



# TECH

UPDATE

...GATE HIGHWAYS AND TR...TION

EXHIBIT NO. 3

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NATIONAL CHILD PASSENGER SAFETY TRAINING PROGRAM

Winter 2010-11

## Value of Child Restraints Confirmed by Real-World Crash Data\*\*

A recent NHTSA study confirmed that child restraint (CR) use reduces the incidence of incapacitating injuries to children in all types of crashes. Using data from two national sources, the report, "Children Injured in Motor Vehicle Traffic Crashes" (May 2010), examines the frequency and types of bodily injury to children under 8 years old in crashes.

Overall, the analysis found that the incidence of injury is significantly higher for children riding unrestrained than for those in CRs or lap-shoulder belts. Children riding in lap-shoulder belts were slightly more likely to be seriously injured compared to those in CRs in all age groups. (See Figure 3.) Following are other key findings of which technicians should be aware:

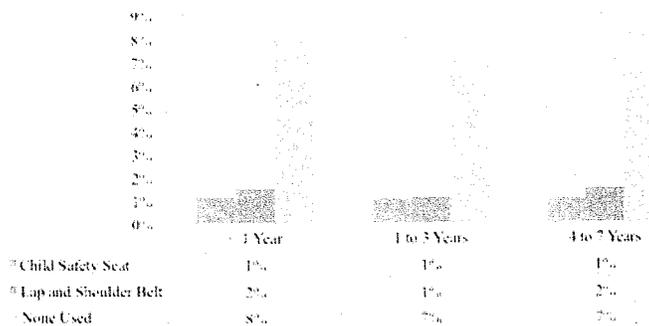
### Types of injury

- Head injuries were the most common injury in all age groups, with concussions and unconsciousness being most common in infants under age 1 and skull fractures most common in older children.
- Liver and spleen injuries were common in all age groups, especially in children under age 4, but intestinal injuries were most frequent in children ages 4 to 7.
- Chest injuries were also typical, with rib fractures most common in infants under age 1 and lung injuries most likely in children older than age 1.
- Spinal injuries were most common in infants under age 1.
- Leg injuries occurred at similar rates in all age groups.

### Types of crashes

Although Federal CR regulations currently focus on frontal crash performance, real-world data show that child restraint systems are effective in reducing the risk of injury in all types of crashes. In rollover crashes, which are most likely to cause serious injury, the risk to unrestrained children is three times greater than to those in CRs. In near-side impacts, unrestrained children are eight times more likely to be seriously injured than those in CRs. Injury rates for all ages are lowest in rear impacts.

Figure 3: Estimated Incidence Rates of Incapacitating Injuries by Police-reported Child Safety Seat Use and Child Passenger Age  
NASS-GES 1999-2008



Estimated Incident Rates of Incapacitating Injuries by Police-reported Child Safety Seat Use and Child Passenger Age, from: "Children Injured in Motor Vehicle Traffic Crashes," DOT HS 811 325, May 2010 (NASS = National Automotive Sampling System; GES = General Estimates System)

*continued on page 2*

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## Seating position

Children riding in the second or third row are half as likely to have incapacitating injuries as children sitting in the front seat.

## Summary

CPS technicians can use findings from the study to help reinforce the importance and value of CR use for all children who do not yet properly fit in an adult seat belt.

## Curbside Notes

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### Using injury research in the field

- Emphasize the study's confirmation of the importance of CRs in reducing the risk of serious injury to all children in all types of crashes.
- Explain that head injuries are the most common type of injury to children in a crash, and that using the appropriate type of CR for each child will provide optimal head protection. Traumatic brain injuries are especially serious due to the long-lasting or late-appearing problems that can result.
- Reiterate the importance of proper harness fit and chest clip placement in order to prevent unnecessary force on the abdomen, chest, and spine.
- Explain the importance of proper booster seat use and seat belt fit for older children to avoid abdominal injury.
- Recommend that all children be placed in the rear seat to reduce the risk of injury, noting that children in the front seat are twice as likely to be seriously injured as those in rear rows during a frontal impact.

