

exemption to be evaluated by an optometrist or ophthalmologist. Both optometrists and ophthalmologists are medically qualified to evaluate the applicant's eye conditions when applying to the vision exemption program. The examination includes identifying and defining the nature of the vision deficiency, how long the deficiency has been present, stability, visual acuity, field of vision, and color vision.

IV. Basis for Exemption Determination

Under 49 U.S.C. 31136(e) and 31315, FMCSA may grant an exemption from the vision standard in 49 CFR 391.41(b)(10) if the exemption is likely to achieve an equivalent or greater level of safety than would be achieved without the exemption. The exemption allows applicants to operate CMVs in interstate commerce.

The Agency's decision regarding these exemption applications is based on medical reports about the applicants' vision as well as their driving records and experience driving with the vision deficiency. The qualifications, experience, and medical condition of each applicant were stated and discussed in detail in the January 16, 2018, **Federal Register** notice (83 FR 2311) and will not be repeated in this notice.

FMCSA recognizes that some drivers do not meet the vision requirement but have adapted their driving to accommodate their limitation and demonstrated their ability to drive safely. The 18 exemption applicants listed in this notice are in this category. They are unable to meet the vision requirement in one eye for various reasons, including amblyopia, aphakia, cataracts, central scarring, complete loss of vision, glaucoma, macular scarring, retinal detachment, retinal scarring. In most cases, their eye conditions were not recently developed. Nine of the applicants were either born with their vision impairments or have had them since childhood. The nine individuals that sustained their vision conditions as adults have had it for a range of 4 to 26 years. Although each applicant has one eye which does not meet the vision requirement in 49 CFR 391.41(b)(10), each has at least 20/40 corrected vision in the other eye, and in a doctor's opinion, has sufficient vision to perform all the tasks necessary to operate a CMV.

Doctors' opinions are supported by the applicants' possession of a valid license to operate a CMV. By meeting State licensing requirements, the applicants demonstrated their ability to operate a CMV, with their limited vision in intrastate commerce, even though

their vision disqualified them from driving in interstate commerce. We believe that the applicants' intrastate driving experience and history provide an adequate basis for predicting their ability to drive safely in interstate commerce. Intrastate driving, like interstate operations, involves substantial driving on highways on the interstate system and on other roads built to interstate standards. Moreover, driving in congested urban areas exposes the driver to more pedestrian and vehicular traffic than exists on interstate highways. Faster reaction to traffic and traffic signals is generally required because distances between them are more compact. These conditions tax visual capacity and driver response just as intensely as interstate driving conditions.

The applicants in this notice have driven CMVs with their limited vision in careers ranging for 3 to 70 years. In the past three years, one driver was involved in a crash, and two drivers were convicted of moving violations in CMVs. All the applicants achieved a record of safety while driving with their vision impairment, demonstrating the likelihood that they have adapted their driving skills to accommodate their condition. As the applicants' ample driving histories with their vision deficiencies are good predictors of future performance, FMCSA concludes their ability to drive safely can be projected into the future.

Consequently, FMCSA finds that in each case exempting these applicants from the vision requirement in 49 CFR 391.41(b)(10) is likely to achieve a level of safety equal to that existing without the exemption.

V. Conditions and Requirements

The terms and conditions of the exemption are provided to the applicants in the exemption document and includes the following: (1) Each driver must be physically examined every year (a) by an ophthalmologist or optometrist who attests that the vision in the better eye continues to meet the standard in 49 CFR 391.41(b)(10) and (b) by a certified Medical Examiner who attests that the individual is otherwise physically qualified under 49 CFR 391.41; (2) each driver must provide a copy of the ophthalmologist's or optometrist's report to the Medical Examiner at the time of the annual medical examination; and (3) each driver must provide a copy of the annual medical certification to the employer for retention in the driver's qualification file, or keep a copy in his/her driver's qualification file if he/she is self-employed. The driver must also

have a copy of the exemption when driving, for presentation to a duly authorized Federal, State, or local enforcement official.

VI. Preemption

During the period the exemption is in effect, no State shall enforce any law or regulation that conflicts with this exemption with respect to a person operating under the exemption.

