Public Comment Response to the HHS Request for Information on RF and EMF Exposure

Occupational exposure experience and recommendations for surveillance, disclosure, and research

Agency	U.S. Department of Health and Human Services
Docket	HHS-OASH-2026-0397
Federal Register	91 FR 59792, September 21, 2026
Respondent	Georgia Dimick
Perspective	Family member and custodian of records concerning a worker with occupational exposure
Date	October 7, 2026

Privacy and scope statement. This public-comment draft summarizes sensitive family-held records without attaching them or reproducing direct identifiers. The worker is described without a name, address, date of birth, record number, claim number, or Social Security number. The submission reports experiences and records; it does not claim that temporal association proves medical causation.

Questions addressed: 2, 3, 9, 10, 11, 16, and 18. Questions requiring specialized scientific or regulatory analysis are not answered beyond the limits of this record.

Executive Summary

I ask HHS to include historical occupational exposures in its RF/EMF work, especially maintenance and repair tasks in which a worker may be close to energized equipment and may lack real-time exposure data. My family holds records concerning an electronics and telecommunications worker who experienced an acute episode while servicing equipment at a remote federal energy worksite in July 1985. A contemporaneous hospital record documents amnesia, vertigo, a severe headache reported in the surrounding narrative, and right-sided instability. The hospital evaluation did not establish RF/EMF exposure as the cause. No calibrated personal RF/EMF measurement for the event appears in the records reviewed.

The worker later reported recurrent symptoms and sought extensive medical evaluation. A 1988 environmental-medicine report described frequency-challenge testing and concluded that he was electrically and chemically sensitive. That report also documented responses during blank exposures that the clinician stated could have been placebo responses, and it did not include an independently replicated exposure assessment. These limitations matter. The record supports investigation and better surveillance; it does not by itself prove a causal relationship.

This experience supports practical federal action: task-based occupational monitoring; preservation of equipment, incident, and measurement records; prompt worker access to those records; a privacy-protective adverse-event and surveillance system; longitudinal follow-up of workers reporting acute events; and coordinated research across HHS, NIOSH, DOE, DOL, and other relevant agencies.

Evidence Boundaries

Category	How it is used in this response
Documented fact	A fact directly stated in a contemporaneous medical, employment, agency, or service record.
Reported experience	The worker's or family's account, preserved as testimony and not treated as a verified exposure measurement.
Clinical observation	A clinician's recorded observation or conclusion, described together with the report's stated limitations.
Reasoned concern	An inference or unanswered question raised by the record, not a finding of causation.
Policy recommendation	A requested action based on the record and the information gaps it reveals.

Response to Question 2

Perspective represented

I respond as the worker's oldest daughter, a family caregiver, a co-researcher with my sister, and a custodian of records concerning a worker with occupational exposure. I also served in local government and encountered community questions about wireless infrastructure near schools. I am not submitting as a clinician, exposure scientist, engineer, attorney, manufacturer, or employer. My response is based on family-

held medical and employment records, government correspondence, the worker's written account, and my firsthand observations.

Personal and Family Impact Statement of Georgia Dimick

I am the worker's oldest daughter. When my father became ill, my sister and I became the principal family researchers. This was before online research was readily available. We searched libraries and assembled binders of historical material about electromagnetic fields, microwave communications, occupational exposure, and possible health effects. We brought what we found to our parents and tried to understand an experience for which our family had no clear explanation.

My father loved his job and took great pride in his technical work. I saw him go to work and, after becoming acutely unwell at the worksite, enter a medical crisis from which his working life never recovered. He wanted to return to work for the rest of his life. Losing that work devastated him. We knew that something serious had happened, but we did not know what exposure, medical event, or combination of factors had caused it. I do not present the timing alone as proof of causation. I present it because it began our family's decades-long search for answers.

My father also described earlier military communications work. He told us about serving in Iceland near powerful communications or tropospheric equipment and about workers standing close to operating systems without thinking they were dangerous. One family story involved an egg being heated on the opposite side of the equipment. We have photographs from his service, but I do not have exposure measurements from that period and cannot identify the equipment or dose with certainty. This is a remembered account, not verified dosimetry.

He was concerned about public safety as well as his own work. I remember him describing the care required to align a microwave link that crossed near a school. He worried about what a misaligned or reflected signal could mean for children. Whether every technical detail in my recollection is correct would require engineering records to determine, but his concern for workers and children was genuine and consistent throughout his life.

After he became ill, our family took him to many physicians and specialty evaluations. We repeatedly heard that his condition was difficult to explain. Some clinicians considered environmental or occupational possibilities, while others attributed his experiences to psychological causes. I remember clinicians discussing unusual eye findings and asking whether his military or communications work might be relevant, but those recollections should not be treated as verified medical conclusions unless confirmed in the underlying records.

