CONSOLIDATED ANONYMOUS PUBLIC COMMENT

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

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Respondent: Anonymous
Perspective: Individual member of the public / consumer

PRIVACY STATEMENT

This submission is intentionally anonymous. It contains no name, address, city, employer, school, family information, medical-record identifiers, personal contact information, account information, or other personally identifying details. The substance is drawn from prior independent policy drafts and theoretical research manuscripts, but identifying titles, authorship information, and personal-history material have been removed.

EXECUTIVE SUMMARY

The central recommendation is that federal policy distinguish four different questions that are often improperly collapsed into one:

1. Does a source comply with an existing exposure limit?

2. Does an individual have a functional limitation for which an accommodation may be appropriate?
3. Did a particular exposure cause a particular biological or health effect?
4. Is there objective evidence of intentional technological misuse?

These questions overlap, but they are not the same. Regulatory compliance is not identical to individualized disability access. Symptoms are not by themselves proof of causation. Unexplained symptoms are not by themselves proof of intentional targeting. At the same time, scientific uncertainty should not be used as a reason to refuse measurement, accommodation, research, evidence preservation, or competent investigation.

This submission therefore recommends:

• rigorous, technology-specific exposure science;
• transparent measurement standards;
• cumulative and long-term exposure research;
• designated effectively no-wireless / near-zero anthropogenic RF accommodation zones;
• wired alternatives in housing, schools, workplaces, healthcare, shelters, and public facilities;
• a federal clinical-consultation pathway for difficult environmental-intolerance cases;
• prospective research on reported electromagnetic hypersensitivity and broader idiopathic environmental intolerance;
• privacy-protective adverse-event and surveillance systems;
• explicit protections for children and other potentially sensitive populations;
• independent review of scientific disagreement;
• a separate evidence-based pathway for complaints involving alleged intentional biologically interactive, neurotechnological, acoustic, electromagnetic, or directed-energy interference; and
• a clear research category for hypotheses that remain speculative and are not yet established by mainstream evidence.

A NOTE ON THE TERM “NO-RADIATION ZONE”

A literal zone containing no electromagnetic radiation is not physically achievable because natural background electromagnetic radiation, thermal radiation, visible light, and other fields remain present. In this submission, “No-Radiation Zone,” “NRZ,” or “effectively no-radiation zone” means an operational accommodation standard:

NO intentional wireless RF transmitters inside the designated space, wired communications available, wireless functions disabled or physically excluded where feasible, unnecessary RF-emitting equipment removed or deactivated, external anthropogenic RF reduced to the lowest practicable level, and objective measurements used to document the resulting environment.

A more technically precise federal term could be “Near-Zero Anthropogenic RF Accommodation Zone,” but the policy objective is the same: a place where a person can sleep, learn, work, obtain healthcare, or recover without being required to remain in an intentionally transmitting wireless environment.

QUESTION 2 — PERSPECTIVE REPRESENTED

This response is submitted anonymously by an individual member of the public and consumer.

The response draws from several categories of material:

• peer-reviewed scientific literature;
• governmental and military records;
• exposure standards and regulatory frameworks;
• published judicial decisions;
• international precautionary approaches;
• prior independent legislative and administrative policy drafts;
• prior theoretical research manuscripts; and
• research hypotheses that are expressly identified as hypotheses rather than established findings.

QUESTION 3 — PUBLIC EXPERIENCES AND REPORTED POTENTIAL ADVERSE HEALTH EFFECTS

Because this is an intentionally anonymous public-record version, no individual medical history, family history, location history, diagnostic information, dates of personal exposure, or other identifying experience is included.

Instead, HHS should create a standardized method for anonymous or de-identified public experience reports. Useful fields include:

• source type;
• technology type;
• approximate frequency band when known;
• whether the source is near-body, in-room, building-mounted, vehicle-based, outdoor infrastructure, occupational equipment, or another source;

• timing, duration, recurrence, and duty cycle where known;
• approximate distance;
• peak and average field measurements where available;
• device or network activity;
• symptoms or functional effects;
• sleep effects;
• whether effects change by location;
• whether effects change after source reduction or removal;
• environmental co-exposures, including smoke, mold/dampness, pesticides, volatile chemicals, noise, lighting, temperature, ventilation, and electrical conditions;
• medical evaluation where the person chooses to report it; and
• supporting measurements, photographs, logs, or other non-identifying documentation.

HHS should distinguish exposure-response-removal patterns from proof of causation. Repeated temporal patterns can be useful for clinical history, hypothesis generation, and research design, but they should be tested prospectively with objective exposure measurements and appropriate controls.

QUESTION 4 — CLINICAL, OCCUPATIONAL, AND RESEARCH OBSERVATIONS

This anonymous submission is not presented as a healthcare-professional response.

A recommended federal clinical framework would document the person's reported experience accurately while preserving diagnostic neutrality. It should neither ridicule the patient nor automatically affirm a disputed causal explanation.

A competent evaluation can consider, as clinically appropriate:

• neurological conditions;
• cardiovascular conditions;
• auditory and vestibular conditions;
• endocrine conditions;
• sleep and circadian disruption;
• toxicological and chemical exposures;
• medication effects;
• indoor-air quality;
• mold and dampness;
• smoke and combustion products;
• pesticide exposure;
• lighting, sound, vibration, temperature, and ventilation;

• autonomic and stress-related physiology;
• psychiatric conditions;
• sensory-processing factors; and
• RF/EMF exposure history.

The clinical record should distinguish:
(1) symptoms;
(2) functional impairment;
(3) exposure history;
(4) diagnosis;
(5) causal attribution; and
(6) accommodation need.

A person may have a genuine functional limitation that warrants accommodation even while the underlying mechanism remains uncertain.

QUESTION 5 — EXPOSURE STANDARDS, GUIDELINES, AND REGULATORY FRAMEWORKS

Federal health agencies should review existing U.S. RF exposure rules, international guidelines, public-health guidance, disability-access law, and precautionary approaches used in other jurisdictions.

At minimum, federal review should consider:

• FCC human-exposure requirements, including 47 C.F.R. §§ 1.1307 and 1.1310;
• ICNIRP's 2020 RF exposure guidelines;
• WHO materials concerning RF/EMF and electromagnetic hypersensitivity;
• precautionary frameworks that impose additional controls at places of prolonged occupancy;
• individualized disability-accommodation principles; and
• Environmental Health Trust v. FCC, 9 F.4th 893 (D.C. Cir. 2021).

