

such as shift length (ie. 12-hour, 8-hour shifts), night work, and rotating work schedules are associated with increased health and safety risks.

Specific Aim 2. Examine how shift work and overtime interact to influence health and safety risks.

Specific Aim 3. Examine if disturbances of sleep, family life, and social life mediate effects of work schedules on health and safety.

The study is based on the theoretical model by Barton et al. (1995) who propose that shift work exerts a negative effect on health and safety outcomes by disturbing sleep, family life, and social life. The study will use a cross-sectional design to survey 1,000 registered nurses

who will be randomly selected from 10 large hospitals. Participants will be asked to complete a survey, complete a 7-day sleep/activity diary, provide one set of blood pressure readings, and provide a copy of their work schedule from their hospital records for the previous 3-month period. The survey includes items for personal characteristics such as age and weight; health history; lifestyle factors such as smoking and alcohol use; sleep characteristics and problems; factors at work and other responsibilities such as child care; work schedule factors; musculoskeletal discomfort; gastrointestinal and cardiovascular symptoms; mood; automobile crashes

and near misses; needlestick injuries; and job satisfaction.

The study will compute a list of work characteristics based on the actual work start and end times. Statistical modeling will be used to examine characteristics of work schedules associated with increased risk while controlling for demographic, health history, lifestyle, and work-related risk factors. A base model will be developed with significant control variables for each outcome. Work schedule variables will then be added to the base model to test for significant relationships while controlling for co-variables. There are no costs to respondents.

Form name	No. of respondents	No. of responses/re-spondent	Avg. burden/response (in hours)	Total burden (in hours)
Survey	1000	1	30/60	500
7-day sleep/activity diary	1000	*7	5/60	583
Total				1,083

*1 response per day \times 7 days = 7.

Dated: June 21, 2002.

Nancy E. Cheal,

Acting Associate Director for Policy, Planning and Evaluation, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60Day-02-64]

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 the CDC Reports Clearance Officer on (404)498-1210.

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. Send comments to Anne O'Connor, CDC Assistant Reports Clearance Officer, 1600 Clifton Road, MS-D24, Atlanta, GA 30333. Written comments should be received within 60 days of this notice.

Proposed Project: A and B Reader Surveys—New—National Institute for Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Since 1970, under the U.S. Code of Federal Regulations [42 CFR 37], screening chest radiographic

examinations have been provided to underground miners at approximate five-year intervals. As part of the mandated Coal Workers' X-ray Surveillance Program (CWXS), the NIOSH B Reader Program requires x-ray classification by physicians who have demonstrated proficiency in the International Labour Office (ILO) radiographic classification system. Competence in the ILO system is demonstrated by physicians who have completed a NIOSH approved educationalseminar (A Reader) or have passed the NIOSH B Reader certification examination (B Reader). The ILO has recently completed a revision of its radiographic classification system (ILO 2000) that will soon be published. As a result, modifications of the B Reader examinations and related training activities and materials will be needed. These revisions provide an opportunity to evaluate the current B Reader Program by surveying A and B Readers. The survey responses from these physicians will be used to develop a workshop agenda and contract specifications to improve the B Reader Program. There are no costs to respondents.

Respondents	Number of respondents	Number of responses/re-spondent	Avg. burden/response (in hrs.)	Total burden in hours
Physicians/B Reader	531	1	10/60	89
Physicians/Former B Reader	333	1	10/60	56
Physicians/A Reader	2834	1	10/60	472

Respondents	Number of respondents	Number of responses/response	Avg. burden/response (in hrs.)	Total burden in hours
Total	617

Dated: June 21, 2002.

