Written comments must be received on or before October 1, 2026.

ADDRESSES: You may submit comments by mail to: Rashaun Roberts, Ph.D., Designated Federal Officer, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, 1090 Tusculum Avenue, Mailstop C–24, Cincinnati, Ohio 45226. Email: *ocas@cdc.gov.*

Written comments received in advance of the meeting will be included in the official record of the meeting.

Meeting Information: The USA toll-free dial-in number is 1–888–994–4478; the passcode is 249193631. The Meeting ID: 286 533 548 251 834; passcode is: Rs7WP9Sg, and the Web conference by Teams meeting connection: *https://teams.microsoft.com/meet/286533548251834?p=vEbJ5Pb8VculYlegd7.*

FOR FURTHER INFORMATION CONTACT: Rashaun Roberts, Ph.D., Designated Federal Officer, National Institute for Occupational Safety and Health, Centers for Disease Control and Prevention, 1090 Tusculum Avenue, Mailstop C–24, Cincinnati, Ohio 45226, Telephone: (513) 533–6800, Email: *ocas@cdc.gov.*

SUPPLEMENTARY INFORMATION:

Background: The Advisory Board was established under the Energy Employees Occupational Illness Compensation Program Act of 2000 to advise the President on a variety of policy and technical functions required to implement and effectively manage the compensation program. Key functions of the Advisory Board include providing advice on the development of probability of causation guidelines, which have been promulgated by the Department of Health and Human Services (HHS) as a final rule; advice on methods of dose reconstruction, which have also been promulgated by HHS as a final rule; advice on the scientific validity and quality of dose estimation and reconstruction efforts being performed for purposes of the compensation program; and advice on petitions to add classes of workers to the Special Exposure Cohort (SEC). In December 2000, the President delegated responsibility for funding, staffing, and operating the Advisory Board to HHS, which subsequently delegated this authority to the CDC. NIOSH implements this responsibility for CDC.

The charter was issued on August 3, 2001, renewed at appropriate intervals, and rechartered under Executive Order 14109 (September 29, 2023) on March 22, 2024. Unless continued by the President, the Advisory Board will terminate on September 30, 2027, consistent with Executive Order 14354 of September 29, 2025.

Purpose: The Advisory Board is charged with (a) providing advice to the Secretary, HHS, on the development of guidelines under Executive Order 13179; (b) providing advice to the Secretary, HHS, on the scientific validity and quality of dose reconstruction efforts performed for this program; and (c) upon request by the Secretary, HHS, advising the Secretary on whether there is a class of employees at any Department of Energy facility who were exposed to radiation but for whom it is not feasible to estimate their radiation dose, and on whether there is reasonable likelihood that such radiation doses may have endangered the health of members of this class.

Matters to be Considered: The agenda will include discussions on the following: Program updates; updates from workgroup and subcommittee reports; update on the status of SEC petitions; and planning for a December 2026 Advisory Board meeting. Agenda items are subject to change as priorities dictate. For additional information, please contact Toll Free 1–800–232–4636.

The Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention, has been delegated the authority to sign **Federal Register** notices pertaining to announcements of meetings and other committee management activities, for both the Centers for Disease Control and Prevention and the Agency for Toxic Substances and Disease Registry.

Kalwant Smagh,

Director, Office of Strategic Business Initiatives, Office of the Chief Operating Officer, Centers for Disease Control and Prevention.

[FR Doc. 2026–14311 Filed 7–15–26; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Docket No. CDC–2026–0892]

Order Under Sections 362 and 365 of the Public Health Service Act Continuing the Suspension of the Right To Introduce Certain Persons From Countries Where a Quarantinable Communicable Disease Exists

AGENCY: Centers for Disease Control and Prevention (CDC), Department of Health and Human Services (HHS).

ACTION: Notice with comment period.

SUMMARY: The Centers for Disease Control and Prevention (CDC), a component of the Department of Health and Human Services (HHS), announces it is issuing an Order under Section 362 and 365 of the Public Health Service Act, and associated implementing regulations, continuing the suspension of the right to introduce certain persons from countries where an outbreak of a quarantinable communicable disease exists. This Order was issued on July 13, 2026, and shall remain in effect through 4:59 p.m. Eastern Daylight Time (EDT) on Wednesday, August 12, 2026. This Order may be amended or rescinded prior to that time at the discretion of the Director.

DATES: This action took effect July 13, 2026, at 5:00 p.m. EDT. Written comments must be received on or before July 31, 2026.

ADDRESSES: You may submit comments, identified by Docket No. CDC–2026–0892 by either of the methods listed below. Do not submit comments by email. CDC does not accept comments by email.

- *Federal eRulemaking Portal: http://www.regulations.gov.* Follow the instructions for submitting comments.
- *Mail:* Division of Global Migration Health, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS H16–4, Atlanta, GA 30329.