Recommended scientific, technical, and regulatory changes include:

• report both peak and time-averaged exposure where scientifically appropriate;
• characterize operating frequency;
• power density;
• SAR where relevant;
• electric-field strength;
• magnetic-field strength;
• modulation and pulse characteristics;

• duty cycle;
• beamforming;
• simultaneous exposure to multiple frequencies;
• duration;
• distance from source;
• proximity to the body;
• cumulative exposure over time;
• prolonged-occupancy exposure;
• sleeping-environment exposure;
• occupational exposure;
• source variability;
• uncertainty and measurement limitations.

Regulatory compliance testing and individualized real-world exposure characterization should be treated as different tasks.

QUESTION 6 — SCIENTIFIC EVIDENCE ABOUT POTENTIAL ADVERSE EFFECTS UNDER CURRENT LIMITS

HHS should divide the evidence into clear categories.

CATEGORY A — ESTABLISHED OR WIDELY ACCEPTED PHYSICAL EFFECTS

RF energy can interact with biological tissue. Sufficiently high RF exposure can produce heating, and established exposure standards address recognized adverse effects using dosimetry and exposure limits.

CATEGORY B — DOCUMENTED PHYSICAL PHENOMENA WITH LIMITED SCOPE

The microwave auditory or Frey effect demonstrates that pulsed RF/microwave exposure can produce an auditory perception under particular experimental conditions. The scientific relevance is narrow but important: externally applied electromagnetic energy can, under

specified conditions, generate a consciously perceived sensory event without ordinary airborne sound.

This does NOT establish:
• that ordinary ambient wireless exposure causes electromagnetic hypersensitivity;
• that arbitrary words or thoughts can be remotely inserted into a person's mind;
• that any specific civilian complaint is caused by such a mechanism; or
• that a documented physical phenomenon can be generalized to every claimed biological effect.

CATEGORY C — CONTESTED SCIENTIFIC LITERATURE

The BioInitiative Report and portions of the peer-reviewed literature argue for biological effects below prevailing exposure limits and recommend more precautionary standards. Those conclusions are disputed and should not be described as universal scientific consensus.

HHS should review such material rather than exclude it categorically, but should evaluate study quality, endpoint, dosimetry, replication, frequency, modulation, exposure duration, statistical methods, confounding, and consistency with the broader evidence base.

CATEGORY D — PUBLIC-HEALTH GUIDANCE ON REPORTED EHS

WHO materials have historically recognized that people reporting electromagnetic hypersensitivity may experience real and sometimes disabling symptoms while not accepting a demonstrated causal relationship between ordinary low-level EMF exposure and the symptom complex.

The policy implication is that symptom validity, disability access, and causal certainty are separate questions.

CATEGORY E — LEGAL PROCESS

Environmental Health Trust v. FCC is relevant to how agencies should handle uncertainty. The D.C. Circuit required the FCC to provide a reasoned explanation addressing portions of the record concerning non-cancer effects, children, long-term exposure, technological

developments, and environmental concerns. The court did not itself resolve the underlying scientific debate.

QUESTION 7 — METHODS FOR CHARACTERIZING HUMAN EXPOSURE

HHS should support standardized use of:

• calibrated broadband RF meters for screening;
• frequency-selective spectrum analyzers;
• validated personal RF dosimeters;
• fixed environmental monitoring;
• time-series logging;
• geospatial mapping;
• laboratory SAR and compliance testing for near-body devices;
• device/network operational data where available;
• repeated measurements across occupancy conditions;
• sleeping-location measurements;
• source-specific engineering analysis for directional or unusual systems; and
• low-frequency electric and magnetic field measurements where power-frequency exposure is also being evaluated.

Every protocol should state:
• calibration;
• frequency range;
• detector bandwidth;
• peak-hold capability;
• averaging method;
• time resolution;
• antenna orientation;
• measurement location;
• distance;
• uncertainty;
• environmental conditions;
• known sources;
• unknown-source limitations; and
• whether the objective is compliance testing, source identification, research, or individualized exposure-reduction planning.

QUESTION 8 — IMPROVEMENTS IN REAL-WORLD EXPOSURE ASSESSMENT

Real-world assessment should capture conditions that a one-time spot measurement can miss:

• transient peaks;
• burst transmissions;
• duty cycle;
• pulsing and modulation;
• beamforming;
• adaptive power control;
• multiple simultaneous sources;
• near-body use;
• building penetration;
• apartment-to-apartment exposure;
• sleeping conditions;
• movement through different environments;
• occupational schedules;
• vehicle environments;
• wearable-device exposure;
• smart-home exposure;
• time variation over hours and days.

Research should also document co-exposures and confounders so that RF/EMF is not treated as the only possible environmental variable.

QUESTION 9 — INFORMATION THAT SHOULD BE DISCLOSED

Where technically applicable, consumers, residents, workers, schools, healthcare providers, and local governments should be able to obtain:

• source/operator identity;
• transmitter location;
• frequency band;
• maximum and typical operating power;
• duty-cycle information;
• beamforming information where relevant;
• applicable compliance documentation;

• measurement dates and methods;
• major equipment changes;
• whether wireless functions can be disabled;
• whether wired service is available;
• whether provider-controlled equipment can be relocated;
• technical support contacts; and
• an accommodation-request process.

MULTIFAMILY HOUSING

Residents may have limited control over neighboring routers, shared infrastructure, provider-installed equipment, smart systems, utility meters, and common-area transmitters. Federal guidance should therefore distinguish voluntary personal device use from building-level or neighboring-source exposure.

QUESTION 10 — PUBLIC-HEALTH SURVEILLANCE AND DATA SYSTEMS

HHS should evaluate a privacy-protective RF/EMF surveillance and adverse-event system that can combine:

• prospective longitudinal cohorts;
• occupational monitoring;
• environmental monitoring;
• symptom and functional-outcome reporting;
• clinician reports;
• device/source metadata;
• validated biomarkers if any are identified;
• cluster investigation;
• exposure measurements; and
• follow-up after environmental changes.

A reporting system should be a signal-detection tool, not a causation engine. A report should not automatically be classified as either proof of RF injury or proof of psychiatric illness.

Data should be de-identified for research and should not be repurposed for unrelated employment, housing, insurance, custody, immigration, law-enforcement profiling, or other secondary uses.

QUESTION 11 — SENSITIVE POPULATIONS

HHS should explicitly study:

• children;
• pregnant people;
• older adults;
• users of implanted medical devices;
• workers with elevated occupational exposure;
• people with preexisting neurological, cardiovascular, sleep, sensory, or other medical conditions; and
• people reporting severe electromagnetic or broader environmental intolerance.

