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March 28, 2013

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NAME:	**EBONY STANFORD**
CARRIER CASE #:	**765505**
DATE OF ACCIDENT:	**12/17/2011**
DATE OF EXAMINATION:	**MARCH 25, 2013**
LOCATION:	**BRONX, NEW YORK**

I saw Ms. Ebony Stanford in the Bronx, New York today March 25, 2013, to evaluate her current medical (orthopedic) condition as relates to a reported motor vehicle collision with claimed injury of December 17, 2011.

Ms. Stanford presented her New York State Driver License as identification and this was used to verify her identity. This was photocopied and is included in the file.

HISTORY OF INJURY AS RELATED BY MS. STANFORD

Ms. Stanford is a 34 year-old, right-handed security guard at Harlem Hospital in New York, New York.

She says she was involved in a motor vehicle collision, however, she says does not remember the date of

the event. *(The medical records indicate December 17, 2011).*

Ms. Stanford says on the day of the collision she was a left rear seat passenger in car that was in traffic on the FDR highway. She says another vehicle struck the car in which she was a passenger from the rear. She says a second vehicle, in turn, struck the vehicle behind hers from the rear that resulted in a second rear impact. She says she was not unconscious. *(The records indicate she was not restrained and she was ambulatory at the scene.)* She says the EMS came and she was taken to New York Presbyterian Hospital at 68th Street in New York City. She says she was examined, x-rayed and discharged without assistive devices.

She says after a few days, she went to an urgent care center on East Tremont Avenue in the Bronx, New York where she was again examined.

She says she then went to The Manhattan Rehabilitation Center at 149th Street and 3rd Avenue in the Bronx, New York, where she underwent x-rays and MRI studies and she was treated with physical therapy.

She says she was out of work for five months and returned to her regular work as a Security Guard, without restrictions.

OCCUPATIONAL HISTORY

She says she is a security guard at Harlem Hospital in New York City.

CURRENT SUBJECTIVE COMPLAINTS

She reports, neck pain, back pain and bilateral leg pain. She reports numbness in her lower back and pins and needles in her lower legs. She reports no difficulty with alimentation or micturition.

SIGNIFICANT PAST MEDICAL HISTORY

Ms. Stanford says she has high blood pressure. She reports no prior accident or injury. *(The medical records indicate Hypertension, Hyperlipidemia and Gastro-esophageal reflux.)*

CURRENT MEDICATIONS

She says she takes a medicine for blood pressure the name of which starts with Nif (she thinks) but she says she is not sure of this. She says does not take any other medicines at this time.

REVIEW OF RECORDS AND DOCUMENTS

I have reviewed a verified bill of particulars Index No. 303750/12.

FDNY Prehospital Care Report, 12/17/11, 2323-2332, 76217696, (signature illegible). "..33 y/o female PT found seated in the rear driver side of car.. PT sts her lower back hurts.. □ LOC..□ neuro deficits.. □ deformities.. □ bleeding.. □ swelling.. □ bruising..DMII ↑ Cholesterol.."

Emergency Department Records, Triage, 12/18/11, 00:06, New York Presbyterian Hospital. "...Patient has a chief complaint of LOWER BACK PN and was triaged to a level 3..123/54..79..hypertension.. hyperlipidemia..BIBA.. low speed MVA.. rear seat unrestrained.."

Emergency Department Records, 18Dec11, 0030h – 0254, Catherine R. Rizzo, RN/Jennine Vexcovi, PA/Matthew O'Neill. "..Ebony Stanfore Gyasi..33 y/o femal hx HTN. Low back pain s/p unrestrained back seat passenger in a taxi that was rearended in a MVA involving 3 cars.. patient states low speed..no airbag deployment, the car was not totaled..and was able to ambulate on scene and get out of car without assistance..no head injury no LOC no dizziness..occupation.. police officer..tenderness L45.. cleared from back board and c collar cleared..