Instructions: All submissions received must include the agency name and Docket Number. All relevant comments received will be posted without change to *http://regulations.gov,* including any personal information provided. For access to the docket to read background documents or comments received, go to *http://www.regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Matthew J. Buzzelli, Chief of Staff, Centers for Disease Control and Prevention, 1600 Clifton Road NE, MS V18–2, Atlanta, GA 30329. Phone: 404–639–7000. Email: *cdcregulations@cdc.gov.*

SUPPLEMENTARY INFORMATION: On May 18, 2026, the Senior Official Carrying out the Delegable Duties of the Director of the Centers for Disease Control and Prevention signed an Order prohibiting the introduction of certain persons who have departed from, or were otherwise present within, specified countries during the last 21 days. On May 22, 2026, the Assistant Secretary for Health (ASH), HHS, signed an Amended Order that reflected updates to 42 CFR 71.40(f), which no longer provided an exemption for lawful permanent residents from such orders. CDC accepted comments on both the original Order and Amended Order through June

22, 2026. On June 21, 2026, the ASH signed a new 30-day Order continuing the previous Order, without change, and provided a 15-day comment period. During this time CDC received five comments, which are addressed below. On July 13, 2026, the ASH signed a new order continuing the previous Order without change and providing updates on the current epidemiologic situation and status of the outbreak. With this Order, CDC continues the suspension of the right to introduce certain persons who have departed from, or were otherwise present within, specified countries during the last 21 days. This Order is effective for a period of 30 days.

Response To Comments on Previous Orders

Comment: One commenter argues that CDC lacks authority to exempt U.S. citizens from the scope of the Order and requests that CDC rescind the exemption. The commenter contends that section 362 of the Public Health Service Act authorizes suspension of the introduction of ''persons'' without distinguishing between U.S. citizens and noncitizens and asserts that public health considerations outweigh any constitutional concerns. The commenter further argues that CDC should exercise its authorities more broadly in responding to the Ebola outbreak.

Response: CDC appreciates this comment, however it is outside the scope of the continued Order. This Order is consistent with CDC's foreign quarantine regulations, including 42 CFR 71.40, which exclude U.S. citizens and U.S. nationals from the suspension authority. CDC is therefore making no changes in response to this comment.

Comment: Another commenter strongly opposed the previous order noting that citizens should have the right to return to the United States given the country's capacity to deal with special pathogens like Ebola.

Response: CDC appreciates this comment. The continued Order does not apply to U.S. citizens or U.S. nationals, who are exempt under 42 CFR 71.40(f).

Comment: Three of the commenters requested that CDC reconsider allowing lawful permanent residents (LPRs) to return under the same screening and monitoring protocols that apply to U.S. citizens as was allowed in the original May 18, 2026, Order.

Response: CDC appreciates these comments. With respect to LPRs, the continued Order is consistent with CDC's current foreign quarantine regulations. The removal of the exemption for LPRs resulted from amendments to 42 CFR 71.40(f) and is outside the scope of this Order. Accordingly, CDC is making no changes in response to this comment.

Commen Two of these commenters also requested that Uganda be evaluated independently and removed from the list of countries noting that since the outbreak began, Uganda has implemented significant measures to reduce the risk of importation from the DRC, including restrictions on cross-border passenger travel, enhanced border screening, and additional public health controls for travelers entering from affected areas.

Response: CDC appreciates this comment but does not agree that Uganda should be removed from the list of designated countries or evaluated independently of the broader regional outbreak at this time. Available epidemiologic information indicates ongoing transmission and the potential for rapid changes in the outbreak. Because the outbreak remains interconnected across national borders, CDC's assessment must consider regional epidemiology, including transmission dynamics in neighboring countries. Accordingly, CDC has determined that applying the Order to persons who have been present in the DRC, Uganda, or South Sudan during the preceding 21 days remains the most effective and administratively practical approach to reducing the risk of Ebola disease introduction into the United States while the public health assessment continues.

CDC carefully considered all comments and determined that they did not warrant changes to the requirements of the Order issued June 21, 2026. The new Order, issued on July 13, 2026, provides updated information regarding the status of the Ebola disease outbreak and CDC response efforts and maintains the previous travel restrictions. CDC will accept comments for this Order using docket CDC–2026–0892. A copy of the Order is provided below and a copy of the signed Order can be found at https://www.cdc.gov/port-health/legal-authorities/evdorder.html.

U.S. Department of Health and Human Services Centers for Disease Control and Prevention (CDC)

Order Under Sections 362 & 365 of the Public Health Service Act (42 U.S.C. 265, 268) and 42 CFR § 71.40

Continuing the Suspension of the Right to Introduce Certain Persons from Countries Where A Quarantinable Communicable Disease Exists

I. Executive Summary

The Centers for Disease Control and Prevention (CDC), a component of the U.S. Department of Health and Human Services (HHS), issues this Order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265, 268, and their implementing regulations. This Order continues the suspension of the right to introduce ''covered aliens,'' as defined herein, into the United States for a period of thirty days, subject to the outcome of an ongoing comprehensive public health risk assessment. This Order is necessary to protect the health of the United States from the serious risk posed by the introduction of Ebola disease into the United States by covered aliens based on the outbreak of Ebola disease caused by the Bundibugyo virus confirmed present in Democratic Republic of the Congo (DRC) and Uganda.

This Order applies to covered aliens who have departed from, or were otherwise present within, DRC, Uganda, or South Sudan during the last 21 days (regardless of their country of origin). This Order is based on an assessment of the most recently available data and current conditions regarding the Ebola disease outbreak.