**Reference:** "Children Injured in Motor Vehicle Traffic Crashes," DOT HS 811 325, May 2010, <http://www-nrd.nhtsa.dot.gov/Pubs/811325.PDF>

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\*\* SRN May/June 2010

## Kidz in Motion Conference Report, 2010

*The 6th Annual National Child Passenger Safety (CPS) Conference, commonly called Kidz in Motion or KIM, was held in Fort Worth, Texas, August 25-28. Approximately 300 people attended, some from as far away as Saipan, and most were Child Passenger Safety Technicians (CPSTs). Several conference workshops are summarized below.*

### Child Passenger Safety in Rural Tribal Communities

Presenter: Barbara Hart, B.A., PHN, (Pawnee), California Rural Indian Health Board

In this workshop, Barbara Hart, a public health nurse with the California Rural Indian Health Board (CRIHB), shared several approaches and tools for promoting CPS among Native American tribes through tribal health clinics. Barbara explained that CRIHB was established in 2000 with a mission to elevate the health status of American Indians/Alaskan Natives (AI/AN) in California. She noted that nearly 35 percent of the total California AI/AN population resides in rural locations. These people are served through Tribal Health Programs, which provide health services, including injury prevention and CPS education.

Barbara reported that motor vehicle crashes are the leading cause of death for AI/AN ages 1 to 44. On average, two Native Americans are killed every day in crashes in the U.S. With a 47 percent seat belt usage rate, California's rural tribal communities' use of seat belts is 20 percent lower than the overall usage rate for all tribes in the state.

Where local law enforcement is minimal, tribal members tend to feel more comfortable with risk-taking behaviors, such as non-use of child safety seats and seat belts.

Barbara stated that, to be most successful, local law enforcement needs to work with tribal police to address these issues together. Tribes can then establish their own policies and safety laws to increase enforcement, which would help increase both child safety seat and seat belt use.

Understanding and respecting tribal sovereignty is important when working with a tribal community. Barbara suggested that "outsiders" need to be aware of the local dynamics and tribal politics when trying to interact with the different groups within the community. She recommended always looking for opportunities to educate tribal leaders on the importance of child passenger safety.

### Kidz in Motion Conference Report, cont.

A one-day, AI/AN-specific basic car seat training course, developed through a partnership between CRIHB and Indian Health Services for individuals who work in the AI/AN community, is available to download: <http://www.ihs.gov/MedicalPrograms/InjuryPrevention/index.cfm?module=toolbox&option=snap> Barbara noted that, after taking this half- to full-day training, staff members have had a better success rate when they go on to take the national CPS technician certification training.

CRIHB also partnered with its tribal epidemiology centers (EpiCenters) and developed an *Indian Specific Injury Prevention Tool Kit* that can be used by anyone at a clinic or within a tribal community to educate on unintentional injuries. Topics include, child safety seats, bicycle helmets, fire safety, and elder safety. Tool kits include a hard copy and CD with fact sheets, brochure, safety seat observation forms, PowerPoint for community outreach, steps to become a CPS technician, and resource list.

**Contact** Barbara.hart@crihb.net for Tool Kit resources or help in finding contacts for tribal health clinics in your area.

### Right Seat, Right Fit...Why Won't They Stay In It?

#### Ideas to Encourage the Use of Car Seat Restraints on Every Ride

Presenters: Julie Adams M.S, CCLS, CEIM, and Jill Bringhurst, M.S., CCLS.

Julie Adams and Jill Bringhurst, child life specialists and CPSTs at Children's Medical Center Dallas, see their roles as not only encouraging the consistent use of CRs, but also promoting realistic expectations for parents and caregivers when traveling with toddlers or older children who are at different developmental stages. They discussed common and challenging childhood behaviors relating to acceptance of occupant restraints, along with age-appropriate tips and simple tools for use by parents and caregivers.