We tried many ways to make daily life tolerable. At different times we moved him to quieter or more remote locations, including a primitive cabin at a family quarry. Our family believed he improved there.

We also placed metal shielding over part of a home, purchased expensive conductive fabric that my mother sewed into clothing, and tried grounding methods, dietary changes, and clinician-directed treatments. Any improvement we observed was temporary and uncontrolled. These experiences do not prove an exposure-response relationship, but they show the burden on a family trying to respond without reliable measurements or guidance.

Ordinary environments sometimes became difficult for him. Our family associated episodes with some communications sites, traffic radar, store security systems, medical equipment, or other electronic environments. We sometimes changed routes, left stores, or sought lower-density locations. We did not have calibrated instruments or blinded conditions, so I offer these as family observations rather than scientific findings.

The uncertainty reached beyond my father. Family members have experienced health problems that caused us to wonder about inherited, developmental, environmental, or take-home occupational factors. This public comment does not identify living relatives or disclose their diagnoses. We have no evidence establishing that our father's work caused those conditions. Our concern supports careful research on workers and families, not a claim that causation has already been proven.

I later served in local government when a wireless facility was proposed near schools. I remember being told that federal telecommunications law sharply limited local consideration of health concerns. That experience reinforced my belief that communities need understandable technical information, meaningful monitoring, and a clear way to raise concerns without having to prove causation before exposure has even been characterized.

My father did not see this primarily as a claim for money. He wanted to know what had happened and to make sure workers, families, and children were safer. The human cost was not only illness. It was the loss of meaningful work, years of uncertainty, repeated medical visits, caregiving, financial strain, and the feeling that no institution was responsible for putting the whole record together. That is why I am submitting his story.

Response to Question 3

Potential adverse health effects believed to be associated with occupational RF and EMF exposure

3a Sources involved. The worker spent much of his career as an electronics and telecommunications technician. Family records describe work involving microwave systems, two-way radio, radar-related systems, telephone carrier equipment, and computers. The principal event occurred while he was servicing a subscriber-line carrier or related circuit-board system at a remote test-area worksite within a federal energy facility in Idaho. The records do not identify a confirmed RF/EMF source responsible for the event.

3b Nature, duration, frequency, and timing. The acute episode was reported in July 1985 during a maintenance task. Government occupational-compensation correspondence later recorded claimed employment at federal energy facilities from 1976 through 1985. The family narrative describes additional earlier military and civilian electronics work, but the present submission does not calculate cumulative exposure because frequency, field strength, power density, modulation, distance, duty cycle, shielding status, and task duration are missing for most work periods. No calibrated personal RF/EMF measurement for the July 1985 event has been located.

3c Potential adverse health effects. A contemporaneous hospital record documents a period of amnesia and vertigo after the worker was brought from the worksite. The admitting examination described rightward instability and slight right-beating nystagmus. The family narrative reports a severe headache during the episode and later recurring dizziness, altered heart rate, sweating, fatigue, weakness, slowed reactions, and predominantly right-sided symptoms. The later symptoms are reported experience and are not presented as proof of a single cause.

3d Onset relative to exposure and later changes. The worker reported that dizziness and abnormal motion began while he was bent over and working on equipment. His memory of the hours that followed was incomplete. He returned to work after hospitalization and reported additional episodes. He later reported symptoms in some locations containing electronic security, communications, or broadcasting equipment. Those later observations were not made with a calibrated exposure instrument and did not rule out other explanations. The family later reported that some episodes appeared to change when he left particular environments or stayed in more remote locations. Those observations were not blinded, were not paired with calibrated measurements, and do not establish an exposure-response relationship.

3e Medical evaluation and treatment. The worker was hospitalized for several days in July 1985. A head CT was reported as normal. The discharge record listed a vertebrobasilar transient ischemic attack, diabetes mellitus, and obesity. Those diagnoses are important alternative or contributing medical considerations and are not evidence that RF/EMF caused the episode. The worker later underwent additional neurological and other evaluations. In 1988, an environmental-medicine clinician reported blinded frequency challenges and concluded that the worker had electrical and chemical sensitivity. The same report noted reactions to six blank exposures that could have been placebo responses and did not provide independent replication or a workplace field reconstruction.

3f Exposure reduction. The worker reported avoiding locations that he believed triggered symptoms and using a consumer radar detector to identify some locations. A consumer detector is not a calibrated personal dosimeter and cannot establish exposure or causation. The family also tried temporary stays in lower-density locations, metal shielding over part of a home, conductive clothing, grounding methods, dietary changes, and clinician-directed treatments. Family members perceived temporary improvement in some settings, including a remote cabin, but the observations were uncontrolled and did not rule out other explanations. The family also reports that, after the event, his worksite access ended and his health and ability to work declined. The available records do not permit a reliable before-and-after causal analysis.

