely on probability design or experimental methods) [ ] Yes   [ x ] No
There are no sensitive questions within this collection (e.g. sexual orientation, gender identity). [ x ] Yes   [ ] No	Sensitive questions will be asked (e.g. sexual orientation, gender identity). [ ] Yes   [ x ] No
Collection does not raise issues of concern to any other Federal agencies. [ x ] Yes   [ ] No	Other Federal agencies may have equities or concerns regarding this collection. [ ] Yes   [ x ] No
Data collection is focused on determining ways to improve delivery of services to customers of a current CDC program. [ x ] Yes   [ ] No	Data will be used to inform programmatic or budgetary decisions, for the purpose of program evaluation, for surveillance, for program needs assessment, or for research. [ ] Yes   [ x ] No
The collection is targeted to the solicitation of opinions from respondents who have experience with the program or may have experience with the program in the future. [ x ] Yes   [ ] No	

Did you select “Yes” to all criteria in Column A?

If yes, the *Collection of Routine Customer Feedback* generic clearance mechanism may be appropriate for your investigation. You may proceed with this form.

Did you select “Yes” to any criterion in Column B?

If yes, the *Collection of Routine Customer Feedback* generic clearance mechanism is **NOT** appropriate for your investigation. Stop completing this form now.

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**TITLE OF INFORMATION COLLECTION:**

Core State Injury Prevention Program (Core SIPP)

**PURPOSE:**

- Determine the level of customer satisfaction among Core State Injury Prevention Program recipients regarding routine technical assistance, meetings, and webinars with CDC support staff.
- Use of Respondent Information
  - o Information gathered via the Routine Customer Feedback will be used to improve trainings and technical assistance, and to inform continuous quality improvement, and future technical assistance offered for Core SIPP recipients.

**DESCRIPTION OF RESPONDENTS:**

Respondents to this information collection are state health department staff who are funded via the Core State Injury Prevention Program (Core SIPP). Core SIPP funds state health departments to identify and respond to existing and emerging injury threats. Core SIPP aims to increase protective factors and reduce risk factors, focusing on Adverse Childhood Experiences (ACEs), Traumatic brain injury (TBI) and transportation safety.

**TYPE OF COLLECTION:** (Check one)

*Instruction: Please sparingly use the Other category*

- ☐ Customer Comment Card/Complaint Form  
☐ Usability Testing (e.g., Website or Software)  
☐ Focus Group

- ☒ Customer Satisfaction Survey  
☐ Small Discussion Group  
☐ Other: \_\_\_\_\_

**CERTIFICATION:**

I certify the following to be true:

1. The collection is voluntary.
2. The collection is low-burden for respondents and low-cost for the Federal Government.
3. The collection is non-controversial and does not raise issues of concern to other federal agencies.
4. The results are not intended to be disseminated to the public.
5. Information gathered will not be used for the purpose of substantially informing influential policy decisions.

Name: \_\_\_\_\_ Karen Angel \_\_\_\_\_

To assist review, please provide answers to the following question:

**Personally Identifiable Information:**

1. Is personally identifiable information (PII) collected? ☐ Yes ☒ No
2. If Yes, is the information that will be collected included in records that are subject to the Privacy Act of 1974? ☐ Yes ☒ No

3. If Applicable, has a System or Records Notice been published? ☐ Yes ☒ No

**Gifts or Payments:**

Is an incentive (e.g., money or reimbursement of expenses, token of appreciation) provided to participants? ☐ Yes ☒ No

**If Yes:** Please describe the incentive. If amounts are outside of customary incentives, please also provide a justification

No incentive will be provided.

**BURDEN HOURS**

Category of Respondent	Form Name	No. of Respondents	Participation Time	Burden
State health department staff funded by Core State Injury Prevention Program (Core SIPP)	Individual Technical Assistance Att 1	160	15 minutes	40
State health department staff funded by Core State Injury Prevention Program (Core SIPP)	Group Technical Assistance Att 2	160	5 minutes	14
<b>Totals</b>				<b>54</b>

**FEDERAL COST:** The estimated annual cost to the Federal government is \$4,615. GS-9- 4 weeks to develop Routine Customer Feedback form and complete and process OMB PRA application.

**If you are conducting a focus group, survey, or plan to employ statistical methods, please provide answers to the following questions:**

**The selection of your targeted respondents**

1. Do you have a customer list or something similar that defines the universe of potential respondents and do you have a sampling plan for selecting from this universe?  
☒ Yes ☐ No

**If Yes:** Please provide a description of both below (or attach the sampling plan)

**If No:** Please provide a description of how you plan to identify your potential group of respondents and how you will select them or ask them to self-select/volunteer

The Routine Customer Feedback form will only be shared with state health department professionals funded by the Core State Injury Prevention Program (Core SIPP). The email listserv is maintained by the lead Project Officer for the Core SIPP cooperative agreement. No sampling will be conducted.

**Administration of the Instrument**

1. How will you collect the information? (Check all that apply)

☒ Web-based or other forms of Social Media

☐ Telephone

☐ In-person

☐ Mail

☐ Other, Explain

2. Will interviewers or facilitators be used? ☐ Yes ☒ No