A sensitive-population framework does not require assuming that RF caused every reported symptom. It means asking whether physiology, development, implant compatibility, body size, exposure duration, occupation, sleep, co-exposures, or functional limitations materially alter risk or access needs.

DESIGNATED NEAR-ZERO ANTHROPOGENIC RF ACCOMMODATION ZONES

HHS should pilot designated NRZ spaces for people who require them as an individualized accommodation and for controlled research.

Priority settings may include:

• selected hospital rooms;
• selected clinic rooms;
• sleeping rooms;
• shelters;
• schools and colleges;
• libraries and public buildings;
• workplaces;
• public housing;
• multifamily housing pilot sites;
• research facilities; and
• other prolonged-occupancy environments.

An NRZ should, where feasible:

• use hardwired Ethernet and wired telephone systems;
• contain no active Wi-Fi access point;
• contain no Bluetooth beacons or unnecessary wireless peripherals;
• avoid wireless-only building controls;
• use wired sensors where feasible;
• permit occupants to keep personal devices in airplane mode or outside the room;
• avoid locating provider-controlled transmitters immediately adjacent to the room;
• provide wired alternatives to smart appliances when feasible;
• use qualified shielding only where engineering review indicates it is appropriate;
• document baseline and post-mitigation RF measurements;
• include low-frequency electric/magnetic field characterization where relevant;
• maintain emergency communication and medical-safety exceptions; and
• be evaluated for actual exposure reduction, not merely labeled “low EMF.”

The purpose is not to claim that everyone medically requires such a zone. The purpose is to create an actual accommodation and research environment for people who do.

QUESTION 12 — EVIDENCE BELOW CURRENT FEDERAL LIMITS

Below-limit evidence should be evaluated with careful separation of:

• acute versus chronic exposure;
• thermal versus proposed nonthermal endpoints;
• in vitro, animal, occupational, epidemiological, and controlled human evidence;
• measured versus modeled exposure;
• frequency;
• modulation;
• pulse structure;
• duration;
• distance;
• dosimetry;
• outcome selection;
• replication;
• statistical power; and
• conflicts of interest.

The BioInitiative Report should be examined as a precautionary compilation, not treated as governmental consensus.

The Frey-effect literature should be considered only for the phenomenon it actually demonstrates.

Environmental Health Trust v. FCC should be understood as a process precedent requiring reasoned consideration of evidence and uncertainty, not as a judicial finding that below-limit RF causes disease.

QUESTION 13 — CUMULATIVE EXPOSURE FROM 5G, 6G, WI-FI, SATELLITES, IOT, WEARABLES, SMART HOMES, SMART CITIES, AUTONOMOUS VEHICLES, WIRELESS MEDICAL DEVICES, AND SMART METERS

HHS should develop a cumulative-exposure framework that characterizes how multiple systems interact over time.

5G / 6G:
• variable power;
• beamforming;
• changing network density;
• multiple frequency ranges;
• handset uplink;
• infrastructure downlink;
• indoor penetration;
• time variation.

Wi-Fi:
• access-point proximity;
• overlapping networks;
• client-device transmissions;
• long-duration indoor exposure;
• sleeping-room exposure;
• school and workplace density.

Satellite systems:
• distinguish satellite downlink from near-body user-terminal or handset uplink;
• characterize user equipment and duty cycle.

IoT / smart homes:
• many low-duty-cycle sources;
• always-on control systems;
• wireless sensors;
• appliance communications;
• cumulative indoor source count.

Wearables:
• near-body placement;
• continuous duration;
• frequency;
• body location;
• duty cycle.

Smart cities:
• public-space infrastructure;
• multiple source types;
• dense monitoring networks;
• cumulative neighborhood exposure.

Autonomous vehicles:
• cabin wireless systems;
• radar/sensing technologies;
• passenger devices;
• multi-source exposure;
• time spent in the vehicle.

Wireless medical devices:
• near-body or implanted operation;
• clinical benefit;
• interference/compatibility;
• individualized risk.

Smart meters:
• transmission timing;
• burst characteristics;
• duty cycle;
• distance from occupied areas;
• location relative to sleeping spaces;
• cumulative contribution relative to household Wi-Fi and cellular sources.

QUESTION 14 — POTENTIAL ENVIRONMENTAL EFFECTS

HHS should coordinate with appropriate environmental agencies to review RF/EMF effects on:

• birds;
• navigation-related endpoints;
• insects;
• pollinators;
• plants;
• livestock;
• wildlife near infrastructure;
• reproduction;
• development;
• behavior;
• chronic versus intermittent exposure;
• frequency and modulation;
• habitat-level cumulative exposure.

Field studies should measure actual exposure and control for heat, pesticides, habitat loss, noise, light pollution, disease, weather, nutrition, and other ecological confounders.

QUESTION 15 — WIRELESS INFRASTRUCTURE

Infrastructure research should measure exposure rather than use distance alone as a substitute.

For homes, schools, childcare facilities, healthcare facilities, and workplaces, research should record:

• transmitter distance;
• measured exposure;
• antenna height;
• antenna orientation;
• frequency;
• power;
• beamforming;
• duty cycle;
• density of surrounding antennas;
• indoor penetration;

• background from other networks;
• occupancy duration; and
• sleeping or prolonged-use spaces.

For small-cell deployment, cumulative neighborhood mapping should be repeated over time rather than inferred from installation count alone.

QUESTION 16 — HIGHEST-PRIORITY FEDERAL RESEARCH GAPS

Priority areas include:

1. Prospective research on reported EHS / idiopathic environmental intolerance using objective exposure measurement.
2. Sleep and circadian outcomes.
3. Long-term cumulative exposure.
4. Multiple simultaneous technologies.
5. Modulation, pulsing, duty cycle, and transient peaks.
6. Beamforming and adaptive networks.
7. Children and development.
8. Pregnancy.
9. Aging.
10. Implanted medical devices.
11. Occupational exposure.
12. Auditory and vestibular endpoints.
13. Neurological outcomes.
14. Autonomic outcomes.
15. Cardiovascular outcomes.
16. Endocrine outcomes where biologically justified.
17. Inflammatory outcomes where biologically justified.
18. Cognitive and functional outcomes.
19. Reproducible biomarkers, if any.
20. Environmental and ecological effects.
21. Effectiveness and unintended effects of shielding.
22. Effectiveness of wired alternatives.
23. Effectiveness of reducing device duty cycle or turning wireless functions off.
24. Effectiveness of airplane-mode and device-distance interventions.
25. Effectiveness of sleeping-room source reduction.
26. Engineering design of near-zero anthropogenic RF accommodation spaces.
27. Multifamily exposure-control problems.
28. Interaction between RF/EMF and other environmental stressors.