**Tips for toddlers** ages 1 to 3, who tend to be egocentric, were to keep them busy in the car and give them a time frame that they can relate to, such as "the trip will take as long as two *Dora, the Explorer* shows." Books, puppets, role playing, and songs can entertain and even teach about car seat use. This is a peak age for temper tantrums due to toddlers' limited vocabulary to express their feelings.

**At ages 3 to 5**, children have a desire to please others and to accomplish tasks. In addition to the tips mentioned above, Jill and Julie suggested providing children with a role in preparing for car travel, as well

as rewards for following through. They encouraged creating simple, personalized picture books for the children about riding in their car seats, as well as writing personalized car seat songs or letting them decorate their car seats (without interfering with the labels on the seat). Creating a personalized storybook does not have to be complicated. The process can be as basic as using a computer to type out the story, cutting and pasting photos or pictures from magazines, and inserting them into an inexpensive, small photo album.

**School-age children** from 6 to 12 are a target age for booster seat use. Many children have been moved out of CRs at this point, but new booster seat laws may mean they have to begin using a booster again. Allow them to help make the choice of their own belt-positioning booster and let them decorate it. It is important to explain why a booster is safer than a seat belt alone, such as showing how easily a lap belt can ride up onto the abdomen, where there are many organs that could be easily injured in a crash.

Julie and Jill noted that these tips can be adapted to meet the needs of children with special needs by focusing on their developmental stage rather than their chronological age. Maintaining reasonable expectations of any child at his or her stage of development is important, as well as maintaining consistency among caregivers regarding the use of appropriate child safety restraints.

**Contacts:** Julie Adams, Julie.Adams@childrens.com  
Jill Bringhurst, JILL.BRINGHURST@childrens.com

### Ride Safe From the Start

#### Innovative Prenatal CPS Education Program Shows Success in Reducing Misuse

Stephanie Tombrello, executive director, SafetyBeltSafe U.S.A. (SBS USA)

"Ride Safe from the Start," a new, online model for CPS education for expectant parents, was developed by SBS USA with a three-year grant from California Kid Plates.

The comprehensive, two-hour, online course is a series of modules, each with a quiz at the end. It uses captivating visuals of infants to draw in the audience members who, in the final months of pregnancy, are deeply interested in their future babies. One module includes self-directed, hands-on practice in the family car, using a print-out from the computer presentation.

The course was pilot tested with over 150 motivated, first-time expectant parents who completed it without assistance from a teacher or CPST. The evaluation, a brief in-person checkup of people who had taken the course and others who had not, showed that the

## Kidz in Motion Conference Report, cont.

error rate was reduced by 63 percent compared to the control group. The percent of CRs found with no usage or installation errors rose from 6 percent in the control group to 27 percent in the pilot group. The misuse rate for failure to lock a seat belt dropped from 29 percent to 5 percent, while the rate of leaving the harness loose dove from 69 percent to 3 percent. The participants were very positive in their comments afterward, and many wanted still more information.

The rationale for developing this new educational tool was based on the:

- Difficulty of getting sufficient information to most parents before they are ready to leave the hospital with their baby.
- Fact that the one-on-one checkup education model can never reach every new parent, despite the best efforts of CPSTs.
- Implication of the checkup model that most adults cannot learn to use CRs properly without professional help.
- Scarcity of resources of local and state CPS programs to reach the parents/caregivers who need the most help.

Stephanie contrasted the scarcity of prenatal CPS classes with the popularity of infant CPR classes. CPR classes are commonly offered to first-time parents but provide information that is rarely—if ever—needed, despite its lifesaving potential. While holding a CPS session during a prenatal class or childbirth class may make sense, few of those classes are able to give sufficient time to the important details of choosing and using an infant CR. Few instructors have up-to-date CPS expertise.

Distribution of the online course can be handled in various ways. The course can be licensed by hospitals or other organizations for their clients. Prenatal instructors can assign the online CPS course to their students, while also referring them to local CPSTs, to eliminate the need to take up class time and for childbirth instructors to be CPST-qualified.

Stephanie commented that if this program is made available to motivated parents-to-be, the scarce resources of organization funding and CPSTs' time could be reserved for focusing on the parents who need extra encouragement and help.