VII. Conclusion

Based upon its evaluation of the 18 exemption applications, FMCSA exempts the following drivers from the vision requirement, 49 CFR 391.41(b)(10), subject to the requirements cited above:

Michael H. Eheler, II (WI)
Roberto Espinosa (FL)
Lee J. Gaffney (OH)
Mark S. Hale (AL)
Raymundo Maldonado (TX)
Mickey D. McCoy (TN)
Colin D. McGregor (WI)
Thomas B. Miller (VA)
Ryan J. Plank (PA)
Donald J. Poague (GA)
Jose R. Ponce (TX)
Ronald F. Prezzia (IL)
Jorge A. Rodriguez (CA)
Jimmy W. Rowland (FL)
Aaron R. Rupe (IL)
Charles L. Sauls (FL)
Gery M. Shoultz (IN)
Juan D. Zertuche, Jr. (TX)

In accordance with 49 U.S.C. 31136(e) and 31315, each exemption will be valid for two years from the effective date unless revoked earlier by FMCSA. The exemption will be revoked if the following occurs: (1) The person fails to comply with the terms and conditions of the exemption; (2) the exemption has resulted in a lower level of safety than was maintained prior to being granted; or (3) continuation of the exemption would not be consistent with the goals and objectives of 49 U.S.C. 31136 and 31315.

Issued on: April 23, 2018.

Larry W. Minor,

Associate Administrator for Policy.

[FR Doc. 2018-08913 Filed 4-26-18; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

National Highway Traffic Safety Administration

[Docket No. NHTSA-2018-0056]

Request for Information: Improving Prehospital Trauma Care

AGENCY: National Highway Traffic Safety Administration (NHTSA), Department of Transportation (DOT).

ACTION: Notice.

SUMMARY: NHTSA, on behalf of the Federal Interagency Committee on Emergency Medical Services (FICEMS), is seeking comments from all sources (public, private, governmental, academic, professional, public interest groups, and other interested parties) on improving prehospital trauma care.

The purpose of this notice is to solicit comments on improving prehospital trauma care, and to request responses to specific questions provided below. This is neither a request for proposals nor an invitation for bids.

DATES: It is requested that comments on this announcement be submitted by July 26, 2018.

ADDRESSES: You may submit comments [identified by Docket No. NHTSA–2018–0056] through one of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the online instructions for submitting comments.

- *Mail or Hand Delivery:* Docket Management Facility, U.S. Department of Transportation, 1200 New Jersey Avenue SE, West Building, Room W12–140, Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except on Federal holidays.

FOR FURTHER INFORMATION CONTACT: Gamunu Wijetunge, Office of Emergency Medical Services, (202) 493–2793, gamunu.wijetunge@dot.gov, located at the United States Department of Transportation; 1200 New Jersey Avenue SE, NP4–400, Room W44–232, Washington, DC 20590. Office hours are from 9 a.m. to 5 p.m., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:**Background**

FICEMS was created (42 U.S.C. 300d–4) by the Secretaries of Transportation, Health and Human Services and Homeland Security to, in part, ensure coordination among the Federal agencies involved with State, local, tribal or regional emergency medical services and 9–1–1 systems. FICEMS has statutory authority to identify State and local Emergency Medical Services (EMS) and 9–1–1 needs, to recommend new or expanded programs and to identify the ways in which Federal agencies can streamline their processes for support of EMS. FICEMS includes representatives from the Department of Defense (DoD) Office of the Assistant Secretary of Defense Health Affairs, the Department of Health and Human Services (HHS) Office of the Assistant Secretary for Preparedness and Response (ASPR), HHS Indian Health

Service (IHS), HHS Centers for Disease Control and Prevention (CDC), HHS Health Resources and Services Administration (HRSA), HHS Centers for Medicare and Medicaid Services (CMS), the Department of Homeland Security (DHS) Office of Health Affairs (OHA), DHS U.S. Fire Administration (USFA), NHTSA, the Federal Communications Commission (FCC) and a State EMS Director appointed by the Secretary of Transportation.

In 2016 the National Academies of Sciences, Engineering, and Medicine (NASEM) published a report, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury* (2016 NASEM Trauma Report), that estimated as many as 20 percent of the nearly of 200,000 annual trauma deaths in the United States could be prevented.

