with LPS. Respondent also used a second image twice, labeling it once as "no LPS" and the second time as "24 hours with LPS."

11. Respondent knowingly and intentionally falsified a figure that purports to represent viral decay in rectal mucosa and included the figure as a slide in two PowerPoint presentations and three NIH grant applications.

12. Respondent knowingly and intentionally falsified: (a) A histopathology figure that was described in a paper published in the *Journal of Infectious Diseases* 83:1466, 2001, as inguinal lymph nodes from an untreated AIDS patient using *in situ* PCR to show the presence of HIV–1 cells when it was actually from a tissue expressing the neomycin marker; (b) the gel images resembling Figures 2A and C, which Respondent claimed to be based on *lymph node cells,* although he reported the gel images elsewhere to represent results from *rectal tissue;* and (c) various versions of these blots that Respondent reported elsewhere and labeled differently with respect to the copy numbers detected and as detecting DNA in some instance and RNA in others.

13. Respondent knowingly and intentionally falsified Figures 2DI and 2DII included in a paper published in the *Journal of Leukocyte Biology* 68:351–359, 2000.

14. Respondent knowingly and intentionally falsified Figure 4, Panels A and B, in NIDCR, NIH, grant application 1 R01 DE014827–01 by manipulating the source images.

15. Respondent knowingly and intentionally falsified a number of figures and made false statements in the text of NIAID, NIH, grant application 1 R01 AI051954–01 submitted jointly with a colleague by relabeling figures based on research carried out with HIV–1 or HIV–2 and identifying the figures and text as research conducted with ovine lentivirus (OvLV).

ORI issued a charge letter enumerating the above findings of misconduct in science and proposing HHS administrative actions. Dr. Brodie subsequently requested a hearing before an Administrative Law Judge (ALJ) of the Departmental Appeals Board to dispute these findings. In January 2009, the ALJ issued a ruling holding that there were no triable issues challenging ORI's findings that there were materially false statements, images, and other data in the relevant publications, presentations, and grant applications. However, the ALJ held that Dr. Brodie raised triable issues about his intent to commit scientific misconduct and the reasonableness of the proposed debarment of seven (7) years.

On January 12, 2010, the ALJ issued a recommended decision to the HHS Assistant Secretary for Health (ASH) granting summary disposition to ORI. The ALJ also stated that Dr. Brodie committed scientific misconduct on multiple occasions and that its extent amply justified debarment for a period of seven (7) years. Pursuant to 42 CFR 93.523(c), the ASH forwarded the ALJ's recommended decision to the HHS Debarring Official, which constituted the findings of fact required under 2 CFR parts 180 and 376.

On February 1, 2010, Dr. Brodie submitted a letter to the HHS Debarring Official with attachments to request that the ALJ's recommended decision be rejected as a whole. On February 26, 2010, Dr. Brodie submitted a letter requesting the opportunity to meet with the HHS Debarring Official to orally present the reasons supporting his request that the ALJ's recommended decision be rejected. However, the HHS Debarring Official determined that Dr. Brodie had been afforded an opportunity to contest ORI's findings of scientific misconduct in accordance with 42 CFR part 93, subpart E. Given the findings of facts in this case, the HHS Debarring Official determined that the issues in his presentation in opposition to the ALJ's recommended decision did not raise a genuine dispute over facts material to the recommended debarment. Accordingly, the HHS Debarring Official also denied Dr. Brodie's request to make an oral presentation and issued a notice of debarment to begin on March 18, 2010, and end on March 17, 2017.

On March 23, 2010, Dr. Brodie submitted a letter requesting a postponement of the effective date of the debarment. This request was denied by the Debarring Official on April 6, 2010.

Thus, the misconduct in science findings set forth above became effective, and the following administrative actions have been implemented for a period of seven (7) years, beginning on March 18, 2010:

(1) Dr. Brodie has been debarred from any contracting or subcontracting with any agency of the United States Government and from eligibility or involvement in nonprocurement programs of the United States Government referred to as "covered transactions" pursuant to the Department of Health and Human Service's Implementation (2 CFR part 376 *et seq.*) of OMB Guidelines to Agencies on Governmentwide Debarment and Suspension, 2 CFR part 180; and

(2) Dr. Brodie is prohibited from serving in any advisory capacity to PHS including but not limited to service on any PHS advisory committee, board, and/or peer review committee, or as consultant.

FOR FURTHER INFORMATION CONTACT: Director, Division of Investigative Oversight, Office of Research Integrity, 1101 Wootton Parkway, Suite 750, Rockville, MD 20852, (240) 453–8800.