**Contact:** Stephanie Tombrello, [stombrello@carseat.org](mailto:stombrello@carseat.org)

## Ambulance Report Offers Practical CPS Guidance

National guidelines for transporting children in ambulances have been very general until now, leaving many unanswered questions. A new report from a NHTSA-funded project offers specific, nationally agreed-upon solutions, as well as practical guidelines if those solutions cannot be put into place completely. This gives EMS providers considerable practical guidance based on current, field-developed research and practices.

The report, "Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances," was developed by a working group made up of experts representing national emergency medical services (EMS) and child health organizations along with representatives of the National Highway Traffic Safety Administration (NHTSA) and U.S. Department of Health and Human Services (DHS). The report focuses on emergency ground ambulance transport and does not attempt to compare the dynamic performance of specific restraint systems, test solutions or equipment in the field, or evaluate the crashworthiness of vehicles.

The overall goal of the report's recommendations is to "prevent forward motion/ejection, secure the torso, and protect the head, neck, and spine of all children transported in emergency ground ambulances." The report considers these practices to be fundamental:

- No children should be transported unrestrained.
- Any CR used for a child must be age/size-appropriate and meet the injury criteria of FMVSS 213.
- Use of a CR must not compromise the child's medical condition.
- No CR should be installed in a side-facing vehicle seat.

### Recommendations for five common scenarios

The working group focused on five common scenarios, specifying the ideal solution as well as guidelines to follow if the ideal cannot be achieved for these situations:

1. Child who is not injured or ill.
2. Child who is ill and/or injured, but whose condition does not require intensive medical monitoring or interventions en route.
3. Child whose condition requires continuous, intensive monitoring or treatment.
4. Child who requires spinal immobilization and/or must lie flat.

5. Child or children who must be transported as part of a group, such as a mother and newborn or multiple children.

The report recommends that all EMS systems plan ahead for how they will handle these situations. It includes sections on selecting CR products to use in ambulances, as well as details on securing convertible CRs and car beds on an ambulance cot.

In addition, the working group issued a number of recommendations to governmental agencies and industries. In particular, government was challenged to develop dynamic test standards for vehicle seats, occupant restraints, cots, incubators, and other transport equipment.

Feedback on the report was shared at an August 5, 2010, public meeting at NHTSA and was generally very positive.

### CPSTs working with local EMS agencies

- Introduce child passenger safety concepts to your local EMS agencies, if they are not already involved. Let them know about the new NHTSA report, and encourage consideration of its recommendations.
- Encourage local EMS agencies to hire (or train) EMTs with CPS experience who can offer a new CPS-EMS course to their staffs (see Tools for Techs).

**Resources:** "Recommendations for the Safe Transportation of Children in Emergency Ground Ambulances," <http://www.nhtsa.gov/Safety/CPS>. Find the draft report and related materials under the subject heading at the lower left of the web page. The final report is expected to be published this winter.

"Improving Occupant Protection for Non-Critical Pediatric Patients in Ambulances: A Training Curriculum for EMS Personnel" (see Tools for Techs).

## When Best Practice and the Real World Collide

### Using Boosters with LATCH\*\*

While belt-positioning boosters (BPBs) provide great protection when in use, they can become dangerous projectiles in a crash when unoccupied. Unsecured BPBs have struck and injured vehicle occupants in crashes. While most CR/BPB manufacturer instructions now state to remove or secure the seat when not in use, this is still not happening widely in the field. One solution that is becoming common is using the LATCH system to secure BPBs (or combination seats used as BPBs).

Some BPBs come equipped with tether and/or lower attachments. This gives families the option of securing the seat, although this option is not required because federal regulations require BPBs to function using only the lap-shoulder belt. Some combination seats allow use of the tether and/or lower anchors in the BPB mode; others do not.