On December 2, 2016 the National Emergency Medical Services Advisory Council (NEMSAC) issued recommendations to FICEMS in response to the NASEM report (https://www.ems.gov/pdf/nemsac/NEMSAC_Advisory_MTSPE_Alignment_Trauma_Care_Report.pdf). NEMSAC recommended that FICEMS develop an integrated Federal strategy to address both the recommendations of the NASEM report and the need to update the Model Trauma Systems Planning and Evaluation (MTPSE) document which includes a Benchmarks, Indicators and Scoring (BIS) tool.

On December 6, 2017, FICEMS and the Council on Emergency Medical Care (CEMC) co-hosted a listening session to hear from stakeholders about the challenges facing prehospital trauma care, especially in rural settings, and how to better integrate military and civilian EMS systems. An integrated national trauma care system would allow lessons learned from the battlefield to be translated to civilian EMS and provide opportunities for improved patient care.

A national trauma care system, that integrates military and civilian capabilities, is a crucial part of our Nation's infrastructure and is vital to preserve the health and productivity of the American people.

The 2016 NASEM report estimates that as many as 20% of the nearly 200,000 annual trauma deaths in the United States could be prevented. In its report, the NASEM defined preventable deaths after injury as those casualties whose lives could have been saved by appropriate and timely medical care, irrespective of tactical, logistical, or environmental issues.

Questions on Improving Prehospital Trauma Care

Responses to the following questions are requested. Please provide references as appropriate.

1. What are the current impediments, and possible solutions, to achieving zero preventable deaths in the following settings:

- a. Wilderness;
- b. Rural;
- c. Suburban; and
- d. Urban.

2. What should be the national aim for preventable prehospital trauma deaths?

3. What should be the interim national goals to achieve zero preventable deaths in the prehospital setting?

4. What are the most promising or innovative opportunities to improve prehospital trauma care in the following settings:

- a. Military;
- b. Wilderness;
- c. Rural;
- d. Suburban; and
- e. Urban.

5. How could the Learning Health System model (as described in the 2016 NASEM Trauma Report) be applied to civilian EMS?

6. Are there actions that could be taken today in the prehospital setting (such as promising clinical interventions) that could dramatically improve outcomes for patients who are:

- a. Suffering from traumatic pain;
- b. Severely injured in a rural roadway crash;
- c. Suffering from penetrating trauma;
- d. Subjected to a compromised

airway;

- e. Suffering from a major hemorrhage;
- f. Suffering from a pneumothorax;
- g. Suffering from blunt force trauma;
- h. Suffering from traumatic brain

injury;

i. Other clinical conditions (please explain).

7. What EMS evidence based guidelines could be developed to improve trauma patient outcomes?

8. As an EMS stakeholder what do you see is the potential role of the National EMS Information System (NEMSIS) and the EMS Compass performance measures in improving prehospital trauma care?

9. How might active duty, National Guard, and reserve component military resources be used to improve civilian trauma care outcomes in the following settings:

- a. Use of military rotary wing assets to support civilian EMS;
- b. Placement of military medics in the field to support and cross train with civilian EMS.

10. What actions can be taken to improve public awareness of traumatic injury as a public health issue?

11. What actions could be taken to improve the rapid extrication of motor vehicle crash patients?

12. What actions could be taken to improve the rapid transport of trauma patients?

13. What actions could be taken to improve prehospital care for pediatric trauma patients?

14. What actions could be taken to improve tribal prehospital trauma care?

15. What research is needed to improve prehospital trauma care during a mass casualty incident?

16. What is the potential role of 9–1–1 in improving prehospital trauma care outcomes?

17. What is the potential role of bystander care, such as Stop the Bleed, in improving prehospital trauma care outcomes?

18. What is the potential role of vehicle telematics in improving prehospital trauma care outcomes?

19. What is the potential role of telemedicine in improving prehospital trauma care outcomes?

20. What is the potential role of community paramedicine, mobile integrated healthcare, and other emerging EMS subspecialties in improving prehospital trauma care outcomes?

21. How could data-driven and evidence-based improvements in EMS systems improve prehospital trauma care?

22. How could enhanced collaboration among EMS systems, health care providers, hospitals, public safety answering points, public health, insurers, and others improve prehospital trauma care?

23. What are some opportunities to improve exchange of evidence based prehospital trauma care practices between military and civilian medicine?