This Order is time-limited and shall be in effect for 30 days from the date of issuance. This Order is intended to address the serious risk of introduction of Ebola disease into the United States, while allowing the U.S. Government to continue an ongoing assessment of the current and evolving conditions of the Ebola disease outbreak in consultation with other stakeholders.

This Order is severable from previously issued Orders under Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265, 268, and their implementing regulations under 42 CFR part 71. Any provision of this Order held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, shall be construed so as to continue to give the maximum effect to the provision permitted by law, unless such holding shall be one of utter invalidity or unenforceability.

II. Authority, Scope, and Purpose

I issue this Order pursuant to Sections 362 and 365 of the Public Health Service (PHS) Act, 42 U.S.C. 265, 268, and their implementing regulations under 42 CFR part 71,[1] which authorize the CDC Director to suspend the right to

[1] Control of Communicable Diseases; Foreign Quarantine: Suspension of the Right to Introduce and Prohibition of Introduction of Persons into United States from Designated Foreign Countries or Places for Public Health Purposes, 85 FR 56424 (Sept. 11, 2020), as amended by 91 FR 31362 (May 27, 2026); 42 CFR 71.40.

introduce [2] persons into the United States when the Director determines that the existence of a quarantinable communicable disease in a foreign country or place creates a serious danger of the introduction of such disease into the United States and the danger is so increased by the introduction of persons from the foreign country or place that a temporary suspension of the right of such introduction is necessary to protect public health.

This Order applies to persons who have departed from, or were otherwise present within, DRC, Uganda, and South Sudan during the last 21 days (regardless of their country of origin), including lawful permanent residents of the United States, subject to the exceptions detailed below. For purposes of this Order, I refer to persons covered by the Order as ''covered aliens.''

This Order does *not* apply to the following:

- U.S. citizens and U.S. nationals; [3]
- Members of the armed forces of the United States and associated personnel, U.S. government personnel serving overseas, associated personnel, and their spouses and children, subject to required assurances; [4]
- Persons whom customs officers determine, with approval from a supervisor, should be excepted from this Order based on the totality of the circumstances, including consideration of significant law enforcement, officer and public safety, humanitarian, and public health interests. The U.S. Department of Homeland Security (DHS) will consult with CDC regarding the standards for such exceptions to help ensure consistency with current CDC guidance and public health recommendations; and
- Persons who would otherwise be subject to this Order, who are permitted to enter the United States based on an exception provisionally granted by CDC with confirmation based on a public health assessment at time of entry under a DHS-approved process documented and shared with CDC which includes appropriate public health mitigation protocols, per CDC guidance.

The purpose of this Order is twofold. First, this Order aims to continue minimizing the number of covered aliens entering the United States who have been within countries experiencing a known or suspected outbreak of Ebola disease and thereby reduce the risk of introduction of Ebola disease into the United States. Second, this Order is intended to facilitate an ongoing public health assessment and risk profile of the Ebola disease outbreak. Thirty days is the amount of time necessary for CDC to conduct an updated public health assessment and determine whether there has been a material change in the outbreak trajectory. Such information will enable the acting CDC Director to make an informed determination regarding what restrictions are necessary going forward and provide the opportunity for the development of a comprehensive mitigation and containment plan in consultation with stakeholders.

III. Factual Basis

A. Ebola Disease

Viral hemorrhagic fever refers to a group of severe illnesses caused by certain viruses that damage the body's blood vessels and affect the ability of the blood to clot properly. Viral hemorrhagic fevers include diseases such as Ebola, Marburg, Lassa fever, and dengue hemorrhagic fever.

Bundibugyo virus disease (BVD) is a severe and often fatal illness caused by one of the viruses in the Ebola family. Ebola disease outbreaks occur mainly in parts of sub-Saharan Africa and can spread rapidly in communities with limited healthcare resources. Ebola disease caused by the Bundibugyo virus is a rare form of Ebola first identified during an outbreak in Bundibugyo District, Uganda, in 2007. Bundibugyo virus is one of several species within the orthoebolavirus family and causes symptoms similar to other forms of Ebola, including fever, weakness, vomiting, diarrhea, and, in severe cases, hemorrhagic complications and organ failure. The disease spreads through direct contact with infected bodily fluids or contaminated materials.

The incubation period for Ebola disease caused by the Bundibugyo virus is typically between 2 and 21 days, with most people developing symptoms within 4 to 10 days after exposure. During this incubation period, infected persons do not spread the virus until symptoms begin.

Screening for Bundibugyo virus disease focuses on identifying symptoms and possible exposure history, such as recent travel to affected areas or contact with infected aliens. Suspected patients are evaluated for symptoms including fever, weakness, vomiting, diarrhea, and bleeding, and laboratory confirmation is performed using specialized tests such as PCR (polymerase chain reaction) to detect the virus in blood and other body fluid samples. Health authorities also use temperature checks, contact tracing, and isolation procedures to prevent transmission.