Among those manufacturers that allow the use of tethers and/or lower anchors to secure a booster, there is little agreement on how tightly a BPB should be secured. As an example, among four of the major CR manufacturers that currently allow the use of LATCH with BPBs, each gives a different recommendation:

- Manufacturer A: Use LATCH lower anchor and tether, install seat tightly with no more than 1 inch movement.
- Manufacturer B: Use lower anchor, install seat loosely with its nonadjustable strap,
- Manufacturer C: Use lower anchor, install seat either tightly or loosely.
- Manufacturer D: Use lower anchor and tether, install seat reasonably tightly (more than 1 inch movement allowed).

A smaller manufacturer that offers a BPB with built-in rigid LATCH attachments requires users to secure the booster with the vehicle seat belt when unoccupied, even if the LATCH attachments are being used. Such details are what make it so important for technicians to carefully read the manufacturer instructions and labels for each booster.

There is consensus, however, among CR and vehicle manufacturers that weight limits on anchors do not apply when a booster is secured by LATCH. This is because the child is restrained by the lap-shoulder belt, not by the LATCH anchors.

When considering using LATCH to secure a booster seat, it is not only important to determine if the CR manufacturer allows it, but also whether or not using LATCH would interfere with seat belt use. In some vehicles, the position of the lower anchors does not align with the seat belts, which can result in poor seat belt fit for the child, buckling difficulties, and undesired friction between the seat belt and LATCH attachments. Lower anchors should not be used to secure a BPB if such attachment interferes in any way with proper use of the vehicle seat belt.

### Curbside Notes

#### Securing boosters in vehicles

- Instruct families to always secure CR/BPBs appropriately when not in use, explaining the risk of injury to other passengers in a crash.

- Remember, today each booster is different! Refer to the CR/BPB owner's manual, manufacturer website, customer support, or CPST technical resources to help families determine the most appropriate method for securing their specific seat.
- Reassure families that vehicle-manufacturer weight limits for LATCH anchors do not apply when used to secure BPBs.

\*\* SRN, May/June 2010

## Steps to a Recall

### Part Two: The NHTSA Recall Process

Under the Motor Vehicle Safety Act, which NHTSA administers, manufacturers of child restraints perform safety recall campaigns in two situations:

1. Where the restraint has been determined to contain a safety-related defect.
2. Where the restraint fails to meet the minimum requirements of the Federal Motor Vehicle Safety Standards (FMVSS) applicable to child restraints.

#### Step One: Identifying a Safety Defect or Noncompliance

In the majority of cases, it is the manufacturer that first discovers the problem and decides its product is defective or fails to meet a Federal Motor Vehicle Safety Standard (FMVSS). These are termed "uninfluenced" recalls. Manufacturers may make a defect or noncompliance decision independent of NHTSA involvement for any number of reasons and based on a multitude of factors, including not only field information and safety risk assessments, but customer satisfaction and cost.

In the case of "influenced" recalls, a model may have failed the standard compliance testing conducted by NHTSA or one of its contractors, or the restraint may have been the subject of an investigation conducted by NHTSA's Office of Defects Investigation (ODI) or Office of Vehicle Safety Compliance (OVSC) based on consumer complaints.

The ODI or OVSC may decide to investigate a restraint based on a wide range of information. Avenues for this information include consumer complaints (called "VOQs" because they arise from Vehicle Owner Questionnaires submitted by the public), early warning information based on manufacturer-supplied field experience that must be reported to NHTSA at quarterly intervals, and compliance testing performance. No specific numbers of complaints or field experience figures are required to trigger an investigation; instead, an assessment is made of the frequency and severity of the problem, time in

service of the restraint, and age of the group of affected CRs. All available information is considered.

#### Step Two: Recalling the Product

Once the manufacturer decides its restraints fail to comply with minimum safety standards or contain a safety defect, it must notify NHTSA within five business days. In its notification it must, among other things, identify the restraints affected specifically and describe the defect or noncompliance as well as the remedy it will offer owners. The manufacturer must also give NHTSA the details of its plan for campaigns to notify owners and dealers/distributors, including when it plans to issue those notifications. In order to receive recall notification, owners must register their CRs with the manufacturer through its website or by using the postage-paid card provided.

