interventions or strategies in their worksites to prevent heart disease, stroke, and related conditions such as hypertension, diabetes, and obesity. The CDC Worksite Health Scorecard will support small, mid-size, and large employer with three primary goals: (1) Reduce the risk of chronic disease among employees and their families through science-based workplace health interventions and promising practices; (2) Assist employers in identifying gaps in their health promotion programs, and help them to prioritize high-impact strategies for health promotion at their worksites; and (3) Increase understanding of the organizational programs, policies, and practices that employers of various sizes and industry sectors have implemented to support healthy lifestyle behaviors and monitor changes over time.

CDC will provide outreach to and register approximately 600 employers per year to use the online survey which is open to employers of all sizes, industry sectors, and geographic locations across the country. Worksite Health Scorecard users will create a user account, complete the online assessment and receive an immediate feedback report that summarizes the current status of their worksite health program; identifies gaps in current programming; benchmarks individual employer results against other users of the system; and provides access to worksite health tools and resources to address employer gaps and priority program areas.

CDC will use the information collected to evaluate the effectiveness of the Worksite Health Scorecard in terms of (1) identifying success drivers for building and maintaining successful workplace health programs; (2) raising awareness and knowledge of science-based worksite health programs, policies and practices; and (3) develop additional worksite health tools and resources for employers. The information will also be used to evaluate the impact of the CDC Worksite Health Scorecard on employer adoption of worksite health programs, policies, and environmental supports.

OMB approval is requested for three years. Participation in the CDC Worksite Health Scorecard is voluntary and there are no costs to participants other than their time. The total estimated annualized burden hours are 300.

ESTIMATED ANNUALIZED BURDEN HOURS

Type of respondent	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hr)
Employers	CDC Worksite Health Scorecard	600	1	30/60

Leroy Richardson,

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.

[FR Doc. 2014–02026 Filed 1–30–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day 14–0955]

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 (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 20503 or by fax to (202) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Early Hearing Detection and Intervention—Pediatric Audiology Links to Service (EHDI-PALS) Survey (0920–0955, Expiration 02/28/2014)—Revision—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Division of Human Development and Disability, located within NCBDDD, promotes the health of babies, children, and adults, with a focus on preventing birth defects and developmental disabilities and optimizing the health outcomes of those with disabilities. Since the passage of the Early Hearing Detection and Intervention (EHDI) Act, 97% of newborn infants are now screened for hearing loss prior to hospital discharge. However, many of these infants have not received needed hearing tests and follow up services after their hospital discharges. The 2011 national average loss to follow-up/loss to documentation rate is at 35%. This rate remains an area of critical concern for state EHDI programs and CDC–EHDI team's goal of timely diagnosis by 3 months of age and intervention by 6 months of age.

Many states cite the lack of audiology resources as the main factor behind the high loss to follow up. To compound the problem, many pediatric audiologists may be proficient evaluating children age 5 and older but are not proficient with diagnosing infants or younger children because children age 5 and younger require a different skill set.

No existing literature or database was available to help states verify and quantify their states' true follow up capacity until this project went live in 2013.

Meeting since April 2010, the EHDI-PALS workgroup has sought consensus on the loss to follow up/loss to documentation issue facing the EHDI programs. A survey based on standard of care practice was developed for state EHDI programs to quantify the pediatric audiology resource distribution within their state, particularly audiology facilities that are equipped to provide follow up services for children age 5 and younger. After nine months of data collection, preliminary data suggested that children residing in certain regions of the United States who were loss to follow up were due to the distance parents had to travel to reach a pediatric audiology facility. For example, parents who reside in western region of Nebraska and Iowa on average have to drive over 100 miles to reach a pediatric audiology facility.

