

are invalid. For example, planning is often based on the following assumptions: (1) That victims will be decontaminated by first responders on the scene; (2) that victims will be transported by ambulances that can be directed to a hospital designated for contaminated casualties; and (3) that hospitals will receive advance notice that casualties will be arriving, so that special preparations can be made to receive them (e.g., lining floors and walls with plastic tarps; donning respirators and chemical resistant clothing).

We propose assessing 10 incidents over a three-year period involving patients treated at hospitals for actual or possible contamination by chemicals

which could pose a threat of illness or injury to the hospital staff that treat them. Data will be collected not only from hospitals but from other emergency medical and public safety organizations, and even members of the public who have become involved in the response. This is because the actions of these groups can have a profound effect on how hospitals carry out their emergency tasks. The lessons-learned during these responses will be collected by a field research team using semi-structured, open-ended interviews of those involved in the responses, for example: patients and their families, hospital staff, police, firefighters, emergency medical technicians,

emergency dispatchers, and others who have knowledge of the response.

Certain standardized data will also be collected, such as: number of victims, chemical identity, distribution of casualties among area hospitals, time of incident, time of hospital notification, type of protective clothing and respiratory protection used by hospital staff. A review of the existing field disaster research literature has failed to identify other studies that have collected this type of information. The results of the project will be used to develop and update training materials for hospitals and other emergency responders. There are no costs to respondents.

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Emergency Responders	100	2	1	200
Patients and/or Family	40	2	1	80
Total	280

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Thomas A. Bartenfeld,

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

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Proposed Data Collections Submitted for Public Comment and Recommendations

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) 498-1210. Send written comments to CDC, Desk Officer, Human Resources and Housing Branch, New Executive Office Building, Room 10235, Washington, DC 20503 or by fax to (202)

395-6974. Written comments should be received within 30 days of this notice.

Proposed Project: Assessment of Exposure to Arsenic through Household Water, OMB No. 0920-0472—Revision—National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC).

Background

Arsenic is a naturally occurring element present in food and water as both organic and inorganic complexes. Epidemiologic evidence shows a strong link between ingestion of water containing inorganic arsenic and an increase in certain cancers (e.g., bladder cancer, lung cancer). Although consumption of arsenic-contaminated food is the major source of arsenic exposure for the majority of U.S. citizens, in some areas of the United States, elevated levels of arsenic occur frequently in water. In such areas, ingestion of water can be the primary source of arsenic exposure.

Currently, point-of-use (POU) devices are the preferred method of treatment of private domestic well water containing elevated levels of arsenic. Bottled water and POU treatment systems are considered effective means of managing arsenic exposure based on the

assumption that people's other water exposures, such as bathing, brushing of teeth, cooking, and drinking occasionally from other taps, contribute relatively minor amounts to a person's total daily intake of arsenic.

We propose to conduct a study to methodically test the validity of the commonly made assumption that secondary water exposures, such as bathing, will not result in a significant increase in arsenic exposure above background dietary levels. Specifically, we are interested in assessing total urine arsenic levels and levels of organic and inorganic arsenic species among people in areas in which ingestion of arsenic-containing water is controlled by either POU treatment or use of bottled water.

Potential participants who are interested in being part of the study will be interviewed by telephone. Recruited participants will be asked to participate in a survey interview about potential exposures to arsenic. Participants in the study will use short-term diaries to record diet, water consumption, and bathing frequency. In addition, we will assess long-term arsenic exposure by analyzing toenail samples for total arsenic.

The total annualized burden hours are estimated to be 2,689.