For recalls of child restraints, the manufacturer may either repair the problem at no cost to the owner or replace the restraint. NHTSA does not approve remedies and, instead, relies upon the manufacturer's expertise in developing the appropriate remedy for its products. The agency will take appropriate action if it is apparent that the remedy will not correct the problem, is not free to owners, or relies upon the consumer to make a repair that is too complicated. Once plans are in place, the manufacturer is required, at a minimum, to notify registered purchasers by first class mail of the safety defect or noncompliance as well as alert its dealers or distributors.

In almost all cases, NHTSA recommends that the consumer continue to use a recalled child restraint until the problem is corrected. This is because using a recalled child restraint is usually better than using no restraint at all. Occasionally, a recall specifies not to use the product in the interim because of immediate danger of injury or death. In this instance, consumers should heed the notification and no longer use the CR.

#### Step Three: Managing the Recall

Manufacturers must file six quarterly reports on their recall campaigns so that NHTSA can keep track of progress. If the notification campaign appears to be unsuccessful, another public notification measure may be necessary.

### Curbside Notes

#### Managing recalls

- Urge CR owners to report CR problems, as well as vehicle problems that affect CR installation, to NHTSA and to the manufacturer. See Tools for Techs for ways to file reports with NHTSA.
- Make sure families know the importance of

returning registration cards for new CRs or registering previously purchased CRs on the manufacturer's website.

- Always review the most current recall list when checking CRs, and strongly encourage owners of a recalled seat to fix their CR. If they have not been notified by the CR manufacturer, make sure they call the manufacturer for the remedy and to register their CR.

## Question: When is Using Seats Risky?

### Answer: When They are Used Outside the Car

Parents and caregivers often use rear-facing restraints (RF CRs) as carriers or as "baby containers," unaware of the safety risks this could entail. A new study from *Pediatrics* offers strong evidence for warning parents of the dangers of using RF CRs this way.

The study reports many injuries and some deaths to infants under age 1 who have fallen out of car seats or tipped the car seat over. (The study does not cover injuries that result when a RF CR's handle breaks, a defect that has been the subject of numerous recalls, or the risks to infants left alone to sleep in a CR at home.)

Using emergency room data, the researchers estimated that three deaths and 43,562 RF CR-related injuries occurred in non-crash events over a five-year period. The average age of the infants involved was 4 months. At least half the injuries occurred at home, 85 percent were related to falls, and the vast majority of injuries were to the head or neck. More than eight percent of the infants were hospitalized as a result.

In two-thirds of the cases, the children fell out of their RF CRs; the researchers assumed that they were not buckled up with the harness. Many infants in CRs fell from raised surfaces or objects, such as tables, counters, or shopping carts. In some cases, the infant CR had tipped over when placed on a soft surface, like a sofa or bed.

The researchers called on physicians and others to educate parents and caregivers about the dangers of these practices. Realizing that RF CRs may be used outside a vehicle in some situations, the researchers stressed the importance of using the harness at all times. They recommended that if a RF CR is placed on a raised surface, it not be close to the edge and that the infant be supervised at all times.

## Curbside Notes

### Warning about dangers of using CRs outside of vehicles

- Make sure expectant parents and caregivers of infants understand the possible risks if they use a RF CR as a carrier or a household seat or put the CR on a shopping cart, table, bed, or laundry machine (often recommended in child care books as a way to soothe a colicky baby).
- Emphasize to parents/caregivers that the harness must always be fastened.

**Reference:** Parikh, S.N., and Wilson, L. "Hazardous Use of Car Seats Outside the Car in the United States, 2003–2007." *Pediatrics*. August 2010. 126(2): 352-7. Epub 5 July 2010.

