I am a primary care physician at Penn Medicine. This submission concerns one of my patients who has been under Penn Medicine care since 2015. I assumed her care in November 2025. The patient's medical history reflects a multi-decade baseline of clinical stability. She maintained a stable body weight for over fifty years, lived in her primary residence since 2015 without any historical occurrence of neurological, vestibular, cardiovascular, psychiatric, chronic pain, sleep disorder, or environmental sensitivity symptoms. Her record demonstrates decades of overall health and stability without any major fluctuations.

Beginning in late 2024, the patient experienced a sudden and severe onset of symptoms that represented a significant change from her baseline. Based on my literature review and ongoing clinical evaluation, I think the patient's symptoms exhibit temporal correlation with possible external technological-based hazards. In reading about these technologies, I think she may be experiencing symptoms due to non-thermal radiofrequency radiation, microwave exposure, acoustic energy, and infrasound.

Her symptoms include intermittent sharp, stabbing pain in the chest, abdomen, head, and eyes, cranial pressure, deep ear pain, vertigo, tinnitus, parotid-region irritation with choking sensations, nightly sleep disruption, palpitations, vibration sensations, and localized heat sensations. She has also involuntarily lost ten percent of her body weight over the past year due to the severity and persistence of these symptoms. The patient's symptom profile is consistent with the symptoms described in patients exposed to radiofrequency radiation, including cranial pressure, vestibular disturbance, autonomic dysregulation, tinnitus, sleep disruption, and internal vibration sensations.

The reproducibility of symptoms across multiple states eliminates local environmental causes and strongly supports a wireless technology-based exposure. The patient's symptoms consistently cease when environmental triggers disappear and reappear when triggers return, demonstrating a repeatable exposure-response pattern. There is no psychiatric illness, cognitive disorder, or psychological condition that could account for the patient's symptoms.

These symptoms are medically documented and closely resemble patterns described in federal scientific analyses of "anomalous health incidents." The patient shared literature that I reviewed. Specifically, the National Academies of Sciences, Engineering, and Medicine have documented neurological, vestibular, autonomic, and systemic injury patterns associated with directed RF and microwave exposure. The Department of Defense and Intelligence Community have published findings describing non-thermal RF effects that include cranial pressure, vestibular disturbance, autonomic dysregulation, tinnitus, sleep disruption, and internal vibration sensations.

Peer-reviewed literature submitted to the FCC and NIH further identifies oxidative stress, neurovascular disruption, and autonomic instability as potential consequences of non-thermal RF exposure. The patient's symptoms align with these documented injury patterns in both character and chronology.

The patient resides in proximity to a drug-trafficking organization. Her symptoms intensify when she stands in specific locations within her home, when she documents events related to her symptoms, when she prepares legal filings or attempts to access the courts, and when unfamiliar vehicles are parked outside her residence for long term. She reports symptom escalation during persistent idling of heavy-vehicles or modified engines near her home and during refrigerator-compressor cycling that produces infrasound-like interior resonance. These patterns are repeatable, location-specific, and temporally linked to external environmental technology-based exposure. Her symptoms disappear when the triggers leave, reappear when the triggers return.  In the spring of 2026, the patient relocated to a different state in an attempt to

escape the painful attacks. She experienced similar symptoms and pain while in the other state. Public reporting later confirmed that a similar drug-trafficking organization was identified in the local area where she relocated, reinforcing the technology-based narcotics retaliatory correlation.

The patient has undergone an extensive medical workup, including CT scans of the head, chest, abdomen, and pelvis; blood panels; EKGs; X-rays; ultrasounds; coronary calcium scoring; colonoscopy; and gastroenterology consultation. All results were negative. No physical, organic, or psychiatric cause has been identified to explain her symptoms. The absence of any medical explanation strongly supports an environmental etiology consistent with federal literature on non-thermal RF-associated anomalous health incidents.

Her case also reflects the institutional gap identified in *Ber v. Centers for Disease Control and Prevention*, 8:26-cv-01822 (M.D. Fla. 2026), in which Dr. Ber and other plaintiffs experiencing symptoms attributed to Havana Syndrome or anomalous health incidents challenged CDC and NIH for failing to recognize civilian cases, failing to issue diagnostic guidance, failing to establish a civilian surveillance system, and failing to provide equal access to NIH research and treatment programs. The patient's case mirrors these deficiencies: medically documented symptoms, environmental correlation, multi-state persistence, and the absence of diagnostic pathways or protective mechanisms.

The patient's symptoms are medically documented, have no identifiable physical or psychiatric cause, correlate with environmental triggers, correlate with drug-trafficking organization activity, occur equally across multiple states, disappear when triggers leave, reappear when triggers return, and match described directed-energy injury patterns. This constellation of factors reveals a critical blind spot in United States public health and safety that allows organized criminal witness retaliation, directed-energy harm, displacement of older adults, and multi-state pursuit without detection or intervention. The unauthorized deployment of environmental-altering technologies against civilians constitutes an urgent public-health hazard. The absence of diagnostic pathways, environmental standards, investigative jurisdiction, inter-agency coordination, and protective mechanisms represents a significant federal vulnerability requiring immediate action.

For these reasons, I urge the Department of Health and Human Services to recognize RF, microwave, acoustic, and infrasound exposure as an emerging environmental health hazard; to develop diagnostic criteria and clinical pathways for suspected exposure cases; to establish exposure-threshold standards and measurement tools for individual patients; to initiate inter-agency coordination with NIH, CDC, DoD, and DHS; to create a civilian surveillance and reporting system for anomalous health incidents; and to issue public-health alerts where appropriate. My patient's health and safety depend on swift federal action to address this emerging environmental threat.

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Submitted in collaboration with the patient