A. Federal Reserve Bank of Minneapolis (Jacqueline G. King, Community Affairs Officer) 90 Hennepin Avenue, Minneapolis, Minnesota 55480–0291:

1. Joyce J. Eickhoff Revocable Trust, and Joyce J. Eckhoff, Trustee, both of Adrian, Minnesota; to acquire voting shares of Adrian Building Corporation, and thereby indirectly acquire voting shares of Adrian State Bank, both of Adrian, Minnesota.

B. Federal Reserve Bank of San Francisco (Kenneth Binning, Vice President, Applications and Enforcement) 101 Market Street, San Francisco, California 94105–1579:

1. Thomas H. Lee Equity Fund VI, L.P.; Thomas H. Lee Parallel Fund VI, L.P.; Thomas H. Lee Parallel (DT) Fund VI, L.P.; and THL Sterling Equity Investors, L.P., all of Boston, Massachusetts; to acquire voting shares of Sterling Financial Corporation, and thereby indirectly acquire voting shares of Sterling Savings Bank, both of Spokane, Washington, and Golf Savings Bank, Mountlake Terrace, Washington.

Board of Governors of the Federal Reserve System, May 6, 2010.

Robert deV. Frierson,

Deputy Secretary of the Board.

[FR Doc. 2010–11113 Filed 5–10–10; 8:45 am]

BILLING CODE 6210–01–S

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day–10–0004]

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 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

National Disease Surveillance Program II. Disease Summaries (OMB No. 0920–0004 Exp. 5/31/2010)—Extension—National Center for Emerging and Zoonotic Infectious Diseases (NCEZID) (proposed), Centers for Disease Control and Prevention (CDC).

Background and Brief Description

Surveillance of the incidence and distribution of disease has been an important function of the U.S. Public Health Service (PHS) since 1878. Through the years, PHS/CDC has formulated practical methods of disease control through field investigations. The CDC National Disease Surveillance Program is based on the premise that diseases cannot be diagnosed, prevented, or controlled until existing knowledge is expanded and new ideas developed and implemented. Over the years, the mandate of CDC has broadened to include preventive health activities and the surveillance systems maintained have expanded. CDC and the Council of State and Territorial Epidemiologists (CSTE) collect data on disease and preventable conditions in accordance with jointly approved plans. Changes in the surveillance program and in reporting methods are effected in the same manner. At the onset of this surveillance program in 1968, the CSTE and CDC decided on which diseases warranted surveillance. These diseases are reviewed and revised based on variations in the public's health. Surveillance forms are distributed to the State and local health departments who voluntarily submit these reports to CDC at variable frequencies, either weekly or monthly. CDC then calculates and publishes weekly statistics via the Morbidity and Mortality Weekly Report (MMWR), providing the states with timely aggregates of their submissions.

The following diseases/conditions are included in this program: Diarrheal disease surveillance (includes campylobacter, salmonella, and shigella), foodborne outbreaks, arboviral surveillance (ArboNet), Influenza virus, including the annual survey and influenza-like illness, Respiratory and Enterovirus surveillance, rabies, waterborne diseases, cholera and other vibrio illnesses, Listeria, Calcinet, Harmful Algal Bloom-related Infectious Surveillance System (HABISS) data entry form, and the HABISS monthly reporting form. These data are essential on the local, state, and Federal levels for measuring trends in diseases, evaluating the effectiveness of current prevention strategies, and determining the need for modifying current prevention measures.

This request is for extension of the currently approved data collection for three years. Because of the distinct nature of each of the diseases, the number of cases reported annually is different for each. There is no cost to respondents other than their time. The estimated annualized burden hours are 22,356.