3g Supporting documentation. The family holds the 1985 hospital record, a written timeline and work history, a 1988 environmental-medicine report, federal occupational-compensation correspondence, a NIOSH dose-reconstruction intake packet concerning a separate ionizing-radiation claim, and historical employment and service records. Raw records are not attached because they contain extensive PII and PHI, and some agency-supplied pages carry handling or privacy markings. A redacted source summary is provided at the end of this response.

Important limitation: records indicating no recorded occupational ionizing-radiation dose do not answer whether RF/EMF exposure occurred. Ionizing-radiation dosimetry and non-ionizing RF/EMF exposure assessment measure different hazards. The absence of a personal RF/EMF measurement is an evidence gap, not proof of exposure or proof of no exposure.

Response to Question 9

Information that should be disclosed to workers

Workers and their authorized representatives should receive timely, understandable, task-specific information sufficient to reconstruct actual exposure conditions. At minimum, HHS should recommend disclosure and retention of the following:

- equipment identity, manufacturer, model, operating frequency, modulation or pulse characteristics, power, duty cycle, and normal versus maintenance mode;
- available electric-field, magnetic-field, power-density, SAR, leakage, and near-field measurements, including the instrument, calibration date, sampling interval, uncertainty, and exact measurement location;
- distance and orientation relative to the source, shielding and interlocks, energized work practices, simultaneous sources, task duration, and cumulative work history;
- alarms, malfunctions, unusual operating conditions, work orders, incident reports, access restrictions, and corrective actions;
- training, PPE or administrative controls, medical-surveillance options, and the worker's right to obtain records without retaliation; and
- clear separation of ionizing-radiation dosimetry from non-ionizing RF/EMF monitoring so that one is not mistakenly treated as evidence about the other.

The case record shows why these fields matter: decades later, a detailed medical history exists, but the technical exposure record needed to test the worker's hypothesis is missing or was never created.

Response to Question 10

Occupational monitoring and public health surveillance

HHS should develop an interoperable, privacy-protective occupational RF/EMF surveillance system. Existing energy-worker programs demonstrate useful elements such as standardized work-history interviews, site-record requests, exposure reconstruction, medical screening, and long-term follow-up. Those systems often focus on ionizing radiation or toxic chemicals; they should not be assumed to capture RF/EMF exposure without an RF/EMF-specific module.

A useful system would include:

- standardized adverse-event reporting for workers and clinicians, including task, equipment, operating mode, timing, distance, symptoms, and immediate response;
- personal and area monitoring for high-exposure tasks, unusual events, and maintenance conditions, with raw time-series data retained;

- a job-exposure matrix linked to equipment inventories and changes over time;
- longitudinal follow-up that can evaluate delayed, recurrent, or cumulative outcomes without assuming causation at intake;
- a mechanism to investigate clusters while protecting identities and avoiding public disclosure of medical records; and
- worker access to their own records and a process for correcting incomplete work histories.

Benefits include earlier signal detection, better exposure reconstruction, and more credible research. Challenges include privacy, inconsistent historical records, changing equipment, confounding medical conditions, selection and recall bias, and the risk of treating unverified reports as confirmed effects. The system should preserve reports while clearly labeling evidence strength.

Response to Question 11

Sensitive populations and workers with elevated occupational exposure

Yes. Exposure assessment for workers should be task-based rather than based only on job title or averaged environmental measurements. Repair and maintenance personnel may work close to energized equipment, bypass normal operating configurations, encounter leaks or malfunctions, or experience short peaks that area averages miss. Historical workers also need methods that account for incomplete equipment inventories and records.

Risk evaluation should separately consider workers with preexisting cardiovascular, neurological, metabolic, renal, sensory, or implanted-device concerns, as well as older workers. This does not mean that such conditions establish RF/EMF causation. It means studies and surveillance should preserve enough information to evaluate susceptibility, alternative explanations, and interactions instead of excluding complex cases from analysis.

Children and families of workers also warrant carefully designed research. Exposure may begin early, continue for many years, and be largely involuntary. Reproductive, developmental, and family health outcomes may be studied in well-characterized occupational cohorts without assuming that a shared illness pattern proves a shared cause. Where RF/EMF may coexist with ionizing radiation, chemicals, heat, noise, or other hazards, each exposure should be characterized separately and possible interactions should be evaluated.

