rapid testing performance evaluation program (HIV Rapid Testing MPEP). This program offers external performance evaluation (PE) for rapid tests such as the OraQuick® Rapid HIV–1 Antibody Test, approved as a waived test by the U.S. Food and Drug Administration, and for other licensed tests such as the MedMira Reveal®. Participation in PE programs is expected to lead to improved HIV testing performance because participants have the opportunity to identify areas for improvement in testing practices. Participants include facilities and testing sites that perform HIV Rapid Testing. This program helps to ensure accurate testing as a basis for development of HIV prevention and intervention strategies.

This external quality assessment program is made available at *no cost* (for receipt of sample panels) to sites performing rapid testing for HIV antibodies. This program offers laboratories/testing sites an opportunity for:

(1) Assuring that the laboratories/testing sites are providing accurate tests through external quality assessment,

(2) Improving testing quality through self-evaluation in a nonregulatory environment,

(3) Testing well characterized samples from a source outside the test kit manufacturer,

(4) Discovering potential testing problems so that laboratories/testing sites can adjust procedures to eliminate them,

(5) Comparing individual laboratory/testing site results to others at a national and international level, and

(6) Consulting with CDC staff to discuss testing issues.

Participants in the MPEP HIV Rapid Testing program are required to complete a laboratory practices questionnaire survey annually. In addition, participants are required to submit results twice/year after testing mailed performance evaluation samples. There is no cost to respondents other than their time. The estimated annualized burden is 625.

ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
HIV Rapid Testing Laboratory Practices Questionnaire	750	1	30/60
HIV Rapid Testing Form EZ	750	2	10/60

Dated: November 9, 2006.

Joan F. Karr,

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

[FR Doc. E6–19369 Filed 11–15–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–07–0222]

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) 639–5960 or send an e-mail to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project

Questionnaire Design Research Laboratory (QDRL) 2007–2009, (OMB No. 0920–0222)—Extension—National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The Questionnaire Design Research Laboratory (QDRL) conducts questionnaire pre-testing and evaluation activities for CDC surveys (such as the NCHS National Health Interview Survey, OMB No. 0920–0214) and other federally sponsored surveys. The QDRL conducts cognitive interviews, focus groups, mini field-pretests, and experimental research in laboratory and field settings, both for applied questionnaire evaluation and more basic research on response errors in surveys.

In a cognitive interview, a questionnaire design specialist interviews a volunteer participant. QDRL participants are usually recruited by expressing their personal willingness to participate. They read or hear about the study through media advertisements, flyers, and word-of-mouth, and either call the laboratory answering machine number or contact a person coordinating the recruitment. Thus, participation is strictly voluntary and participants are not chosen randomly.

The most common questionnaire evaluation method is the cognitive interview. The interviewer administers the draft survey questions as written, but also probes the participant in depth about interpretations of questions, recall processes used to answer them, and adequacy of response categories to express answers, while noting points of confusion and errors in responding. Interviews are generally conducted in small rounds of 10–15 interviews; ideally, the questionnaire is re-worked between rounds and revisions are tested interactively until interviews yield relatively few new insights. When possible, cognitive interviews are conducted in the survey's intended mode of administration. For example, when testing telephone survey questionnaires, participants often respond to the questions via a telephone in a laboratory room. Under this condition, the participant answers without face-to-face interaction. QDRL staff watch for response difficulties from an observation room, and then conduct a face-to-face debriefing with in-depth probes. Cognitive interviewing provides useful data on questionnaire performance at minimal cost and respondent burden. Similar methodology has been adopted by other Federal agencies, as well as by academic and commercial survey organizations. NCHS is requesting 3 years of OMB Clearance for the project. There are no costs to respondents other than their time. The total estimated annualized burden hours are 600.

ESTIMATED ANNUALIZED BURDEN HOURS

Projects	Number of participants	Number of responses/participant	Average hours per response
QDRL Interviews:			
(1) NCHS Surveys	120	1	1.25
(2) Other questionnaire testing	120	1	1.25
(3) Research on the effects of alternative questionnaire design	500	1	18/60
(4) General Methodological Research	60	1	1.25
Focus Groups (5 groups of 10)	50	1	1.5

Dated: November 9, 2006.

Joan F. Karr,

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

[FR Doc. E6–19373 Filed 11–15–06; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30 Day–07–0607]

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) 639–5960 or send an e-mail to *omb@cdc.gov.* Send written comments to CDC Desk Officer, Office of Management and Budget, Washington, DC or by fax to (202) 395–6974. Written comments should be received within 30 days of this notice.

Proposed Project

The National Violent Death Reporting System—extension—National Center for Injury Prevention and Control (NCIPC), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Violence is an important public health problem. In the United States, homicide and suicide are the second and third leading causes of death, respectively, in the 1–34 year old age group. Unfortunately, public health agencies do not know much more about the problem than the numbers and the sex, race, and age of the victims, all information obtainable from the standard death certificate. Death certificates, however, carry no information about key facts necessary for prevention such as the relationship of the victim and suspect and the circumstances of the deaths, thereby making it impossible to discern anything but the gross contours of the problem. Furthermore, death certificates are typically available 20 months after the completion of a single calendar year. Official publications of national violent death rates, *e.g.* those in Morbidity and Mortality Weekly Report, rarely use data that is less than two years old. Public health interventions aimed at a moving target last seen two years ago may well miss the mark.

Local and Federal criminal justice agencies such as the Federal Bureau of Investigation (FBI) provide slightly more information about homicides, but they do not routinely collect standardized data about suicides, which are in fact much more common than homicides. The FBI's Supplemental Homicide Report system (SHRs) does collect basic information about the victim-suspect relationship and circumstances, like death certificates, it does not link violent deaths that are part of one incident such as homicide-suicides. It also is a voluntary system in which some 10–20 percent of police departments nationwide do not participate. The FBI's National Incident Based Reporting System (NIBRS) addresses some of these deficiencies, but it covers less of the country than SHRs, still includes only homicides, and collects only police information. Also, the Bureau of Justice Statistics Reports do not use data that is less than two years old.

CDC therefore proposes to continue a state-based surveillance system for violent deaths that will provide more detailed and timely information. It taps into the case records held by medical examiners/coroners, police, and crime labs. Data is collected centrally by each State in the system, stripped of identifiers, and then sent to the CDC. Information is collected from these records about the characteristics of the victims and suspects, the circumstances of the deaths, and the weapons involved. States use standardized data elements and software designed by CDC. Ultimately, this information will guide states in designing programs that reduce multiple forms of violence.

Neither victim families nor suspects are contacted to collect this information. It all comes from existing records and is collected by state health department staff or their subcontractors. Health departments incur an average of 2.0 hours per death in identifying the deaths from death certificates, contacting the police and medical examiners to get copies of or to view the relevant records, abstracting all the records, various data processing tasks, various administrative tasks, data utilization, training, communications, etc.

Violent deaths include all homicides, suicides, legal interventions, deaths from undetermined causes, and unintentional firearm deaths. There are 50,000 such deaths annually among U.S. residents, so the average state will experience approximately 1,000 such deaths each year.

There are no costs to the respondents other than their time. The total estimated annualized burden hours are 55,000.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Task name	Number of respondents	Number of responses/respondent	Average burden/response (in hours)
State Health Departments	Case Abstraction	20	1,000	2