Nancy E. Cheal,

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Center for Disease Control and Prevention

[Program Announcement 02193]

Centers of Excellence in Health Statistics; Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC), through the Office of Public Health Practice Program Office "PHPPPO" and the National Center for Health Statistics (NCHS) announce the availability of fiscal year (FY) 2002 funds for a cooperative agreement to support Centers of Excellence in Health Statistics (CEHS). This program addresses the "Healthy People 2010" focus area(s) of Disability and Secondary Conditions; Environmental Health; Maternal, Infant, and Child Health; Public Health Infrastructure; Cancer; Heart Disease and Stroke; Tobacco Use.

The purpose of this program is to: Support Infrastructure (Administrative Core); Enhance the organizational setting to promote research on methods for health statistics, drawing upon multiple disciplines and involving collaboration with multiple partners.

Support Research Projects (Research Component): Support methodology and analytic research projects aimed at advancing the state of the art of collection, analysis, and interpretation of health statistics. Integrate the fields of statistics, health services research, survey research, public health, epidemiology, behavioral and social sciences, computer science and technology among others. Through such multi-disciplinary research, explore new approaches to enhance the capability of the statistical system to meet the rapidly changing needs of disease surveillance, public health research, and prevention research.

Measurable outcomes of the program will be in alignment with one or more of the following performance goals for the National Center for Health Statistics:

1. Monitor trends in the nation's health through high-quality data systems; addressing issues relevant to decision makers.
2. Improve the nation's vital statistics system.
3. Improve racial and ethnic data for programmatic and policy decision-making.
4. Disseminate health data in innovative ways.

B. Authority and Catalog of Federal Domestic Assistance Number

This program is authorized under section 306 of the Public Health Service Act, [42 U.S.C. section 242k] as amended. The Catalog of Federal Domestic Assistance number is 99.283.

C. Eligible Applicants

Applications may be submitted by public and private nonprofit organizations and by governments and their agencies; that is, universities, colleges, technical schools, research institutions, hospitals, other public and private nonprofit organizations, community-based organizations, faith-based organizations, State and local governments or their bona fide agents, including the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, the Commonwealth of the Northern Mariana Islands, American Samoa, Guam, the Federated States of Micronesia, the Republic of the Marshall Islands, the Republic of Palau, federally recognized Indian tribal governments, Indian tribes, or Indian tribal organizations.

Note: Title II of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive Federal funds constituting an award, grant or loan.

D. Availability of Funds

Approximately \$1,200,000 is available in FY 2002 to fund approximately three awards. It is expected that the average award will be \$400,000 in total costs, ranging from \$350,000 to \$450,000. It is anticipated that the awards will begin on or about September 30, 2002, and will be made for a 12-month budget

period. Funding estimates may change. Project period for one year.

Continuation awards within an approved project period will be made on the basis of satisfactory progress as evidenced by required reports and the availability of funds.

Use of Funds

Applicants should include sufficient travel funds within their budgets to travel to the NCHS, Hyattsville Maryland, facility for an annual meeting of all awarded research center principal investigators.

Funding Preferences

There is programmatic interest in supporting Centers that conduct a wide range of research, analytic, and implementation activities pertaining to health statistics and information systems for health promotion and disease prevention research and application. Examples of relevant research topics include, but are not limited to, those listed below:

1. *Survey methodology:* New sampling approaches, new designs for hard-to-reach populations, new approaches for linking and integrating health surveys, improved capabilities for conducting longitudinal and cross-sectional studies, improved methods for addressing language and cognitive issues in conducting surveys.

2. *Health Promotion and Disease Prevention:* Development of standards in terms, definitions, and methods; development of health status indicators for within-population group comparison; examination of protective or wellness factors and health seeking behaviors particular to population groups; assessment of limitations of and alternatives to randomized designs for community intervention trials.

3. *Data linkages:* Improved use of existing administrative data sets (e.g., Medicare, Medicaid, Veterans Administration, National Death Index, hospital discharges, and employer health files), expanded use of data sources from outside the public health arena, approaches to tracking patient health episodes across different providers, and methods for linking or matching different data sources to move toward population coverage.

4. *Data analysis:* Analytic approaches to interpreting poverty and socioeconomic status and their effect on