29. Interaction among smoke, mold/dampness, pesticides, volatile chemicals, light, noise, temperature, ventilation, sleep disruption, and sensory sensitivity.
30. Longitudinal comparison of high-wireless and low-wireless built environments.
31. Research that clearly separates functional accommodation outcomes from claims of disease causation.
32. Separate ethical research on intentional biologically interactive and neurotechnological exposures.

PROPOSED RESEARCH PROTOCOLS TRANSLATING THE MEASUREMENT AND SLEEP RECOMMENDATIONS

Pilot A — Exposure metrology and controlled accommodation comparison. An RF engineering/instrumentation team could first characterize the electromagnetic environment in three reproducible conditions: a conventional wireless room, a reduced-transmission room, and a near-zero anthropogenic RF accommodation room. Calibrated instrumentation should map frequency-specific sources, time variation, occupied locations, peak and time-averaged exposure, measurement uncertainty, equipment self-emissions, and low-frequency electric and magnetic fields as appropriate. Environmental conditions such as temperature, lighting, ventilation, noise, chemical exposure, and sleep arrangements should be held as comparable as possible. Engineering validation should come BEFORE any health-effect interpretation; if the conditions cannot be reliably distinguished or controlled, the project should remain a method-development study rather than make biological claims.

Pilot B — Preregistered sleep and autonomic pilot. Under faculty supervision and IRB approval where human subjects are involved, a separate team could test whether defined and independently measured environmental conditions are associated with reproducible changes in sleep, autonomic, or functional outcomes. A small within-subject crossover design, randomized condition order, preregistered primary endpoint, blinded or sham conditions where feasible, and an independent analysis plan would reduce interpretive bias. Potential endpoints to select BEFORE enrollment include actigraphy/sleep efficiency, heart-rate variability, blood pressure, electrodermal activity, reaction time, validated symptom measures, and functional tolerance. The analysis must separately report participants who experience symptoms without measurable physiological change, those with physiological change without perceived symptoms, those with both, and those with neither; no one outcome should be assumed in advance.

Protocol safeguards. Both pilots should define safety stop rules, electrical and RF measurement expertise, emergency communications, recruitment protections for disabled participants and caregivers, technical feasibility, power calculations where applicable, prospective confounder

plans, and adverse-event monitoring. Particular care is needed with crossover carryover, order and expectancy effects, circadian schedules, co-exposures, medications, caffeine, stress, environmental changes, and missing data. A protocol should distinguish engineering efficacy, reported comfort, verified functional accommodation benefit, and evidence of a causal biological effect. Even a demonstrated accommodation benefit would not by itself establish that RF/EMF caused an underlying diagnosis. Results, including null or adverse findings, should be publishable with methods sufficient for independent replication.

The two pilots can be coordinated methodologically without treating them as one experiment: instrumentation establishes what exposure manipulation was achieved; sleep/physiology researchers assess whether any independently specified outcome changed. HHS could encourage such cross-disciplinary, preregistered collaborations as examples of research that directly addresses Questions 7, 8, 11, and 16.

QUESTION 17 — FEDERAL RESEARCH COORDINATION

A coordinated federal program should assign complementary roles.

NIH:
• mechanistic research;
• epidemiology;
• clinical research;
• sleep/circadian research;
• neurological research;
• environmental-health research;
• replication studies.

FDA:
• wireless medical devices;
• consumer-device safety;
• device testing assumptions;
• adverse-event data;
• near-body exposure;
• product-specific questions.

CDC:
• surveillance;
• population health;

• clinician guidance;
• exposure-history templates;
• public-health communication;
• longitudinal cohort infrastructure.

Coordination should also include agencies with engineering, occupational, communications, standards, environmental, and measurement expertise.

Research safeguards should include:

• preregistration where appropriate;
• standardized dosimetry;
• publication of protocols;
• raw-method transparency;
• conflict-of-interest disclosure;
• independent replication;
• negative-result publication;
• open data where privacy permits;
• explicit uncertainty;
• labels distinguishing established findings, plausible but unconfirmed findings, disputed conclusions, and unsupported claims.

QUESTION 18 — ADDITIONAL SCIENTIFIC, TECHNICAL, DATA, LEGAL, AND POLICY RECOMMENDATIONS

A. FEDERAL NRZ / NEAR-ZERO ANTHROPOGENIC RF ACCOMMODATION STANDARD

HHS should develop a model standard for effectively no-wireless accommodation zones.

Operational definition:

An NRZ is a designated area in which intentional nonessential wireless RF transmissions are eliminated inside the space, wired alternatives are supplied, external anthropogenic RF is reduced to the lowest practicable level, and objective measurements document the result.

Minimum elements:

• wired internet;
• wired telephone option;
• no Wi-Fi access point in the room;
• no unnecessary Bluetooth transmitter;
• no wireless-only environmental controls;
• no required wearable transmitter;
• wired or manually controllable lighting/HVAC where feasible;
• no smart speaker;
• no wireless-only appliance requirement;
• ability to place personal devices outside the room;
• external source survey;
• measurement before and after mitigation;
• qualified engineering assessment for shielding;
• emergency and medically necessary exceptions;
• transparent posted technical specification.

HHS should test whether such zones improve access, sleep, tolerability, healthcare participation, educational participation, work participation, or other functional outcomes among people requesting low-exposure accommodations.

B. WIRED ACCESS AS A DISABILITY-ACCESS OPTION

Federal model guidance should identify hardwired internet, wired telephone, workstation relocation, remote participation, alternative room placement, equipment relocation, scheduling changes, reduced-wireless rooms, and similar measures as potential accommodations subject to ordinary individualized analysis.

Granting an accommodation should not be treated as a governmental finding that RF caused the person’s underlying condition.

C. MULTIFAMILY HOUSING

Housing policy should recognize that residents often cannot control:

• neighboring routers;
• provider-installed access points;
• telecommunications infrastructure;
• smart-building equipment;

• utility equipment;
• common-area transmitters.

Where feasible, residents requesting accommodation should be able to seek:

• wired service;
• relocation away from provider-controlled transmitters;
• notice before new installations;
• code-compliant reversible mitigation;
• a unit with lower measured exposure;
• ability to opt out of wireless-only building systems where an alternative exists.

