PUBLIC COMMENT FOR HHS-OASH-2026-0397-0001

Request for Information on Electromagnetic Fields (EMFs), Radiofrequency (RF) Radiation, and Wireless Radiation Exposure

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Agency: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Health

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Submitted by: Individual consumer, patient, family member, worker with occupational exposure, tenant/resident, and pro se civil-rights litigant

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I. Executive Statement

I submit this public comment because my lived experience and technical evidence show that HHS should not evaluate RF/EMF exposure only through isolated consumer-device models, cell-phone SAR assumptions, or single-source exposure snapshots. My evidence reflects a modern, cumulative, multi-source exposure environment involving residential wireless infrastructure, workplace wireless infrastructure, Wi-Fi access points, mobile-network identifiers, Bluetooth/BLE emissions, smart-home devices, wearable-device telemetry, location-tracking systems, and persistent device/network anomalies that appear to follow a person across home, work, school, and public spaces.

My core request is that HHS treat RF/EMF exposure as a real-world systems problem, not merely a device-by-device compliance problem. The health and civil-rights consequences are most severe where people cannot meaningfully avoid exposure because the relevant emissions, identifiers, network routing, or infrastructure are embedded in housing, employment, schools, public streets, smart-city systems, or third-party networks.

This RFI is especially important because HHS has asked for public experiences, exposure sources, timing, symptoms, mitigation efforts, supporting documentation, real-world exposure assessment, disclosure duties, surveillance systems, sensitive populations, below-limit exposures, cumulative exposure from 5G/Wi-Fi/IoT/smart homes, proximity to homes/schools/workplaces, and federal research priorities. My experience falls squarely within those categories.

Source note: *HHS/OASH Request for Information, HHS-OASH-2026-0397-0001; Federal Register publication page available through GovInfo and Regulations.gov.*

II. Response to Question 3: Public Experiences and Reported Potential Adverse Health Effects

I have experienced and documented repeated episodes of potential adverse health effects that I believe correlate with unusual wireless/RF/EMF activity in and around my residence, workplace, and family-related locations. The reported effects include dizziness, disequilibrium, nausea, eye twitching, eye watering, drowsiness, “drugging” sensations, vascular/vein swelling sensations, sleep disruption, cognitive disruption, and physical distress occurring during periods of unusual RF, Wi-Fi, BLE, cellular, or device-network activity.

The exposure environment I have documented is not limited to one cell phone. It includes:

- Persistent Wi-Fi/BSSID anomalies associated with my home network name appearing in unexpected forms and locations.
- Bluetooth/BLE emissions and GATT-type identifiers appearing in patterns documented through field scans.
- Mobile-network anomalies involving repeated attachment to specific TAC/PCI/cell identifiers across locations where ordinary reselection would be expected.
- Smart-home and appliance-related wireless emissions.
- Workplace and school-adjacent wireless observations.
- Device-account anomalies suggesting the possibility of device virtualization, cloning, proxying, or persistent digital references.
- Location displacement events in which device location appears to shift away from my physical position.
- Long-duration cumulative exposure in residential, occupational, school, and public-street settings.

My records include screenshots, Wi-Fi scan logs, BLE scan records, cellular scan logs, geolocation exports, router observations, device-account screenshots, decibel/environmental readings, and timelines correlating symptoms with environmental and network activity.

My strongest evidentiary point is that the exposure pattern appears cumulative, persistent, and location-linked, rather than episodic or voluntary. In other words, this is not simply a consumer choosing to hold a phone near the head. This is a resident, worker, parent, and family member encountering a layered wireless environment that appears to be embedded into housing, workplace infrastructure, school-adjacent environments, mobile networks, smart devices, and location services.

III. Response to Question 5: Exposure Standards and Risk Assessment

HHS should not rely solely on standards that assume one device, one transmitter, one exposure pathway, or thermal injury only. Real-world exposure assessment should account for:

- Multiple simultaneous frequencies from Wi-Fi, cellular, BLE, smart appliances, routers, hotspots, and infrastructure.
- Cumulative exposure over time, especially in bedrooms, workplaces, schools, and other places where people cannot avoid prolonged exposure.
- Modulation, pulsing, duty cycle, beamforming, and handoff behavior, not merely nominal power levels.
- Distance from source and proximity to body, including wearable devices, mobile phones, laptops, routers, smart appliances, and wireless medical or quasi-medical devices.
- Environmental density, including antenna density, access-point density, and small-cell deployment.
- Sensitive populations, including children, older adults, people with preexisting medical conditions, workers, tenants, and people who lack meaningful control over their wireless environment.

