access this information via the CDC EHDI Web site (*www.cdc.gov/ncbddd/hearingloss/ehdi-data.html*).

Given the lack of a standardized and readily accessible source of data, the CDC EHDI program developed a survey to be used annually that utilizes uniform definitions to collect aggregate, standardized EHDI data from states and territories. The request to complete this survey is planned to be disseminated to respondents via an email, which will include a summary of the request and other relevant information. Minor changes to this survey, based on respondent feedback, are planned in order to make the survey easier to complete and further improve data quality. These changes include splitting the previously combined question about the number of infants that were non-residents or moved out jurisdiction into two separate questions and adding new questions. These include questions about how many infants were in a neonatal intensive care unit for more than 5 days, transferred without any documentation of a hearing screening, unable to be screened or receive diagnostic testing due to a medical reason, number of cases where a primary care physician did not refer an infant for diagnostic testing, and cases of permanent hearing loss among non-resident infants. The table for reporting type and severity of hearing loss data has also been updated so this data can be reported using either the classification system from the American Speech and Hearing Association or the current system from the Directors of Speech and Language Programs in State Health and Welfare Agencies.

A total of 59 respondents will be asked to complete the updated data request each year during the 3-year requested data collection approval timeframe. Based on findings from the previous information collection, it is estimated that the burden for individuals to read through the survey and decide whether or not to complete it is 10 minutes per person. The 10 minute calculation was based on feedback received in pre-tests with 5 individuals and confirmed by the experience with the survey since the original Office of Management and Budget (OMB) approval.

It is expected that 55 of the 59 potential respondents will complete the survey and therefore incur an additional burden of up to 4 hours per respondent. However, based on feedback from consulted experts about the length of time required to complete the original information collection it is anticipated that it will only take some respondents a few minutes to complete the revised data request. This is because jurisdictions often have already gathered and compiled the requested data for their own internal uses. Nevertheless, the more conservative time estimate of 4 hours per response from each of the 55 anticipated participants is shown in the table below. The estimated annualized burden is 230 hours. This estimate is identical to the time estimate for the reinstated OMB approved estimate from 2010; the only change is the estimated number of respondents. There are no costs to the respondents other than their time.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Form name	No. of respondents	No. of responses per respondent	Average burden per response (in hours)	Total burden (in hours)
State and territory EHDI Program Coordinators.	Survey Directions	59	1	10/60	10
EHDI Program State Program Coordinators.	Survey	55	1	4	220
TOTAL					230

Dated: March 21, 2013.

Ron A. Otten,

Director, Office of Scientific Integrity, Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Statement of Organization, Functions, and Delegations of Authority

Part C (Centers for Disease Control and Prevention) of the Statement of Organization, Functions, and Delegations of Authority of the Department of Health and Human Services (45 FR 67772–76, dated October 14, 1980, and corrected at 45 FR 69296, October 20, 1980, as amended most recently at 78 FR 5812, dated January 28, 2013) is amended to reflect the reorganization of the Office of the Associate Director for Science, Office of the Director, Centers for Disease Control and Prevention.

Section C–B, Organization and Functions, is hereby amended as follows:

Revise the functional statement for the Office of Science Quality (CASH), as follows:

After item (11), insert the following: (12) Plans, develops, coordinates, and manages policies and/or activities that assure CDC intellectual property transfer, scientific training and technical assistance, critical external laboratory partnerships and the provision of essential laboratory services; (13) transfers and translates research findings, technologies, and information from CDC's laboratory and science in practice recommendations; and (14) manages CDC's intellectual property (e.g., patents, trademarks, copyrights) and promotes the transfer of new technology from CDC research to the private sector to facilitate and enhance the development of diagnostic products, vaccines, and products to improve occupational safety

Dated: March 7, 2013.

Sherri A. Berger,

Chief Operating Officer, Centers for Disease Control and Prevention.

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