D. MEDICAL CONSULTATION NETWORK

HHS should create a multidisciplinary clinical consultation network for difficult environmental-intolerance cases.

The network should:
• document symptoms and function;
• document exposure timing and place;
• evaluate differential diagnoses;
• review indoor environmental factors;
• interpret measurement limitations;
• help clinicians write accommodation-focused documentation;
• avoid ridicule;
• avoid automatic affirmation of unverified intentional targeting.

E. MEASUREMENT STANDARDS FOR ACCOMMODATION

Federal guidance should distinguish:
• compliance measurement;
• source identification;
• personal exposure assessment;
• accommodation planning;
• forensic technical investigation.

A single low reading at one time should not automatically characterize a dynamic environment, and a single high reading should not by itself establish medical causation.

F. BODILY AUTONOMY, NEUROTECHNOLOGY, AND HUMAN-SUBJECT PROTECTION

Federal policy should examine technologies capable of intentionally affecting sensation, neural activity, physiology, sleep, cognition, behavior, or collecting neural/cognitive information.

The governing principle should be technologically neutral:

A technology should not escape ordinary rules of informed consent, bodily autonomy, mental integrity, privacy, human-subject protection, disability access, evidence, and due process merely because it operates remotely, is called “nonlethal,” is difficult for a layperson to identify, or combines surveillance with biological interaction.

G. MICROWAVE AUDITORY / FREY EFFECT

The microwave auditory phenomenon should be accurately represented.

It supports the proposition that externally applied pulsed RF/microwave energy can produce an auditory perception under particular conditions.

It does not by itself establish:
• semantic thought transmission;
• remote mind control;
• ambient-wireless disease causation;
• case-specific targeting.

The federal research value is that it demonstrates why sensory effects from energy exposure belong inside serious technical and ethical review rather than being excluded by category.

H. GOVERNMENTAL “BIOEFFECTS OF SELECTED NONLETHAL WEAPONS” MATERIAL

Publicly released governmental literature concerning nonlethal technologies has discussed categories including microwave heating, microwave hearing, and disruption of neural control.

Its relevance should be narrowly stated:
government institutions have examined biological and sensory effects of certain energy-based technologies.

It does NOT establish that a particular civilian was exposed, that a particular system was deployed, or that every theoretical effect became an operational capability.

I. INTENTIONAL INTERFERENCE COMPLAINT PATHWAY

HHS should coordinate with appropriate investigative and technical agencies on a neutral process for complaints alleging intentional biologically interactive, neurotechnological, acoustic, electromagnetic, optical, electrical, or directed-energy interference.

A neutral pathway should:

• document the allegation;
• assess urgent medical and safety needs;
• preserve objectively relevant evidence when lawful;
• allow technical review;
• consider medical, neurological, toxicological, environmental, psychiatric, interpersonal, and technological explanations;
• avoid treating an allegation as proven merely because it is reported;
• avoid treating an allegation as disproven merely because the alleged method is unfamiliar;
• refer credible evidence to the appropriate authority.

Potential evidence may include:

• spectrum data;
• environmental measurements;
• device logs;
• network records;
• equipment information;
• access records;
• surveillance authorizations;
• geolocation records obtained through lawful process;
• procurement records;
• research protocols;
• medical timelines;
• witness information.

J. EVIDENCE PRESERVATION

Where an allegation meets a defined objective threshold, agencies and courts should have procedures for preserving potentially ephemeral technical evidence.

The existence of a patent, historical program, general scientific literature, or a government document should not satisfy case-specific causation by itself.

K. NEUROTECHNOLOGY, AGENCY, AND CRIMINAL-LAW RESEARCH

Prior theoretical work proposes a concept of “technological agency interference”: if a defendant ever produced credible, particularized evidence that an external technology materially affected perception, cognition, affect, or motor control, criminal adjudication would need to evaluate voluntariness, mens rea, causation, coercion, and alternative explanations rather than treating sole internal authorship as an irrebuttable premise.

This is a legal-theoretical proposal, not a claim that such interference occurred in any particular criminal case.

Relevant ordinary legal doctrines include:
• mens rea;
• voluntariness;
• causation;
• duress;
• insanity/capacity rules;
• evidentiary thresholds;
• expert testimony;
• forensic preservation.

Published cases that provide ordinary criminal-law background include:
• Morissette v. United States, 342 U.S. 246 (1952);
• Kahler v. Kansas, 589 U.S. 271 (2020);
• Dixon v. United States, 548 U.S. 1 (2006).

The proposal is that courts should require case-specific corroboration before materially altering normal agency assumptions.

L. PATENTS AND TECHNICAL CLAIMS

Patent publications can document that a technical claim was made. They do not establish that a device works, that it has been independently validated, that it was built, or that it was used.

Any patent concerning electromagnetic influence on perception or cognition should therefore be classified as a technical claim requiring independent validation, not as proof of capability or deployment.

M. PUBLIC EDUCATION

Federal materials should explain:

• non-ionizing versus ionizing radiation;
• what current RF limits are designed to address;
• what measurement can and cannot establish;
• what the microwave auditory effect does and does not show;
• what is established versus contested in EHS literature;
• how to use wired connections;
• how device distance changes near-field exposure;
• how to disable unnecessary wireless functions;
• how to create a lower-wireless sleeping environment;
• how to avoid unsafe or technically inappropriate shielding;
• how to request accommodations;
• how to document unusual exposure without unsafe confrontation.

N. PRIVACY AND ANTI-RETALIATION

Do not create a public registry of people reporting EHS or environmental intolerance.

Limit medical documentation to what is reasonably necessary for the clinical, research, or accommodation purpose.

Protect complaint data from unrelated surveillance, employment screening, housing decisions, custody disputes, profiling, and other secondary uses.

O. INDEPENDENT SCIENTIFIC REVIEW

Create a multidisciplinary review body including:

• epidemiology;
• occupational/environmental medicine;

• RF engineering;
• electrical engineering;
• neuroscience;
• neurology;
• audiology;
• sleep medicine;
• toxicology;
• public health;
• statistics;
• exposure science;
• building science;
• disability law;
• privacy law;
• human-subject ethics;
• affected-community representation.

The panel should explicitly categorize evidence as:

1. established;
2. replicated but limited;
3. plausible but unconfirmed;
4. contested;
5. speculative;
6. unsupported;
7. falsified or inconsistent with available evidence.