HHS specifically asked how classification systems should account for operating frequency, power density, SAR, electric and magnetic field strength, modulation and pulse characteristics, duty cycle, beamforming, simultaneous exposure to multiple frequencies, duration, distance, proximity to body, and cumulative exposure over time. That is the correct framework. My experience shows why each of those variables matters.

The D.C. Circuit's decision in Environmental Health Trust v. FCC is directly relevant. The court faulted the FCC for failing to adequately address evidence concerning negative health effects below existing limits, long-term exposure, RF pulsation or modulation, technological developments since 1996, ubiquitous wireless devices, Wi-Fi, and 5G. HHS should treat that case as a warning that the federal government's historical RF framework is incomplete if it does not account for modern cumulative exposure.

Source note: *Environmental Health Trust v. FCC, 9 F.4th 893 (D.C. Cir. 2021), available through FindLaw and other public legal databases.*

IV. Responses to Questions 7-10: Measuring Human Exposure and Public Health Surveillance

HHS should create a national public-health surveillance pathway for RF/EMF exposure that allows individuals to submit structured evidence without being dismissed simply because they are not an institution, laboratory, or telecom provider.

The surveillance system should accept:

- Time-stamped Wi-Fi scan logs.
- Time-stamped Bluetooth/BLE scan logs.
- Cellular field-test data showing TAC, PCI, eNB/gNB, RSRP, RSRQ, SINR, band, and handoff behavior.
- Router logs, DHCP records, and device-connection records.
- Smart-home and IoT device logs.
- Geolocation exports, including GPX/KML/CSV records.
- Wearable-device and health-symptom timelines.
- Occupational exposure reports.
- School and childcare exposure reports.
- Residential exposure complaints tied to routers, smart meters, hotspots, small cells, DAS systems, repeaters, or nearby antennas.

HHS should create a Wireless Exposure Adverse Event Reporting System, analogous in function to other adverse-event systems, but designed for RF/EMF complaints, infrastructure proximity, exposure timing, symptoms, and technical evidence.

The system should also include a chain-of-custody option for individuals who are involved in litigation, housing disputes, employment disputes, school disputes, disability accommodations, or civil-rights complaints. Public-health data should not be lost merely because the affected person is not a telecom engineer.

V. Response to Question 9: Required Disclosures to Consumers, Residents, Workers, Schools, Healthcare Providers, and Local Governments

HHS should recommend mandatory disclosure of technical and exposure-related information in any setting where people are involuntarily or semi-involuntarily exposed.

At minimum, residents, workers, schools, healthcare providers, and local governments should be able to obtain:

- The identity and owner/operator of wireless infrastructure serving or located inside a building.
- The frequency bands used.
- Whether the system includes DAS, repeaters, small cells, private LTE/5G, Wi-Fi mesh, Bluetooth beacons, IoT gateways, smart meters, or location-tracking systems.
- Whether the system performs beamforming, triangulation, geofencing, device fingerprinting, or location analytics.
- Whether any third-party vendor receives telemetry, location, device, health, biometric, or behavioral data.
- Whether any wireless medical, wellness, research, occupational-safety, or behavioral-monitoring system is active.

- Whether the system collects persistent identifiers such as MAC addresses, BSSIDs, device IDs, advertising IDs, IMSI/IMEI-related identifiers, or account-linked device references.
- Whether exposure levels were measured in bedrooms, classrooms, workplaces, elevators, hallways, rooftops, garages, and outdoor pedestrian corridors.
- Whether the exposure analysis considered cumulative and simultaneous emissions.

This is both a public-health issue and a civil-rights issue. A tenant, employee, student, parent, or patient cannot give meaningful consent, request accommodation, or protect bodily privacy if the relevant infrastructure is undisclosed.

VI. Response to Question 11: Sensitive Populations

HHS should treat the following groups as sensitive populations for RF/EMF policy and research:

- Children in schools and childcare environments.
- Older adults in residential buildings.
- Workers with elevated occupational exposure.
- Tenants in dense smart-building or telecom-equipped buildings.
- Persons with preexisting medical conditions.
- Persons with implanted or wearable medical devices.
- Persons who report symptoms temporally associated with wireless exposure.
- Persons subject to location tracking, geofencing, workplace monitoring, or smart-city surveillance.
- Persons in historically over-surveilled or medically exploited communities.