## Tools for Techs

### CPS Training Curriculum Published for EMS Providers

"Improving Occupant Protection for Non-Critical Pediatric Patients in Ambulances: A Training Curriculum for EMS Personnel" is a new course from the Automotive Safety Program, Riley Hospital for Children, Indianapolis, Indiana. The course, funded in part by NHTSA, is designed to teach EMS personnel about selection and installation of ambulance-specific restraints and various conventional child restraints on the ambulance cot. Course instructors are required to be certified child passenger safety technicians with current, hands-on experience in transporting patients in ambulances, such as emergency medical technicians, paramedics, and others involved in pediatric emergency transport. A disk containing all of the course materials is available to qualified instructors.

**Contact** Jody Yoder, Automotive Safety Program at Riley Hospital for Children, 1-800-KID-N-CAR, jodyoder@iupui.edu, for an instructor application and the course disk. For other questions regarding the course, please contact Judith Talty, jtalty@iupui.edu, or Laura Novak, lwillia2@clarion.org.

### Avenues for Reporting CR and Vehicle Issues to NHTSA

- [www.safercar.gov](http://www.safercar.gov): Use this website to review safety recalls and prior/current investigations or to file a complaint (VOQ) about a child restraint, other item of motor vehicle equipment, or a motor vehicle. The site also contains a detailed paper explaining the investigatory and recall process, which is downloadable as a PDF.

*continued on page 8*

## Tools for Techs, cont.

- Auto Safety Hotline, 1-888-327-4236 or 1-800-424-9393: Use this telephone-based service operated by NHTSA as an alternative way to report product complaints or obtain recall information about a vehicle or item of motor vehicle equipment, including a child restraint.

Calls are toll free from anywhere in the United States, Puerto Rico, or the Virgin Islands; Spanish-speaking representatives are available, and a dedicated number, 1-800-424-9153, exists for persons with hearing impairments.

### **LATCH Manual, 2011 Edition**

The new edition of the LATCH Manual is now available from Safe Ride News Publications, [www.saferidenews.com](http://www.saferidenews.com).

## Save the Dates

**March 11–16, 2011**

### **Transporting Students with Disabilities and Preschoolers**

Kansas City, MO  
Hyatt Regency Crown Center  
<http://www.eduprogroup.com>

CEU opportunity: March 13, Child Passenger Safety Restraint Systems on School Buses National Training (NHTSA), separate registration (6 CEUs)

**March 27–29, 2011**

### **Lifesavers Conference**

(includes CEU sessions)

Phoenix, AZ, Phoenix Convention Center  
<http://www.lifesaversconference.org>

Early-Bird Registration: up to January 28  
Discount Registration: up to February 25

### **More CEU opportunities at Lifesavers:**

March 26, 12–2 PM, Hot Topics that Need Resolution and Direction—CPS Technical Update and Strategic Discussion (1 CEU)

March 26, CPS Latest Technology Workshop (2 CEUs)

March 25–26, Safe Transportation of All Children—Transporting Children with Special Health Care Needs Training. (Enrollment limited, additional fee: for registration information, contact Jody Yoder at [jodyoder@iupui.edu](mailto:jodyoder@iupui.edu), 1-800-755-0912, [www.preventinjury.org](http://www.preventinjury.org) (under Training Dates heading)

**August 10–13**

### **Kidz in Motion (KIM) Conference**

Orlando, FL  
<http://www.kidzinmotion.org>

**September 18–24**

### **CPS Week**

September 24, Seat Check Saturday  
Contact Sandy Sinclair, [sandy.sinclair@dot.gov](mailto:sandy.sinclair@dot.gov), 202-366-2723

### **Sign up for Free Recertification Drawing**

Sign up to be notified via e-mail whenever significant announcements or updates to the CPS Board website are made. Signing up also makes currently certified CPS technicians and instructors eligible to WIN a free CPS recertification—a \$50 or \$60 value—from Safe Kids Worldwide. To read the rules for the drawing and sign up for the CPS Board e-mail list, visit [www.cpsboard.org/elist.htm](http://www.cpsboard.org/elist.htm).

**We thank Safe Kids Worldwide for making this recertification prize possible.**

Please send comments or suggestions for *Tech Update* to Deborah Stewart, editor, [dstewart@saferidenews.com](mailto:dstewart@saferidenews.com).

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