P. RESEARCH HYPOTHESES DERIVED FROM PRIOR THEORETICAL MANUSCRIPTS

The following ideas are submitted as hypotheses for research prioritization, NOT as established scientific facts.

1. Bioelectrical signaling and whole-organism electromagnetic ecology

Prior theoretical work argues that biological organisms depend on electrical signaling, membrane potentials, nervous-system activity, cardiac electrical activity, ionic gradients, and electromagnetic interactions, and asks whether chronic anthropogenic RF/EMF environments can perturb some part of that signaling ecology.

The established premise is that living organisms use electrical and electrochemical signaling. The broader claim that modern wireless exposure broadly disrupts a unified whole-body

“electromagnetic communication system” requires specific mechanistic evidence and should be tested rather than assumed.

2. DNA / antenna hypotheses

Earlier theoretical work described DNA as an electromagnetic or “fractal antenna” and proposed that environmental electromagnetic fields could alter information exchange or gene expression.

The gene-expression question is experimentally testable. The broader “fractal antenna communicating with the universe” formulation is not presented here as established biology and would require extraordinary evidence.

3. Sympathetic compensation hypothesis

Earlier theoretical work proposed that some people may not consciously feel environmental exposure because sympathetic nervous-system activation could partially mask or compensate for effects.

This is not established as a general explanation for people who do not report EHS. It could be reformulated as a research question involving autonomic measures such as heart-rate variability, catecholamine-related endpoints, sleep, arousal, and blinded exposure.

4. EHS as an early-warning phenotype

Earlier theoretical work described highly sensitive individuals as “canaries in the coal mine,” hypothesizing that rapid symptoms might function as an avoidance signal.

This is a hypothesis. It should be tested by comparing objectively measured exposure, blinded symptom response, long-term health outcomes, autonomic responses, and environmental-intolerance phenotypes rather than assuming either exceptional vulnerability or universal injury.

5. Sleep as a high-priority endpoint

Prior work repeatedly emphasizes sleep as a period of repair and as a functional outcome that may be highly sensitive to environmental disruption.

HHS should prioritize sleep because it is measurable and clinically important regardless of whether RF/EMF is ultimately shown to be causal in any particular case.

6. Grounding / Earth-contact hypotheses

Prior theoretical work proposed that conductive contact with Earth may affect physiology and help restore electrical equilibrium.

This should not be treated as established RF protection. If studied, trials should distinguish electrical grounding effects from expectation, sleep-environment changes, temperature, movement, and other confounders.

7. Schumann-resonance hypotheses

Prior theoretical work proposed that Earth-ionosphere resonance frequencies may have biological regulatory significance and that urban electromagnetic environments may alter effective exposure to those frequencies.

This remains a research hypothesis and should not be used as a basis for consumer-product claims without independent evidence.

8. Shielding and abstinence / source reduction

Prior work strongly favored source reduction, wired connections, disabling unnecessary wireless functions, increasing distance, and shielding over pendant-type or “neutralizing” consumer products.

HHS should directly test:
• source reduction;
• wired Ethernet;
• nighttime wireless shutdown;
• device distance;
• airplane mode;
• shielding fabrics;
• canopies;
• building shielding;
• equipment relocation;
• changes in electrical wiring/grounding.

Outcomes should include actual measured exposure, sleep, symptoms, function, and unintended consequences.

9. Technological hyper-observation / observer-density hypothesis

A later theoretical model proposes that biological systems are continuously interacting with environmental radiation, electromagnetic fields, thermal emission, sensory inputs, matter, and information. It extends established quantum decoherence and environmental interaction concepts into a speculative hypothesis that excessive technological measurement, observation, or information density could alter biological flexibility or “grounding.”

The manuscript itself states that this extension is unproven.

HHS should not treat quantum observer-density language as established biological mechanism. If any part is researched, experiments must first control known physical exposure pathways — electromagnetic, thermal, acoustic, mechanical, chemical, behavioral, and psychological — before invoking a new informational mechanism.

10. Developmental hyper-grounding hypothesis

Prior theoretical work asks whether dense technological monitoring of development could have biological effects beyond ordinary physical exposure pathways.

This remains speculative. Prenatal and developmental technologies must be evaluated modality by modality. Ultrasound, RF, optical imaging, cameras, wired monitors, wireless monitors, and passive records are physically different and should never be merged into one exposure category.

11. Species-dependent sensory architecture

Prior theoretical work emphasizes that different organisms detect different parts of the physical environment and that human perception is not a complete instrument for environmental interaction.

The policy implication is modest: absence of conscious perception should not be treated as a measurement of absence, while subjective perception alone should not be treated as proof of an external source.

12. Environmental density and biological regulation

Prior theoretical work treats organisms as embedded in complex environments containing light, heat, electromagnetic interactions, chemistry, microbiology, sound, vibration, gravity, social signals, and repeated information exchange.

This supports a systems-level research design that measures RF/EMF alongside other environmental variables rather than pretending one exposure occurs in isolation.

13. Bioelectromagnetic coherence / oscillatory hypotheses

Prior research notes that nervous systems operate through oscillatory electrical activity and that biological function can be described partly through coupled dynamic systems.

This does not establish one universal “healing frequency,” one disease frequency, or a simple resonance cure.

Research should distinguish:

• neural oscillation;
• field exposure;
• entrainment;
• autonomic regulation;
• sensory gating;
• network synchronization;
• subjective experience.

14. “Entrainment” claims

Earlier theoretical work argued that electromagnetic pollution may force biological systems into unnatural oscillatory patterns.

That generalized claim is not established. It can be converted into a testable question: under what exposure parameters, if any, do external fields measurably alter neural, cardiac, autonomic, or cellular oscillations, and are such changes harmful, adaptive, neutral, transient, or dose-dependent?

15. Disease-burden claims

Earlier theoretical work made very broad claims assigning a large fraction of modern disease to electromagnetic pollution.

Those quantitative claims are NOT presented here as established evidence. They should not be repeated as epidemiological fact without supporting population-level data.

The appropriate federal question is narrower: what fraction, if any, of particular outcomes is associated with particular well-characterized exposures after confounding, reverse causation, exposure misclassification, and multiple-comparison problems are addressed?

Q. THE “NO-RADIATION ZONE” AS A TESTABLE POLICY INTERVENTION

The NRZ proposal is valuable precisely because it can be evaluated rather than argued about abstractly.

A federal pilot could compare:

• conventional wireless room;
• reduced-wireless room;
• near-zero anthropogenic RF room.