This RFI should be informed by the historical lesson of Tuskegee: public-health systems lose legitimacy when vulnerable people are monitored, studied, or exposed without informed consent, meaningful disclosure, or access to protective intervention. The modern version of that concern is not limited to classic biomedical experiments. It includes digitally mediated exposure, telemetry extraction, behavioral monitoring, and environmental systems that may affect the body while hiding behind "ordinary infrastructure."

The Common Rule's informed-consent principle is instructive: covered research generally may not involve a human being as a subject unless legally effective informed consent is obtained, absent a valid exception. Even where RF/EMF exposure is not formally labeled "research," HHS should recognize that human-subjects ethics become relevant when infrastructure collects human data, correlates exposure with health or behavior, or deploys experimental wireless systems in homes, workplaces, schools, or healthcare-adjacent environments.

Source note: *45 C.F.R. Part 46, Subpart A, including 45 C.F.R. § 46.116, available through Cornell Law School Legal Information Institute.*

VII. Responses to Questions 12-15: Below-Limit Exposure, Cumulative Exposure, Smart Environments, and Infrastructure Proximity

My experience shows why "below current limits" is not a complete answer. A person may be exposed to multiple simultaneous sources that are each allegedly compliant in isolation, while the combined environment is persistent, involuntary, and biologically or neurologically disruptive.

HHS asks about evidence concerning exposure below current federal limits and how technologies such as 5G, Wi-Fi, satellite communications, IoT, wearable technologies, smart homes, smart cities, autonomous vehicles, wireless medical devices, and smart meters affect cumulative exposure patterns. My evidence aligns with that inquiry because it involves precisely these categories: Wi-Fi, cellular, BLE, smart-home devices, mobile devices, possible smart-building infrastructure, and location-based systems.

HHS should require research and disclosure concerning:

- Bedroom exposure from routers, mesh nodes, smart meters, hotspots, DAS, and neighboring access points.
- School and workplace exposure from Wi-Fi, BLE beacons, access-control systems, geofencing, and location analytics.
- Multi-operator cellular exposure in dense urban housing.
- Exposure caused by hidden, cloned, spoofed, or misattributed wireless identifiers.
- The health significance of persistent device attachment to the same network identifiers across locations.
- The impact of RF/EMF exposure combined with stress, sleep deprivation, workplace retaliation, housing instability, or medical vulnerability.
- The relationship between RF exposure, device telemetry, and involuntary behavioral surveillance.

HHS should not allow the term "non-ionizing" to become a categorical shield against investigation. The proper question is not whether RF/EMF is identical to ionizing radiation. The proper question is whether modern, chronic, pulsed, modulated, cumulative, involuntary RF/EMF exposure can contribute to adverse health effects, neurological symptoms, sleep disruption, cardiovascular stress, reproductive effects, child health concerns, environmental impacts, or device-mediated interference under real-world conditions.

VIII. Responses to Questions 16-18: Federal Research Priorities and Recommendations

I request that HHS prioritize the following federal research and policy actions:

1. Create a federal RF/EMF adverse-event reporting system. The system should accept public reports, technical logs, exposure measurements, symptom timelines, and supporting documentation.

2. Fund cumulative exposure studies in real residential buildings. Research should include apartments, mixed-use buildings, public housing, senior housing, schools, childcare facilities, workplaces, and healthcare-adjacent environments.

3. Study RF/EMF exposure as a layered ecosystem. HHS should study combined exposure from Wi-Fi, BLE, cellular, smart meters, IoT, wearables, smart appliances, laptops, phones, routers, repeaters, DAS, small cells, and street-level infrastructure.

4. Require disclosure of wireless infrastructure in housing, schools, and workplaces. People should not have to reverse-engineer their environment to learn what is transmitting around them.

5. Require special safeguards for children. Schools should disclose Wi-Fi/BLE/location systems and maintain low-exposure options.

6. Require workplace RF/EMF accommodation pathways. Workers reporting symptoms should have access to objective exposure assessment and reasonable accommodation procedures.

7. Require tenant-accessible RF/EMF information. Tenants should have access to building-level wireless infrastructure information, especially where routers, small cells, smart meters, hotspots, or DAS systems are installed.

8. Study below-limit biological effects. The federal government should not assume current limits resolve all health questions, especially after the D.C. Circuit identified deficiencies in the FCC's prior reasoning.