There are currently no widely approved vaccines or specific antiviral treatments for the Bundibugyo strain of Ebola disease. Treatment mainly consists of supportive care, including intravenous fluids, electrolyte replacement, oxygen support, pain and fever management, and treatment of secondary infections. Early medical care significantly improves survival chances. Robust public health measures such as early detection, rapid isolation, strong infection prevention measures (*i.e.,* use of personal protective equipment [PPE]), and monitoring of contacts are critical to controlling outbreaks and reducing deaths. A clinical trial of monoclonal antibodies is presently underway in DRC.[5] However, experts expect it will be several months before these therapeutics are potentially available for wider use.

B. Ongoing Bundibugyo Virus Disease Outbreak

The confirmed ongoing outbreak of Ebola virus disease caused by the Bundibugyo virus in DRC and Uganda continues to escalate in intensity. The outbreak remains centered in eastern DRC's Ituri Province, although cases have been identified in North Kivu, South Kivu, Haut-Uele, and Tshopo provinces. This geographic expansion is concerning, particularly given that response efforts are still not at the scale required for outbreak containment. On June 15, 2026, when the last Order was issued, DRC reported 837 confirmed cases across 31 health zones. As of July 12, 2026, DRC reports 1,873 confirmed cases and 672 deaths across 41 health zones, with cases more than doubling since issuance of the June 22 Order.

As recently as July 10, 2026, the ongoing Bundibugyo Ebola virus outbreak in DRC continues to spread despite response efforts. In the outbreak's epicenter, an estimated 80 percent of newly confirmed cases are not linked to known contacts, indicating substantial undetected community transmission.[6] Recent assessments

[2] *Suspension of the right to introduce* means to cause the temporary cessation of the effect of any law, rule, decree, or order pursuant to which a person might otherwise have the right to be introduced or seek introduction into the United States. 42 CFR 71.40(b)(5).

[3] 42 CFR 71.40(f).

[4] 42 CFR 71.40(e)(1) and (2).

[5] WHO, *Patient enrolment begins in a scientific trial to identify the first effective treatments for Bundibugyo virus disease, https://www.who.int/news/item/02-07-2026-patient-enrolment-begins-in-a-scientific-trial-to-identify-the-first-effective-treatments-for-bundibugyo-virus-disease* (last accessed July 12, 2026).

[6] Bonnerot, C., Reuters, *Congo Ebola outbreak still spreading largely undetected, WHO official says,* available at *https://www.reuters.com/business/healthcare-pharmaceuticals/congo-ebola-outbreak-*

indicate that the true magnitude of the outbreak may be two to four times greater than reported surveillance data suggest. Surveillance challenges persist in the most heavily affected areas, with conflict and insecurity, weak health infrastructure, and relatively porous borders in the region complicating containment efforts. Although contact tracing efforts are underway, they remain insufficient because the expected number of contacts has not yet been identified and the daily follow-up necessary to rapidly detect symptomatic individuals and ensure their prompt isolation has not been achieved.

As of July 12, 2026, Uganda reports 20 confirmed cases of Ebola disease and two confirmed deaths, as well as one probable case and one probable death. All cases in Uganda have been epidemiologically linked to the ongoing outbreak in DRC, with cross-border importations have occurred, resulting in secondary transmission among family members and caregivers [7] Ugandan authorities have activated emergency response systems, expanded surveillance, and strengthened screening at borders and health facilities. Uganda has significant prior experience managing Ebola disease outbreaks, including the Sudan virus strain outbreak in 2025, which improved preparedness and response capacity. Although the outbreak in Uganda has been concentrated in Kampala and despite Uganda's response efforts, continued overland travel from DRC poses an ongoing risk of cross-border transmission, particularly among healthcare workers and in western Ugandan districts that serve as points of entry for travelers seeking medical care.

To date, South Sudan has not reported any confirmed Ebola disease cases in the current outbreak.[8] However, it is considered at high risk because of its close border with affected areas in eastern DRC and Uganda, limited healthcare infrastructure, and cross-border population movement. Regional and international agencies, including WHO and Africa CDC, are supporting preparedness measures, surveillance, and coordination among the three countries to prevent wider spread. Despite these efforts there continues to be a risk that the outbreak in DRC and Uganda could spread to South Sudan through cross-border travel by infected individuals during the virus's incubation period, when they have been exposed but are not yet showing symptoms.

Travelers moving between affected countries and major international transit hubs could unknowingly carry the Bundibugyo virus before becoming ill. Such travelers may spread the outbreak beyond the affected countries and ultimately reach the United States. DRC, Uganda, and South Sudan are connected to the global aviation network through a series of regional and international transit hubs that provide pathways into the United States. Travelers departing from outbreak-affected regions frequently transit through densely populated metropolitan airports such as Addis Ababa Bole International Airport (ADD), Jomo Kenyatta International Airport (NBO) in Nairobi, Brussels Airport (BRU), Hamad International Airport (DOH) in Doha, Dubai International Airport (DXB), and Istanbul Airport (IST), all of which maintain extensive passenger connectivity to major U.S. gateway airports including John F. Kennedy International Airport (JFK), Washington Dulles International Airport (IAD), Hartsfield-Jackson Atlanta International Airport (ATL), Chicago O'Hare International Airport (ORD), and Los Angeles International Airport (LAX). These international transportation corridors support continuous movement of travelers between Central and East Africa and major U.S. metropolitan centers, increasing the likelihood that aliens exposed to Ebola disease could enter the United States before symptoms become apparent. Complex multi-leg itineraries and the rapid pace of international travel create substantial challenges for identifying potentially infected travelers before arrival.