Keep other variables as similar as possible:
• temperature;
• lighting;
• ventilation;
• noise;
• bedding;
• schedule;
• expectation management where feasible;
• chemical exposures;
• air quality.

Measure:
• RF spectrum;
• low-frequency electric and magnetic fields;
• sleep;
• heart-rate variability;
• cognitive performance;
• symptom reports;
• functional tolerance;
• blinded or partially blinded periods where feasible;
• persistence of effects after leaving the room.

This would generate evidence about an actual accommodation intervention without requiring HHS to decide in advance that every proposed mechanism is correct.

R. LEGAL AUTHORITIES RELEVANT TO THE POLICY FRAMEWORK

Brown v. Los Angeles Unified School District, 60 Cal. App. 5th 1092 (2021):
Relevant to individualized disability accommodation. It should not be cited as scientific proof of RF causation.

Environmental Health Trust v. Federal Communications Commission, 9 F.4th 893 (D.C. Cir. 2021):
Relevant to reasoned agency treatment of evidence and uncertainty. It should not be cited as a judicial finding that ordinary below-limit RF exposure causes disease.

47 U.S.C. § 332(c)(7)(B)(iv):
Relevant to the limits on state and local regulation of certain wireless-facility decisions based on RF environmental effects where facilities comply with FCC requirements. Federal review is therefore important where state/local authority is constrained.

Morissette v. United States, 342 U.S. 246 (1952); Kahler v. Kansas, 589 U.S. 271 (2020); Dixon v. United States, 548 U.S. 1 (2006):
Relevant only to the separate legal-theoretical question of criminal agency, intent, capacity, coercion, and causation if reliable evidence of external neurotechnological interference were ever presented.

R.1. CONSOLIDATED POLICY DESIGN FROM THE TWO PRE-EXISTING LEGISLATIVE FRAMEWORKS

The following is an integrated federal-policy translation of two earlier state-level working proposals: one concerning electromagnetic environmental health, reasonable accommodation, wired access, and healthy homes; the other concerning bodily autonomy, neurotechnology, consent, technical evidence, and accountable complaint handling. These are PROPOSED policy options, not enacted law and not empirical proof of an RF/EMF health effect. They are included here as one coherent set of recommendations relevant to HHS Questions 8, 10, 11, 16–18. Federal authority, state authority, communications preemption, and the responsibilities of independent investigative agencies must remain distinct.

1. Disability accommodation without premature scientific adjudication. Guidance developed with the relevant civil-rights and housing agencies could distinguish four independently answerable questions: regulatory compliance; an individual's functional limitation and accommodation request; exposure-specific health causation; and independently corroborated unlawful technological conduct. An accommodation review should examine the applicable law, the documented functional limitation, feasibility, efficacy, essential program requirements, and legally applicable defenses. Providing a wired connection or alternative room need not constitute a government finding that RF caused a person's symptoms. Equally, a source's compliance with a population-level exposure limit does not itself answer every individualized access question. Any guidance must preserve undue-hardship, fundamental-alteration, direct-threat, and other defenses where applicable.

2. Practical wired-access alternatives. A federal model-accessibility toolkit could describe wired Ethernet, wired telephone options, workstation or classroom relocation, wired-capable equipment, remote participation, room scheduling, and optional reduction of nonessential indoor transmissions. Pilot settings could include public universities, schools, healthcare facilities, workplaces, shelters, and publicly supported housing. These are options for individualized assessment, not a requirement that all facilities eliminate wireless service or an assertion that wireless equipment harms every occupant. A technical accessibility assessment should document whether the alternative actually permits education, employment, healthcare, housing, or civic participation.

3. Near-zero anthropogenic RF accommodation rooms. The previously proposed “No-Radiation Zone” is operationally a near-zero ANTHROPOGENIC RF accommodation zone, not an assertion that all natural electromagnetic radiation can be eliminated. A federal pilot standard could specify: no nonessential transmitting devices inside the room; reliable wired communication; user control of voluntary personal devices; external source surveys; calibrated before/after spectral measurements; emergency and medically necessary exceptions; HVAC, lighting, noise, ventilation, temperature, and chemical-environment equivalence; accessibility standards; and protocols for reassessment as building equipment changes. Trials should report achieved RF reduction and practical usability rather than treating room designation alone as a treatment.

4. Multifamily housing and healthy-building coordination. Residents may not control shared wireless systems, building-installed routers, common-area transmitters, smart appliances, electrical installations, or provider-level communication contracts. Model housing guidance could address pre-installation notice where relevant, disclosure of wired options, resident-controlled alternatives, technically feasible relocation within a property, and code-compliant reversible modifications. It should integrate RF assessment with established indoor-environment evaluation for dampness, mold, wildfire smoke, pesticides, ventilation, heat, lighting, and acoustic conditions so that an intervention does not unintentionally introduce another hazard.

5. Targeted mitigation funding with engineering safeguards. If public funds are considered for accommodation demonstrations, the eligible interventions should be tied to functional access and independently verified performance: wired-network retrofits, professional RF exposure surveys, equipment relocation, alternative room provision, or technically justified shielding. Qualified engineers should examine unintended reflections, indoor signal changes, blocked emergency connectivity, electrical safety, ventilation, accessibility, fire code, and other risks. Consumer pendants, unverified “neutralizers,” or universal treatment claims should not qualify merely because marketed as electromagnetic protection.

6. Standardized measurement and disclosure. Measurement guidance should define the question being asked: population-standard compliance, personal exposure characterization, source finding, change after accommodation, or forensic technical examination. Reports should identify calibrated equipment, detector bandwidth and uncertainty, frequency coverage, waveform or modulation where available, peak and time-averaged readings, near-/far-field limitations, spatial maps, simultaneous sources, body position, changing traffic load, and collection times. Consumer-meter readings must not be represented as definitive medical or forensic evidence. Consumers, schools, workers, housing providers, and healthcare professionals should receive clear source and measurement disclosures proportionate to their legitimate need.

7. Multidisciplinary clinical consultation. HHS could convene or support an environmental-intolerance consultation network that documents reported symptoms, chronology,

functional limitation, sleep, exposure-related beliefs, and patient-led environmental changes while maintaining differential diagnosis and diagnostic neutrality. Depending on the clinical presentation, assessment may consider sleep, endocrine, neurological, auditory, cardiovascular, medication-related, toxicological, air-quality, psychiatric, and other explanations. Clinicians should avoid dismissive treatment, but should not presume a contested RF mechanism or a specific perpetrator without evidence. The network's outputs could inform functional accommodation records, anonymized research protocols, and ethical referral pathways.