Response to Question 16

Highest priority research gaps

- Prospective studies of occupational maintenance and repair tasks using calibrated personal monitoring and time-resolved symptom and event data.
- Methods to reconstruct historical RF/EMF exposure from equipment records, work orders, job tasks, source distance, operating modes, and contemporaneous measurements, with quantified uncertainty.
- Research that distinguishes electric fields, magnetic fields, RF power density, frequency, modulation, pulse characteristics, near-field conditions, and simultaneous multi-frequency exposure instead of relying on a single average metric.
- Evaluation of short-duration peaks, intermittent exposures, cumulative exposure, and mixed occupational environments under realistic conditions.
- Pre-registered, adequately blinded and controlled provocation studies with verified exposure conditions, transparent reporting of blank and sham responses, and independent replication.
- Longitudinal research on workers with well-characterized exposure, including medical confounders and susceptible subgroups, with both positive and negative findings published.
- Research on practical exposure-reduction controls that can be evaluated without presuming either safety or harm.

Response to Question 18

Additional recommendations

- Create a federal minimum data set for RF/EMF occupational incidents and require consistent terminology across HHS, CDC/NIOSH, DOE, DOL, VA, and other agencies that hold relevant worker records.
- Require preservation schedules long enough to support delayed health questions, including equipment specifications, monitoring data, work orders, access logs, incident reports, and medical-surveillance records.
- Provide workers and families a clear route to request a consolidated exposure record and an explanation of what was searched, what was found, and what no longer exists.
- Establish independent review procedures for unusual occupational events, including prompt measurements and preservation of the equipment configuration before it changes.
- Fund expert assistance for historical cases so families are not expected to reconstruct complex exposures from fragmented medical and administrative records on their own.
- Publish federal assessments with clear distinctions among documented exposure, reported symptoms, clinical observations, association, mechanism, and causation.

- Give clinicians and families a standard way to record exposure timing, symptoms, alternative explanations, objective findings, and uncertainty without prematurely assigning or dismissing causation. Include clear warnings that unvalidated shielding products or costly treatments may not be effective.
- Give schools and local governments access to underlying technical and monitoring data, not only a statement of regulatory compliance, and create a meaningful channel for community concerns about siting and cumulative exposure.

Conclusion

My family's records cannot determine whether RF/EMF exposure caused this worker's health problems. They show why the question remains unresolved: an acute worksite event was medically documented, later evaluation occurred, and information needed for credible exposure reconstruction is absent. The family's testimony also records the human consequences: loss of meaningful work, years of caregiving and uncertainty, and repeated efforts to find help. My father wanted to work, wanted answers, and wanted other people to be safe. HHS can reduce such uncertainty for future workers through better monitoring, disclosure, record preservation, surveillance, and independent research. I respectfully ask HHS to treat historical occupational experience as a core part of its RF/EMF public-health work.

Redacted Source Summary

The following sources support this response. They are summarized rather than attached because the originals contain direct identifiers, detailed medical information, signatures, claim numbers, addresses, and other sensitive material. Page references correspond to the uploaded PDF page sequence.

ID	Source	Date and pages	Proposition supported
S1	Family timeline and work history	Undated compilation; PDF pp. 1-5 and 19	Worker's narrative of the July 1985 event, later reported experiences, occupational electronics history, and family account.
S2	Regional hospital record	July 18-23, 1985; PDF pp. 8 and 11-12	Contemporaneous presentation, examination, normal head CT, hospital course, and discharge diagnoses.
S3	Environmental Health Center Dallas report	April 26, 1988; PDF pp. 1-9	Clinical opinion, frequency-challenge observations, computer-exposure observation, blank responses, and stated limitations.
S4	Federal energy-worker compensation correspondence	2007-2008; selected correspondence	Claimed employment period, evidence requests, work-history development, and the distinction between documented medical conditions and proof of occupational causation.
S5	INL medical and employment materials	1977 and later agency-produced copies	Historical job and health-history context; records contain protected identifiers and agency privacy markings.
S6	NIOSH dose-reconstruction intake packet	February 8, 2010; PDF pp. 1-14	Example of structured work-history interviews and exposure reconstruction for a separate ionizing-radiation claim; not evidence of RF/EMF dose or causation.

ID	Source	Date and pages	Proposition supported
S7	Personal and family impact statement of Georgia Dimick	October 7, 2026	Firsthand family observations, caregiving experience, historical research, and reported family impact; not independent proof of exposure or causation.

Official RFI Sources

U.S. Department of Health and Human Services. Request for Information on Electromagnetic Fields, Radiofrequency Radiation, and Wireless Radiation Exposure. 91 FR 59792-59794, September 21, 2026.

HHS. HHS Seeks Public Input on Electromagnetic Fields and Wireless Radiation. September 17, 2026.

Regulations.gov. Docket HHS-OASH-2026-0397 public comment form. Comments due October 21, 2026.