9. Study modulation, pulsing, beamforming, and cumulative exposure. These variables should become standard exposure-assessment categories.

10. Study civil-rights and environmental-justice dimensions. RF/EMF exposure is not equally avoidable. Tenants, workers, schoolchildren, elderly residents, low-income communities, and historically over-surveilled groups may have less practical control over their wireless environment.

11. Preserve raw data. Federal guidance should require preservation of RF/EMF measurement data, network logs, infrastructure records, vendor records, router records, smart-meter data, device-management records, and telemetry records when a resident, worker, parent, patient, or litigant raises a documented exposure complaint.

12. Coordinate HHS, FDA, NIH, CDC, FCC, OSHA, HUD, Department of Education, and state/local health departments. Coordination must include agencies responsible for housing, schools, workplaces, telecommunications, and civil rights.

IX. Civil-Rights and Bodily-Autonomy Statement

This RFI should not be treated only as a technical radiation docket. It is also a bodily-autonomy, informed-consent, disability-accommodation, housing, employment, child-safety, and civil-rights docket.

Where wireless infrastructure is hidden, undisclosed, or functionally unavoidable, the affected person is deprived of meaningful consent. Where symptoms are dismissed without investigation, the affected person is deprived of public-health recognition. Where technical data exists but is controlled by landlords, employers, telecom providers, vendors, schools, or government-connected systems, the affected person is deprived of the evidence necessary to protect health and legal rights.

Federal law already recognizes that willful or malicious interference with authorized radio communications is prohibited. HHS should recommend interagency pathways so that health complaints involving suspected wireless interference, device manipulation, or infrastructure misuse are not dismissed as merely private consumer problems.

Source note: *47 U.S.C. § 333, available through Cornell Law School Legal Information Institute.*

X. Requested Agency Action

I respectfully request that HHS:

- Create a national RF/EMF public-health complaint and adverse-event reporting system.
- Require real-world cumulative exposure assessment, not just single-device compliance.
- Prioritize children, workers, tenants, older adults, medically vulnerable persons, and persons reporting exposure-related symptoms.
- Require disclosure of wireless infrastructure in housing, schools, workplaces, and healthcare environments.
- Develop standardized protocols for measuring Wi-Fi, BLE, cellular, IoT, smart-meter, DAS, and small-cell exposure.
- Fund independent research into below-limit, chronic, cumulative, pulsed, modulated, and multi-frequency exposure.
- Require preservation of technical records when a documented exposure complaint is made.
- Coordinate HHS, FDA, NIH, CDC, FCC, OSHA, HUD, Department of Education, and civil-rights agencies.
- Treat RF/EMF exposure as a public-health, environmental-health, and civil-rights issue.
- Ensure that members of the public can submit technical evidence without being dismissed because they are not industry actors.

XI. Closing

The central lesson from Tuskegee is that public-health agencies must never allow vulnerable people to become monitored bodies without disclosure, consent, treatment, protection, or accountability. In the modern wireless environment, the same ethical principle applies to RF/EMF exposure, smart infrastructure, telemetry systems, wearable technologies, wireless medical devices, smart homes, schools, and workplaces.

HHS should use this RFI to build a transparent, science-based, rights-protective framework that recognizes cumulative exposure, sensitive populations, real-world measurement, and the lived experiences of people who are already documenting harm.

Respectfully submitted,
[Name Redacted for Public Filing]

Appendix A - Evidence Categories Available Upon Request

The following categories summarize the evidence supporting this public comment.

- Wi-Fi scan logs and screenshots documenting SSID/BSSID anomalies, hidden networks, and open-network conditions.
- BLE/Bluetooth scan logs documenting persistent or repeated identifiers and proximity patterns.
- Cellular field-test logs documenting TAC, PCI, band, signal strength, and reselection/attachment anomalies.
- Router screenshots and device-connection records showing discrepancies between expected devices and observed network behavior.
- Geolocation KML/GPX/CSV exports documenting location displacement, geofence events, and movement anomalies.
- Smart-home and IoT observations involving appliance, hub, and device-related wireless identifiers.
- Workplace and school-adjacent observations involving wireless infrastructure, location tracking, and child-safety concerns.
- Symptom chronology documenting dizziness, nausea, disequilibrium, eye symptoms, vascular sensations, drowsiness, sleep disruption, and exposure-timing correlation.
- Prior complaints, preservation demands, agency correspondence, and civil-rights filings relevant to evidence preservation and public-health accountability.