CDC is requesting an Office of Management and Budget (OMB) approval to continue collecting audiology facility information from audiologists or facility managers so both parents, physicians and state EHDI programs will have a tool to find where

the pediatric audiology facilities are located. This survey will continue to allow CDC-EHDI team and state EHDI programs to compile a systematic, quantifiable distribution of audiology facilities and the capacity of each facility to provide services for children age 5 and younger. The data collected will also allow the CDC-EHDI team to analyze facility distribution data to improve technical assistance to State EHDI programs.

Two additional questions will be added to the existing survey. The two questions will ask for more information from audiology facilities that provide services by remote telepractice technology. This information will be of vital interest and benefit for both parents who live in remote regions of the US and state EHDI programs to maximize resource coverage.

Respondents will all be audiologists who manage a facility or provide audiologic care for children age 5 and younger. To minimize burden and improve convenience, the survey will continue to be available via a secure password protected Web site. Placing the survey on the internet ensures convenient, on-demand access by the audiologists. Financial cost is minimized because no mailing fee will be associated with sending or responding to this survey.

EHDI-PALS currently has 892 facilities in the database since the beginning of the data collection. All 892 facilities' contacts will receive a brief email from the University of Maine to remind them to review their survey answers. It is estimated that approximately 800 audiologists will do so.

It takes approximately nine minutes per person to review the survey answers. Both the American Speech-Language-Hearing Association (ASHA) and American Academy of Audiology (AAA) are members of the EHDI-PALS workgroup and will continue to disseminate a request through association e-newsletters and e-announcements to all audiologists who provide services to children younger than 5 years of age to complete the EHDI-PALS survey. It is estimated that, potentially, an additional 400 new audiologists will complete the revised survey, which will take approximately nine minutes per respondent. The nine minutes calculation is based on a previous timed pre-test with six volunteer audiologists.

There are no costs to respondents other than their time. The total estimated annual burden hours are 180.

ESTIMATES OF ANNUALIZED BURDEN HOURS

Respondents	Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Audiologists who have completed survey.	Annual Survey Review	800	1	9/60
New Audiologists	Revised Survey	400	1	9/60

Leroy A. Richardson,

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.

[FR Doc. 2014–02027 Filed 1–30–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30-Day–14–0881]

Agency Forms Undergoing Paperwork Reduction Act Review; Data Calls for the Laboratory Response Network; Cancellation

AGENCY: Centers for Disease Control and Prevention (CDC), National Center for Emerging and Zoonotic Infectious Diseases (NCEZID), Department of Health and Human Services (HHS).

ACTION: Notice cancellation.

SUMMARY: The Centers for Disease Control and Prevention is cancelling the 30-Day Information Collection Request, 14–0881, concerning the *Data Calls for the Laboratory Response Network* (79 FR 4165), published January 24, 2014.

The purpose behind this notice cancellation is that a 60-day FRN was previously published on December 2, 2013 (78 FR 27087). The public must have 60 days to provide comment to the agency's 60-day FRN. The agency should not publish a 30-day FRN until all public comments have been received.

DATES: The 30-day FRN published on January 24, 2014 at 79 FR 4165 is withdrawn as of January 27, 2014. FOR FURTHER INFORMATION CONTACT: (404) 639–7570 or send comments to CDC: LeRoy Richardson, 1600 Clifton Road, MS D–74, Atlanta, GA 30333 or send an email to *omb@cdc.gov.*

LeRoy A. Richardson,

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.

[FR Doc. 2014–01977 Filed 1–30–14; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Meeting of the Community Preventive Services Task Force (Task Force)

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice of meeting.

SUMMARY: The Centers for Disease Control and Prevention (CDC) announces the next meeting of the Community Preventive Services Task Force (Task Force). The Task Force is an independent, nonfederal, and uncompensated panel. Its members represent a broad range of research, practice, and policy expertise in prevention, wellness, health promotion, and public health, and are appointed by the CDC Director. The Task Force was convened in 1996 by the Department of Health and Human Services (HHS) to identify community preventive programs, services, and policies that increase healthy longevity, save lives and dollars and improve Americans' quality of life. CDC is mandated to provide ongoing administrative, research, and technical support for the