8. Education and employment implementation. Federal demonstration projects could measure whether hardwired communication, low-transmission rooms, remote/hybrid participation, alternate equipment placement, and accessible scheduling improve documented access outcomes. School studies involving minors and workplace studies involving unequal power relationships require independent ethical review. The primary outcomes should include participation, attendance, sleep, tolerance, absenteeism, accommodation feasibility, cost, and adverse consequences. Agencies should not conflate an accommodation's effectiveness with proof of a single biological mechanism.

9. Cumulative environmental and sleep research. A research program could study whether reported electromagnetic intolerance co-occurs with sleep disruption, sensory intolerance, dampness/mold, wildfire smoke, pesticides, volatile chemicals, temperature, light, noise, ventilation problems, or stress. Participants should not be pre-classified as having established RF-caused disease. Prospective and, where feasible, blinded studies should use objective exposure measurements alongside validated clinical and functional endpoints. This systems approach can distinguish whether improvement after an environmental change tracks a specific measured RF intervention, the broader room environment, expectation, or some combination.

10. Bodily autonomy, neural privacy, and human-subject protections. Emerging devices capable of intentionally influencing sensation or neural function, or collecting neural/cognitive data, raise consent, privacy, safety, and research-ethics questions separate from ordinary ambient wireless exposure. HHS and appropriate partners could review whether existing human-subject rules and medical-device oversight adequately describe exposure parameters, recruitment safeguards, adverse-event reporting, contractor accountability, data retention, independent review, and meaningful consent for vulnerable or dependent populations. Historical technical literature should be evaluated by method and independently replicated effect; it does not demonstrate any present-day individual exposure, unlawful use, or operational deployment.

11. Objective complaint intake and lawful evidence preservation. Allegations of intentional electromagnetic, acoustic, optical, neural, or other technical interference should be evaluated through a separate, proportionate, evidence-based pathway rather than merged with environmental-intolerance accommodation decisions. A neutral intake model could document the reported event, assess urgent health and safety needs, preserve available objective records when a defined factual threshold is met, and refer credible material to the competent investigative or regulatory authority. Potential records include validated environmental measurements, equipment identifiers, device and access logs, research protocols, lawful

procurement records, and corroborating witness evidence. No allegation should be deemed proven from symptoms, an old patent, a government research paper, or a theoretical device description alone. Investigation must follow ordinary privacy, due-process, jurisdictional, and legal standards.

12. Privacy, anti-retaliation, and independent review. Federal demonstrations should minimize identifiable health and family information, keep optional participation genuinely voluntary, protect whistleblowers and complainants through applicable law, and avoid creating public registries of persons reporting environmental intolerance. Independent technical panels should include exposure scientists, RF/electrical engineers, epidemiologists, environmental and occupational clinicians, sleep researchers, neuroscience and audiology experts, biostatisticians, disability-law specialists, ethics and privacy experts, building scientists, and affected-community representatives. The panel should publish uncertainty, conflicts of interest, null results, methodological limitations, and reproducible protocols.

13. Jurisdiction and implementation. The state proposals motivating these ideas do not themselves grant HHS authority to create new criminal offenses, change private telecommunications siting law, or compel state legislative action. Recommendations in this RFI should therefore focus on research, public-health coordination, voluntary demonstrations, technically grounded guidance, evidence standards, and appropriate referrals to agencies with independent authority. Telecommunications preemption and disability-law requirements warrant separate legal review before a federal agency translates a model proposal into binding policy.

R.2. LEGAL-THESIS SYNTHESIS: FIVE LEVELS OF EVIDENCE, NOT FIVE PROOFS

A related legal-theoretical manuscript proposes a useful claim-status discipline for emerging neurotechnology. It is incorporated here ONLY to inform evidence governance; it is not offered as biomedical evidence that ordinary ambient RF exposure causes disease or that unlawful individual targeting has occurred.

Level 1 — Established physical or neurophysiological phenomenon: controlled demonstrations such as the microwave auditory effect, implant-based brain stimulation, or clinically studied noninvasive neuromodulation establish only their particular verified effects and experimental conditions.

Level 2 — Technical proposal: a patent, concept paper, military analysis, or research specification establishes that an idea was proposed or studied, not that a practical system works, exists in a claimed configuration, or has ever been deployed against an individual.

Level 3 — Governance recognition: research-ethics, medical-device, neural-data, human-rights, or privacy frameworks may demonstrate that a class of technology deserves oversight, without establishing any particular disputed allegation.

Level 4 — Case-specific objective evidence: a claim about a particular person, incident, or technology requires independently assessable facts capable of distinguishing competing explanations, such as lawful technical records, replicated measurements, medical evidence, and corroboration. General literature cannot substitute for these facts.

Level 5 — Legal consequence: if reliable case-specific evidence exists, a competent court or agency decides relevance under the actual jurisdiction's rules governing admissibility, causation, intent, voluntariness, and available remedies. This paper does not ask HHS to decide guilt, identify alleged perpetrators, or rewrite criminal defenses through an RF public-health docket.

The resulting administrative principle is to maintain separate evidence pathways for established physics, unverified hypotheses, technical proposals, policy ideas, and allegations about individual events. Clinical accommodations can be evaluated without resolving a criminal allegation, while a substantiated technical allegation must satisfy its own ordinary evidentiary and procedural requirements.

S. FINAL POLICY REQUEST

HHS should adopt a framework that is capable of holding scientific uncertainty without institutional indifference.

The federal government can:

• measure what can be measured;
• distinguish exposure compliance from individual exposure;
• distinguish exposure from causation;
• distinguish disability from mechanism;
• distinguish environmental disability from intentional assault;
• accommodate functional limitations without declaring disputed mechanisms settled;
• create actual near-zero anthropogenic RF accommodation spaces;
• study those spaces as interventions;
• preserve evidence where objective facts justify it;
• protect privacy;
• regulate consent and human-subject issues in emerging neurotechnology;
• review contested literature without misrepresenting it as consensus;
• reject unsupported quantitative claims unless evidence supports them;
• convert historical or speculative theories into falsifiable research questions; and
• update policy as evidence changes.

The core recommendation is practical:

Create places where people can actually get away from intentional wireless RF exposure, measure those places, study what happens there, and provide wired access so participation in modern life does not require continuous wireless exposure.

SELECTED PUBLIC REFERENCES AND AUTHORITIES

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