A traveler infected in outbreak regions of DRC and Uganda may transit through multiple countries and major international airports before developing fever or other clinical signs of disease. The risk of Bundibugyo virus disease introduction into the United States is heightened by the virus's incubation period, which can extend up to 21 days, allowing infected persons to travel internationally while asymptomatic and therefore unlikely to be detected through routine symptom-based screening measures. The current outbreak has already demonstrated this risk: a physician infected while providing patient care in DRC traveled internationally before becoming ill and was diagnosed only after arriving in France.[9] That case required extensive public health coordination, including federal, state, and local government efforts to identify, notify, and monitor potentially exposed U.S. citizens, demonstrating that a single infected traveler can impose significant cross-border public health response demands even without onward transmission occurring within the United States. Accordingly, the interconnected nature of global air travel presents a credible pathway for Bundibugyo virus disease importation into the United States, underscoring the importance of aggressive surveillance, traveler monitoring, airport public health screening, healthcare preparedness, and rapid containment capabilities.

While the France case illustrates the public health challenges posed by infected travelers moving internationally before becoming symptomatic, the ongoing outbreak has also demonstrated that substantial U.S. public health resources may be required to respond to an Ebola exposure or infection in any U.S. citizen. On July 10, 2026, CDC announced that an additional U.S. citizen working for a humanitarian organization in DRC had tested positive for Bundibugyo virus disease.[10] The individual, who was not involved in direct patient care,[11] prompted an extensive U.S. public health response. CDC, in coordination with the humanitarian organization, initiated contact tracing, exposure risk assessments, and monitoring activities to identify high-risk contacts and evaluate potential exposures among humanitarian personnel who had recently returned to, or are planning to return to, the United States. The Department of State arranged medical evacuation outside of DRC for treatment. This incident demonstrates that even when an infected U.S. citizen remains overseas, the outbreak can require substantial U.S. public health resources to identify, assess, and monitor potentially exposed individuals associated with international humanitarian operations.

Travelers utilizing air transit pathways originating in or passing through DRC, Uganda, and South Sudan

still-spreading-largely-undetected-who-official-says-2026-07-10/ (last accessed July 12, 2026).

[7] CDC internal data.

[8] CDC, *Ebola Outbreak: Current Situation, https://www.cdc.gov/ebola/situation-summary/index.html* (last visited June 17, 2026).

[9] World Health Organization, *WHO Director-General's opening remarks at the media briefing—24 June 2026,* available at *https://www.who.int/news-room/speeches/item/who-director-general-s-opening-remarks-at-the-media-briefing—24-june-2026* (last accessed July 12, 2026).

[10] CDC, CDC Statement on Ebola Outbreak in the Democratic Republic of Congo and Uganda: 7/10/26, *https://www.cdc.gov/media/releases/2026/cdc-ebola-outbreak-in-democratic-republic-of-congo-and-uganda.html* (last accessed July 12, 2026).

[11] Walsh, D. and Yoon, J., *U.S. Citizen Tests Positive for Ebola in Democratic Republic of Congo, https://www.nytimes.com/2026/07/11/world/africa/dr-congo-ebola-american-us-citizen.html?unlocked_article_code=1.w1A.A4kv.spNPZlf8jap6&smid=url-share* (last accessed July 12, 2026).

include non-U.S. citizens, including regional migrants, foreign contract workers, humanitarian personnel, business travelers, students, refugees, and third-country nationals moving through international aviation hubs in Africa, the Middle East, and Europe. Many travelers entering U.S.-bound itineraries from these pathways may do so under temporary visas, refugee or asylum processing mechanisms, international organizational travel, or multi-country itineraries that obscure their original point of departure. As a result, public health screening and border security systems face heightened operational complexity in identifying travelers with recent exposure histories linked to Ebola-affected regions, particularly when travelers originate from or transit through multiple jurisdictions prior to arrival at major U.S. metropolitan airports.

CDC issued a Level 2 Travel Health Notice (THN, practice enhanced precautions) for Ituri and North Kivu provinces of DRC and a Level 1 THN (practice usual precautions) for Uganda on May 15, 2026.[12] On May 18, 2026,[13] CDC escalated the Level 2 THN for to a Level 3 THN (reconsider nonessential travel) for Ituri and North Kivu Provinces; South Kivu was added to the Level 3 on May 22, 2026. On May 27, 2026, the THN for Uganda was elevated to a Level 2. On June 15, 2026 CDC issued a Level 2 THN for the remainder of DRC and Uganda.[14] This modification reflects the geographic distribution of reported cases and does not indicate a reduced level of concern regarding the outbreak, which continues to expand in affected areas and poses a risk of further transmission and geographic spread.