John Dahlberg,

Director, Division of Investigative Oversight, Office of Research Integrity.

[FR Doc. 2010–10605 Filed 5–4–10; 8:45 am]

BILLING CODE 4160–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–10–0733]

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 Maryam I. Daneshvar, 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) 395–5806. Written comments should be received within 30 days of this notice.

Proposed Project

Early Hearing Detection and Intervention Hearing Screening and Follow-up Survey (OMB No. 0920–0733 exp. 10/31/2009)—Reinstatement With Change—National Center on Birth Defects and Developmental Disabilities (NCBDDD), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

The National Center on Birth Defects and Developmental Disabilities at CDC promotes the health of babies, children, and adults with disabilities. As part of these efforts the Center is actively involved in addressing hearing loss (HL) among newborns and infants. HL is a common birth defect that affects approximately 12,000 infants each year and, when left undetected, can result in developmental delays. As awareness about infant HL increases, so does the

demand for accurate information about rates of screening, referral, loss to follow-up, and prevalence. This information is important for: (a) Helping to ensure infants and children are receiving recommended screening and follow-up services, (b) identifying reasons for not receiving recommended services and (c) documenting the occurrence of differing degrees of HL among infants. These data will also assist the States in Early Hearing Detection and Intervention (EHDI) programs with quality improvement activities and provide information that will be helpful in assessing the impact of Federal initiatives. The public will be able to access this information via the CDC EHDI Web site (*http://www.cdc.gov/ncbddd/ehdi*).

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 57 respondents via an e-mail, which will include a summary of the request and other relevant information. We anticipate that about 50 of the 57 coordinators will complete and return the survey. 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 adding a question about how many infants with hearing loss are receiving only monitoring services, simplifying the table for reporting type and severity of hearing loss data, and expanding the maternal race categories in the demographic section. There are no costs to the respondents other than their time. The estimated annualized burden hours are 210.

ESTIMATED ANNUALIZED BURDEN HOURS

Respondents	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
EHDI Program State Program Coordinators Contacted	57	1	10/60
EHDI Program State Program Coordinators Who Return the Survey	50	1	4

Dated: April 28, 2010.

Maryam I. Daneshvar,

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

[FR Doc. 2010–10587 Filed 5–4–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[60 Day–10–10CV]

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. Alternatively, to obtain a copy of the data collection plans and instrument, call 404–639–5960 and send comments to Maryam I. Daneshvar, CDC Reports Clearance Officer, 1600 Clifton Road, NE., MS–D74, Atlanta, Georgia 30333; comments may also be sent by e-mail to *omb@cdc.gov.*

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 a 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 clarify 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 information technology. Written comments should be received within 60 days of this notice.

Proposed Project

Early Aberration Reporting System (EARS) Registration Module—New—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) (proposed), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

To support two of CDC's main priority areas: (1) Improving CDC's support for state and local health departments, and (2) strengthening surveillance and epidemiology, CDC is requesting approval from the Office of Management and Budget (OMB) to improve the Early Aberration Reporting System (EARS) by collecting data from individuals who request a download of EARS from the CDC website.

The Early Aberration Reporting System, developed within the Division of Bioterrorism Preparedness and Response, is a web-enabled tool that analyzes public health surveillance data using methods that detect abnormal trends that could possibly indicate an outbreak of infectious disease. The local public health professionals manage the entire tool and can implement the defaults or can adjust the tool in order to meet their local needs. The goal of this process is to assist public health professionals in the early identification of outbreaks of disease as well as bioterrorism events. EARS is used to assess whether the current number of reported cases of an event is higher than usual.

The term syndromic surveillance is used to describe surveillance that uses health-related data that precede diagnosis and that signals a sufficient probability of a case or an outbreak of infectious disease to warrant further public health response. Syndromic surveillance systems are used by state, local, national and international health departments to monitor syndrome-based (*e.g.,* case information collected in emergency departments (EDs) and diagnostic data sources for early detection of outbreaks and other public health events). More recently these systems are used during public health responses to provide more rapid near real-time situational awareness regarding the health status of the target population. EARS was the first software platform to support local syndromic surveillance systems. EARS has been designed and used to monitor syndromic data from emergency departments, 911 calls, physician office data, school and business absenteeism, over-the-counter drug sales, laboratory testing and results data and reportable disease surveillance systems. In the past several years, EARS systems have been integral in the local public health surveillance arsenal. EARS has been used at events such as the Beijing Summer Olympics; multiple