24. Do you have any additional comments regarding prehospital trauma care?

Authority: 44 U.S.C. Section 3506(c)(2)(A).

Issued in Washington, DC, on April 19, 2018.

Jeff Michael,

Associate Administrator, Research and Program Development.

[FR Doc. 2018–08504 Filed 4–26–18; 8:45 am]

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DEPARTMENT OF TRANSPORTATION

Office of the Secretary of Transportation

Notice of Funding Opportunity for the Department of Transportation's National Infrastructure Investments Under the Consolidated Appropriations Act, 2018

AGENCY: Office of the Secretary of Transportation, DOT.

ACTION: Notice of funding opportunity.

SUMMARY: The Consolidated Appropriations Act, 2018 (Pub. L. 115–141, March 23, 2018) (“FY 2018 Appropriations Act” or the “Act”) appropriated \$1.5 billion to be awarded by the Department of Transportation (“DOT” or the “Department”) for National Infrastructure Investments. This appropriation stems from the program funded and implemented pursuant to the American Recovery and Reinvestment Act of 2009 (the “Recovery Act”). This program was previously known as the Transportation Investment Generating Economic Recovery, or “TIGER Discretionary Grants,” program and is now known as the Better Utilizing Investments to Leverage Development, or “BUILD Transportation Discretionary Grants,” program. Funds for the FY 2018 BUILD Transportation program are to be awarded on a competitive basis for projects that will have a significant local or regional impact. The purpose of this Final Notice is to solicit applications for BUILD Transportation Discretionary Grants.

DATES: Applications must be submitted by 8:00 p.m. E.D.T. on July 18, 2018.

ADDRESSES: Applications must be submitted through *Grants.gov*.

FOR FURTHER INFORMATION CONTACT: For further information concerning this notice, please contact the BUILD Transportation program staff via email at *BUILDgrants@dot.gov*, or call Howard Hill at 202–366–0301. A TDD is available for individuals who are deaf or hard of hearing at 202–366–3993. In addition, DOT will regularly post answers to questions and requests for clarifications as well as information about webinars for further guidance on DOT’s website at *www.transportation.gov/BUILDgrants*.

SUPPLEMENTARY INFORMATION: Many of the selection criteria of BUILD Transportation grants overlap with previous rounds of National Infrastructure Investments discretionary grants, though the program is refocused on infrastructure investment that will

make a positive impact throughout the country. The FY 2018 BUILD Transportation program will continue to give special consideration to projects located in rural areas. For this round of BUILD Transportation Discretionary Grants, the maximum grant award is \$25 million, and no more than \$150 million can be awarded to a single State, as specified in the FY 2018 Appropriations Act. Each section of this notice contains information and instructions relevant to the application process for these BUILD Transportation Discretionary Grants, and all applicants should read this notice in its entirety so that they have the information they need to submit eligible and competitive applications.

Table of Contents

- A. Program Description
- B. Federal Award Information
- C. Eligibility Information
- D. Application and Submission Information
- E. Application Review Information
- F. Federal Award Administration Information
- G. Federal Awarding Agency Contacts
- H. Other Information

A. Program Description

The Consolidated Appropriations Act, 2018 (Pub. L. 115–141, March 23, 2018) (“FY 2018 Appropriations Act” or the “Act”) appropriated \$1.5 billion to be awarded by the Department of Transportation (“DOT” or the “Department”) for National Infrastructure Investments. Since this program was first created, \$5.6 billion has been awarded for capital investments in surface transportation infrastructure over nine rounds of competitive grants. Throughout the program, these discretionary grant awards have supported projects that have a significant local or regional impact.

The Department is committed to addressing the unmet transportation infrastructure needs of rural areas. Rural America is home to many of the nation’s most critical transportation infrastructure assets, including 444,000 bridges, 2.98 million miles of roadways, and 30,500 miles of Interstate highways. More than 55 percent of all public road miles are locally-owned rural roads. While only 19 percent of the nation’s population lives in rural areas, 49 percent of all traffic fatalities occur on rural roads (2015). In addition, Americans living in rural areas and on Tribal lands continue to disproportionately lack access to basic broadband service. The Department believes that underinvestment in rural transportation systems has allowed a slow and steady decline in the transportation routes that connect rural