CDC modeling indicates that, absent rapid and sustained public health interventions, the outbreak could become one of the largest Ebola epidemics ever recorded.[15] The analysis further demonstrates that early identification of cases, contact tracing, isolation and treatment of symptomatic persons, community engagement, and safe burial practices are critical to reducing transmission and mitigating outbreak growth.[16] CDC has concluded that the current outbreak is already the largest known outbreak of Bundibugyo virus disease and that large-scale, sustained public health measures are necessary to prevent further international spread of the disease and to reduce the risk of introduction of infected persons into the United States.[17] Commensurate with the deterioration of the epidemiological situation in DRC, CDC escalated its response to the outbreak to a Level 1, the highest level within the agency's Graduated Response Framework.[18] Designating the response as a Level 1 indicates the gravity of the situation and allows additional staffing support from across the response, with immediate lines of communication with agency leadership.

Restricting entry of covered aliens into the United States reduces the volume of higher-risk international arrivals requiring public health monitoring and follow-up. By limiting the number of potentially exposed travelers entering through major U.S. ports of entry, federal, state, and local public health authorities have concentrated finite surveillance, screening, contact tracing, quarantine management, and medical monitoring resources on returning U.S. citizens and U.S. nationals, including those who have worked in the outbreak areas.

Paired with the DHS arrival restrictions redirecting travelers to specific U.S. airports,[19] this approach has reduced operational strain on airport screening systems, CDC port health stations, public health laboratories, and healthcare facilities responsible for evaluating suspected Bundibugyo virus disease cases. It also has improved the ability of authorities to conduct detailed exposure assessments, ensure compliance with monitoring requirements during the 21-day incubation period, rapidly identify symptomatic travelers, and allocate specialized isolation and treatment capacity more effectively. In the context of a rapidly evolving Bundibugyo virus disease outbreak with significant cross-border mobility, prioritizing surveillance efforts toward a smaller and more traceable traveler population has strengthened the overall effectiveness of U.S. disease containment and border health security operations.

IV. Legal Basis for This Order Under Sections 362 and 365 of the Public Health Service Act and 42 CFR 71.40

CDC is issuing this Order pursuant to sections 362 and 365 of the Public Health Service Act (42 U.S.C. 265, 268) and the implementing regulation at 42 CFR 71.40. In accordance with these authorities, the CDC Director is permitted to prohibit, in whole or in part, the introduction into the United States of persons from designated foreign countries (or one or more political subdivisions or regions thereof) or places, only for such period of time that the Director deems necessary to avert the serious danger of the introduction of a quarantinable communicable disease,[20] by issuing an Order in which the Director determines that:

(1) By reason of the existence of any quarantinable communicable disease in a foreign country (or one or more political subdivisions or regions thereof) or place there is serious danger of the introduction of such quarantinable communicable disease into the United States; and

(2) This danger is so increased by the introduction of persons from such country (or one or more political subdivisions or regions thereof) or place that a suspension of the right to introduce such persons into the United States is required in the interest of public health.[21]

Section 362 and the implementing regulation provide the Director with a public health tool to suspend introduction of persons not only to prevent the introduction of a quarantinable communicable disease, but also to aid in continued efforts to mitigate spread of that disease.[22]

The term ''introduction into the United States'' is defined in 42 CFR 71.40 as ''the movement of a person from a foreign country (or one or more political subdivisions or regions thereof) or place, or series of foreign countries or places, into the United States so as to bring the person into contact with persons or property in the United States, in a manner that the Director determines

[12] CDC, *Ebola Bundibugyo Virus Disease in Parts of the Democratic Republic of the Congo, https://wwwnc.cdc.gov/travel/notices/level3/ebola-democratic-republic-of-the-congo* (last accessed June 16, 2026). CDC subsequently updated the notice on May 22, 2026, as the outbreak expanded to additional provinces, while maintaining the Level 3 designation.

[13] CDC, *Ebola Bundibugyo Virus Disease in the Democratic Republic of the Congo and Uganda, https://wwwnc.cdc.gov/travel/notices/level2/ebola-drc-uganda* (last accessed June 17, 2026).

[14] CDC, *Ebola Bundibugyo Virus Disease in Parts of the Democratic Republic of the Congo, https://wwwnc.cdc.gov/travel/notices/level3/ebola-democratic-republic-of-the-congo* (last accessed June 16, 2026).

[15] Mooring EQ, Koval WT, Routledge I, et al. *Modeled Scenario Projections for the Ebola Disease Outbreak Caused by Bundibugyo Virus, 2026.* MMWR Morb Mortal Wkly Rep 2026;75:285–289. DOI: *http://dx.doi.org/10.15585/mmwr.mm7522e1.*

[16] *Id.*

[17] *Id.*

[18] CDC, Internal Decision Memo, June 26, 2026.

[19] DHS, Arrival Restrictions Applicable to Flights Carrying Persons Who Have Recently Traveled From or Were Otherwise Present Within the Democratic Republic of the Congo, Uganda, or South Sudan, 91 FR 29896 (May 21, 2026).

[20] *See* Exec. Order No. 13,295, Revised List of Quarantinable Communicable Diseases (April 2, 2003) (adding viral hemorrhagic fevers, including Ebola, to the U.S. federal list of quarantinable communicable diseases).

[21] 42 U.S.C. 265; 42 CFR 71.40.

