

representative data regarding high school students and tobacco. Moreover, the National Youth Tobacco Survey is the only source of such national data for middle school students (grades 6–8). The data have significant implications

for policy and program development for school health programs nationwide.

To provide contextual data, in each participating school, the principal or another designated administrator will be asked to complete a questionnaire on the school's tobacco-related policies.

The lead health teacher identified by the principal will be asked to complete a questionnaire on the school's tobacco-related programs and curricula.

The only cost to respondents is their time to complete the survey.

Respondents	Number of respondents	Number of responses per respondent	Average burden per responses (in hrs.)	Total burden (in hrs.)
Students .....	24,500	1	45/60	18,375
School Administrator Arrangements .....	236	1	30/60	118
School Administrator Policy Survey .....	236	1	20/60	79
School Teacher Program Survey .....	236	1	20/60	79
Total .....				18,651

Dated: July 17, 2003.

**Nancy E. Cheal,**

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

[FR Doc. 03–18800 Filed 7–23–03; 8:45 am]

BILLING CODE 4163–18–P

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Disease Control and Prevention

[60Day–03–100]

#### 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:* Workplace Exacerbation of Asthma (0920–0495)—EXTENSION—National Institute of Occupational Safety and Health (NIOSH), Centers for Disease Control and Prevention (CDC).

Work-related asthma is the most common lung disease seen in occupational health clinics in the United States based on data from the Association of Occupational and Environmental Clinics for 1991–1996. Work-related asthma includes both new onset asthma initiated by workplace exposures and pre-existing asthma exacerbated by workplace environments, because in both types of cases repeated exposure to asthmatic agents can lead to chronic pulmonary impairment. Also, the 1985 American Thoracic Society statement “What Constitutes an Adverse Health Effect of Air Pollution” identified exacerbation of asthma as one of the serious effects of environmental air pollution. While anecdotal evidence suggests that as many as one-half of work-related asthma patients treated in occupational medicine clinics had pre-existing asthma that was exacerbated by workplace conditions, there are few data from studies in the United States to support this claim.

This study is investigating the frequency, causes, and consequences of workplace exacerbation of asthma (WEA). Given the diversity of workplace agents and processes associated with asthma, a population-based, rather than industry-based, study is needed to ascertain the full extent of the problem. This will be achieved by surveying adults with asthma. The Specific Aims

of the study are: (1) To determine the frequency of WEA. (2) To determine the work circumstances associated with exacerbation of asthma. (3) To determine the social and economic costs associated with WEA. (4) To determine the sensitivity and specificity of self-reported WEA. (5) To determine whether WEA contributes to progression of disease. The design is a prospective cohort study with a nested validation study. The study consists of three parts: a Baseline Study addressing Specific Aims 1–3, a Validation Study addressing Specific Aim 4, and a Follow-up Study addressing Specific Aim 5.

To date, the Baseline Study telephone interviews have been completed with a total of 615 participants. Also, patient care records have been obtained in order to ascertain cost of care for asthma for each participant (Specific Aim 3). Currently, a subset of employed subjects with and without WEA are being enrolled in the Validation Study. All subjects from the Baseline Study will be asked to participate in the Follow-up study.

The data collected in this study will be used to further current understanding of the frequency of workplace-exacerbated asthma, the social and economic impacts of this problem, and the implication of self-reporting WEA for subsequent asthma severity. This information can be used to prioritize resources for addressing this problem. The data collected in this study will also identify which jobs and exposures are likely to exacerbate existing asthma, thus providing guidance on where to focus preventive efforts. Collected data on the validity of self-reporting WEA will be useful to both clinicians and researchers who attempt to treat or study individuals with this problem.

There will be no costs to respondents.