ESTIMATE OF ANNUALIZED BURDEN HOURS

Respondents state epidemiologists Form	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
Diarrheal Disease Surveillance: *Campylobacter* (electronic)	53	52	3/60
Diarrheal Disease Surveillance: *Salmonella* (electronic)	53	52	3/60
Diarrheal Disease Surveillance: *Shigella* (electronic)	53	52	3/60
Foodborne Outbreak Form	54	31.5	20/60
Arboviral Surveillance (ArboNet)	57	1421	4/60
—Influenza virus (fax, Oct–May)	8	33	10/60
—Influenza virus (fax, year round)	15	52	10/60
Influenza virus (Internet; Oct–May)	13	33	10/60
Influenza virus (Internet; year round)	24	52	10/60
—Influenza virus (electronic, Oct–May)	9	33	5/60
—Influenza virus (electronic, year round)	14	52	5/60
Influenza Annual Survey	83	1	15/60
Influenza-like Illness (Oct–May)	824	33	15/60
Influenza-like Illness (year round)	496	52	15/60
Monthly Respiratory & Enterovirus Surveillance Report:—Excel format (electronic)	25	12	15/60

ESTIMATE OF ANNUALIZED BURDEN HOURS—Continued

Respondents state epidemiologists / Form	Number of respondents	Number of responses per respondent	Average burden per response (in hours)
National Respiratory & Enteric Virus Surveillance System (NREVSS)	90	52	10/60
Rabies (electronic)	50	12	8/60
Rabies (paper)	3	12	15/60
Waterborne Diseases Outbreak Form	57	1	20/60
Cholera and other *Vibrio* illnesses	450	1	20/60
Outbreak Report of Suspected Viral Gastroenteritis (Clicivirus surveillance)	20	5	5/60
Listeria Case Form	53	1	30/60
HABISS data entry form	10	12	8
HABISS monthly reporting form	10	12	30/60

Dated: May 5, 2010.

Maryam I. Daneshvar,

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

[FR Doc. 2010–11178 Filed 5–10–10; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[30Day-10–09BQ]

Agency Forms Undergoing Paperwork Reduction Act Review

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Proposed Project

Examining In-vehicle Exposures to Air Pollutants and Corresponding Health Outcomes of Commuters—New—National Center for Environmental Health, (NCEH) and Agency for Toxic Substances and Disease Registry (ATSDR), Centers for Disease Control and Prevention, (CDC).

Background and Brief Description

Numerous studies have found associations between ambient fine particulate matter ($PM_{2.5}$) and adverse cardiovascular outcomes. Several recent epidemiologic studies suggest that vehicle-related emissions, in particular, may be linked to many of the these adverse effects and that specific sub-populations may be more susceptible to health risks due to their enhanced exposures to vehicle-related $PM_{2.5}$ sources. Commuters are a potentially susceptible, yet poorly characterized, sub-population. Importantly, recent epidemiologic studies indicate that specific sub-groups, including those with asthma, may be at risk to cardio respiratory health effects due to their pre-existing health condition. A more complete understanding of in-vehicle exposures for the commuter population, especially those with asthma, is therefore becoming increasingly necessary as commuting durations and roadway congestion have steadily increased throughout the U.S. during the last 20 years. The National Center for Environmental Health (NCEH), Centers for Disease Control and Prevention (CDC) will conduct this study to characterize in-vehicle exposures to traffic-related air pollutants among commuters, with and without asthma, and any health impacts that these exposures may have on the commuter.

A total of 40 participants (20 adults with physician-diagnosed asthma and 20 healthy adults) living in the Atlanta metro area will be recruited for participation in this study. Participants will be excluded if they meet specific criteria including: ever being diagnosed with severe asthma, ever suffering a myocardial infarction, smoking tobacco products, or ever being diagnosed with a pulmonary disease such as emphysema, chronic obstructive pulmonary disorder (COPD), or any type of lung cancer, will be excluded.

Prior to their scheduled commute, participants will complete a one-time baseline questionnaire to assess medical history and general exposures. Additionally, a short symptom diary recording any respiratory symptoms will be completed by the participant prior to the commute and health measurements for lung function, lung inflammatory markers, heart rate, and biomarkers of systemic inflammation will be conducted by a trained field technician. In-vehicle exposures to particulate matter and other air pollutants will then be measured for all participants during their commute. After the commute, the symptom diary and health measurements will be conducted again to assess any potential changes in respiratory and cardiovascular health effects. Each participant will conduct the commute two times during the study year. The information learned from the health measurements and diary entries before and after the commute will be important in better understanding the potential acute health impacts associated with exposures to in-vehicle traffic pollutants and respiratory and cardiovascular health, and whether urban commuters—especially those with asthma—should be viewed as a susceptible sub-population given their enhanced exposures to $PM_{2.5}$ and gas-phase pollutants.

There is no cost to participants other than their time. The estimated annual burden hours are 180 hours.