[22] 85 FR 56424 at 56425–26.

to present a risk of transmission of a quarantinable communicable disease to persons, or a risk of contamination of property with a quarantinable communicable disease.'' 42 CFR 71.40(b)(1). Similarly, the term ''serious danger of the introduction of such quarantinable communicable disease into the United States'' is defined as, ''the probable introduction of one or more persons capable of transmitting the quarantinable communicable disease into the United States, even if persons or property in the United States are already infected or contaminated with the quarantinable communicable disease.'' 42 CFR 71.40(b)(3).

Section 71.40(b)(2) defines ''[p]rohibit, in whole or in part, the introduction into the United States of persons'' in Section 362 to mean ''to prevent the introduction of persons into the United States by suspending any right to introduce into the United States, physically stopping or restricting movement into the United States.'' *See also* 42 U.S.C. 265 (authorizing the prohibition when the danger posed by the communicable disease ''is so increased by the introduction of persons . . . from such country . . . that a suspension of the right to introduce such persons . . . is required in the interest of public health'').

As stated in the Final Rule for 42 CFR 71.40, CDC ''may, in its discretion, consider a wide array of facts and circumstances when determining what is required in the interest of public health in a particular situation . . . includ[ing] . . . [t]he overall number of cases of disease; any large increase in the number of cases over a short period of time; the geographic distribution of cases; any sustained (generational) transmission; the method of disease transmission; morbidity and mortality associated with the disease; the effectiveness of contact tracing; the adequacy of state and local health care systems; and the effectiveness of state and local public health systems and control measures.'' [23]

As stated in 42 CFR 71.40, this Order does not apply to U.S. citizens, U.S. nationals, members of the armed forces of the United States and associated personnel if the Secretary of War provides assurance to the Director that the Secretary of War has taken or will take measures such as quarantine or isolation, or other measures maintaining control over such individuals, to prevent the risk of transmission of the quarantinable communicable disease into the United States, or United States government employees or contractors on orders abroad, or their accompanying family members who are on their orders or are members of their household, if the Director receives assurances from the relevant head of agency and determines that the head of the agency or department has taken or will take measures such as quarantine or isolation, to prevent the risk of transmission of a quarantinable communicable disease into the United States.[24]

In addition, this Order does not apply to additional classes of persons excepted by the CDC Director. Creating exceptions in the Order is consistent with Section 362 and 42 CFR 71.40. Section 362 explicitly states that the prohibition of introduction into the United States may be ''in whole or in part.'' This phrase is also included in section 71.40(a) and, as explained in the Final Rule, is intended to allow the Director to narrowly tailor the use of the authority to what is required in the interest of public health.[25] As noted in the Final Rule for 42 CFR 71.40, the CDC Director may also take into account international obligations and humanitarian concerns.[26] Pursuant to this capability, CDC is therefore excepting certain categories of persons, as described herein.

This Order will be in effect for 30 days to avert the serious danger of the introduction, transmission, and spread of Ebola disease into the United States. Finally, as directed by 42 CFR 71.40(c), this Order sets out the following:

(1) The foreign countries (or one or more political subdivisions or regions thereof) or places from which the introduction of persons is being prohibited;

(2) The period of time or circumstances under which the introduction of any persons or class of persons into the United States is being prohibited;

(3) The conditions under which that prohibition on introduction will be effective, in whole or in part, including any relevant exceptions that the Director determines are appropriate;

(4) The means by which the prohibition will be implemented; and

(5) The serious danger posed by the introduction of the quarantinable communicable disease in the foreign country or countries (or one or more political subdivisions or regions thereof) or places from which the introduction of persons is being prohibited.

V. Determination and Implementation

Based on the foregoing, I hereby determine that Ebola disease, a highly transmissible quarantinable communicable disease, is confirmed present in DRC and Uganda. There is a material risk that the outbreak will spread to South Sudan. I also determine that the prevalence of Ebola disease in these foreign countries constitutes a serious danger of the introduction of this disease into the United States due to the limited screening and testing and mitigation measures currently available. Finally, I determine that a temporary 30-day suspension of the right to introduce covered aliens is necessary to protect the public health from the serious danger of the introduction of Ebola disease into the United States, pending an ongoing public health assessment of the Ebola disease outbreak.

I consulted with the Department of State, DHS, and other federal departments as needed before I issued this Order and requested that DHS aid in the enforcement of this Order because CDC does not have the capability, resources, or personnel needed to do so.[27] As part of the consultation, DHS developed operational plans for implementing this Order. These plans are consistent with the language of this Order.

Although this Order is not a rule subject to notice and comment under the Administrative Procedure Act (APA) and is issued with immediate effect, in order to ensure that the forthcoming public health risk assessment is informed by public input, the Order is being issued with a simultaneous 15-day comment period.

This Order takes effect at 5:00 p.m. Eastern Daylight Time on Monday, July 13, 2026. For individuals intending to travel to the United States by air, the Order will apply to flights departing after 4:59 p.m. Eastern Daylight Time on Tuesday, July 13, 2026.

* * * * *

In testimony whereof, the Assistant Secretary for Health, U.S. Department of Health and Human Services, has hereunto set his hand at Washington, DC this 14th day of July, 2026.

Dated: 07/14/2026.

Admiral Brian Christine, MD, Assistant Secretary for Health (ASH) and Head of the United States Public Health Service (USPHS) Commissioned Corps, Department of Health and Human Services.

Public Participation

Interested persons or organizations are invited to participate by submitting

[23] *Id.* at 56444.

[24] 42 CFR 71.40(e) and (f).

[25] 85 FR 56424 at 56444.

[26] *Id.* at 56447.

[27] 42 U.S.C. 268; 42 CFR 71.40(d).

written views, recommendations, and data so that the public can provide input that may inform the forthcoming public health risk assessment and whether any subsequent exercise of this authority is necessary.

Please note that comments received, including attachments and other supporting materials, are part of the public record and are subject to public disclosure. Comments will be posted on *https://www.regulations.gov.* Therefore, do not include any information in your comment or supporting materials that you consider confidential or inappropriate for public disclosure. If you include your name, contact information, or other information that identifies you in the body of your comments, that information will be on public display. CDC will review all submissions and may choose to redact, or withhold, submissions containing private or proprietary information such as Social Security numbers, medical information, inappropriate language, or duplicate/near duplicate examples of a mass-mail campaign. Do not submit comments by email. CDC does not accept comment by email.

Authority

The authority for this order is Sections 362 and 365 of the Public Health Service Act (42 U.S.C. 265, 268), as amended.

Dated: July, 14, 2026.

Brian Christine,

Admiral, Assistant Secretary for Health (ASH) and Head of the United States Public Health Service (USPHS) Commissioned Corps, Department of Health and Human Services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier: CMS–10450 and CMS–643]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, Health and Human Services (HHS).

ACTION: Notice.

SUMMARY: The Centers for Medicare & Medicaid Services (CMS) is announcing an opportunity for the public to comment on CMS' intention to collect information from the public. Under the Paperwork Reduction Act of 1995 (PRA), federal agencies are required to publish notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, and to allow a second opportunity for public comment on the notice. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including the necessity and utility of the proposed information collection for the proper performance of the agency's functions, the accuracy of the estimated burden, ways to enhance the quality, utility, and clarity of the information to be collected, and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

DATES: Comments on the collection(s) of information must be received by the OMB desk officer by August 17, 2026.

ADDRESSES: Written comments and recommendations for the proposed information collection should be sent within 30 days of publication of this notice to *www.reginfo.gov/public/do/PRAMain.* Find this particular information collection by selecting ''Currently under 30-day Review—Open for Public Comments'' or by using the search function.

To obtain copies of a supporting statement and any related forms for the proposed collection(s) summarized in this notice, please access the CMS PRA website by copying and pasting the following web address into your web browser: *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing*

FOR FURTHER INFORMATION CONTACT: William Parham at (410) 786–4669.

SUPPLEMENTARY INFORMATION: Under the Paperwork Reduction Act of 1995 (PRA) (44 U.S.C. 3501–3520), federal agencies must obtain approval from the Office of Management and Budget (OMB) for each collection of information they conduct or sponsor. The term ''collection of information'' is defined in 44 U.S.C. 3502(3) and 5 CFR 1320.3(c) and includes agency requests or requirements that members of the public submit reports, keep records, or provide information to a third party. Section 3506(c)(2)(A) of the PRA (44 U.S.C. 3506(c)(2)(A)) requires federal agencies to publish a 30-day notice in the **Federal Register** concerning each proposed collection of information, including each proposed extension or reinstatement of an existing collection of information, before submitting the collection to OMB for approval. To comply with this requirement, CMS is publishing this notice that summarizes the following proposed collection(s) of information for public comment.

Information Collection

1. *Type of Information Collection Request:* Revision of a currently approved Information Collection; *Title of Information Collection:* Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for Merit-based Incentive Payment Systems (MIPS); *Use:* This is a request to revise the information collection for the CAHPS for MIPS Survey. The CAHPS for MIPS survey is used in the Quality Payment Program (QPP) to collect data on fee-for-service Medicare beneficiaries' experiences of care with eligible clinicians participating in MIPS and is designed to gather only the necessary data that CMS needs for assessing physician quality performance, and related public reporting on physician performance, and should complement other data collection efforts. The survey consists of the core Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician & Group Survey, version 3.0, plus additional survey questions to meet CMS's information and program needs. The survey information is used for quality reporting, the compare tool on the Medicare.gov website, and annual statistical experience reports describing MIPS data for all MIPS eligible clinicians.

This 2026 information collection request addresses the requirements related to the statutorily required quality measurement. The CAHPS for MIPS survey results in burden to three different types of entities: groups, virtual groups, and subgroups; vendors; and beneficiaries associated with administering the survey. Virtual groups are subject to the same requirements as groups and subgroups; therefore, we will refer only to ''groups'' as an inclusive term for all entities unless otherwise noted.

The revision consists of a change to the vendor participation form to collect cost information from survey vendors. The collection of this cost information was proposed in the CY 2025 PFS final rule (*89 FR 62010*) and (*89 FR 62123*). The revision also includes changes to the vendor participation form to collect information related to the addition of web to the existing mail-phone administration protocol. The addition of web as the first mode of administration was proposed in the CY 2026 PFS final rule (*90 FR 49266*) and (*90 FR 49760*).