An interpretation of x-rays, lumbosacral spine, 2 views, 12/18/11, 1:26 AM, Daniel Rosenbaum, MD.

"....No evidence of acute osseous injury or subluxation in the lumbosacral spine.."

An interpretation of x-rays, dorsal and lumbar spine, multiple views, 12/28/11, Jacob Lichy, MD "...Normal plain film of the lumbar spine. Normal plain films of the dorsal spine.."

(There is not doctor's visit to indicate the reason for this x-ray and the report does not indicate who referred her.)

A partly typewritten/part handwritten/part check-off/part circled word: "Initial Evaluation Form, 12/28/11, Vincent R. Vasile, RPT, PC 384 East 149th Street, Suite 518, Bronx, New York..

An Initial Psychological Evaluation, 1/04/12, Debra H. Goldman, Ph.D. "...back seat passenger in a taxi that stopped short while traveling on the FDR drive.. rear ended by two cars.. was thrown forward and back with considerable force.. became "hysterical" .. inability to work due to pain and worry.." *(There is no referring doctor. This history is dramatically different from the EMS and the emergency room and defies the laws of momentum.)*

A partly typewritten/part handwritten/part check-off/part circled word: Initial Examination Report, 1/17/12, Okon Umana, MD, Internal Medicine. "..post traumatic cervical spine.. post traumatic lumbar spine.."

A series of "Medical Disability Certificates", D. Andrew Davy/D. Ranga Krishna/Allan Wattenmaker, DC

A "Balance Center Report", 1/19/12, Infrared/video ENG report.

An interpretation of Electrical Studies, 1/20/12, R.C. Krishna, MD. "...The above electro diagnostic study reveals evidence of a mild bilateral sensory median nerve neuropathy at the wrist. This is consistent with the clinical diagnosis of Carpal Tunnel Syndrome. The above electro diagnostic study reveals evidence of right C5-C6 radiculopathy.." *(The findings are not sufficient to diagnose any medically significant condition.)*

An interpretation of an MRI, lumbar spine, without contrast, 1/20/12, Jacob Lichy, MD. "...Ranga Krishna, MD..There is minimal bulging of the neural foramina bilaterally at L3-4 and L4-5.." *(No findings to suggest injury are reported.)*

An interpretation of an MRI Scan, cervical spine, without contrast, 1/20/12, Jacob Lichy, MD. "...Straightening of the normal cervical lordosis consistent with pain and muscle spasm.." *(No findings to suggest injury are reported. Straightening by itself means nothing except normal posture variation.)*

A partly typewritten/part handwritten/part check-off/part circled word: note 1/30/12, (signature illegible), Orthopedic Surgery. "..PRN.."

A "Preliminary Medical Report", 1/30/12, Stanley Liebowitz, MD. "...I initially examined Ms.

Stanford.. 1/30/12..post traumatic symptoms continued.. Post traumatic bilateral carpal tunnel syndrome. Post traumatic right C5-6 radiculopathy/straightening of the normal cervical lordosis with pain and muscle spasm. Post traumatic poster lateral bulging of the neural foramina bilaterally at L3-4 and L4-5 intervertebral discs..JTech test done 1/181/2 revealed..WP impairment 25%.." *(This test has been proven to be of no scientific merit as relates to the spine.)*

Physiotherapy Report, 1/30/12, Vincent Vasile, RPT, PC. "...Post traumatic bilateral carpal tunnel syndrome. Post traumatic multiple muscular spasms.."

Medical Disability Certificate, 2/3/12, Andrew Davy, MD

A note, 2/3/12, Andrew Davy, MD

An "Initial Consultation: note, 2/3/12, Andrew Davy, MD. "....Low back pain secondary to lumbar post-traumatic disc pathology, lumbar radiculopathy, multiple myofascial trigger points, cannot rule out facet syndrome. Upper back pain secondary to myofascial trigger points, cannot rule out facet syndrome. Neck pain secondary to cervical post-traumatic disc pathology, cervical radiculopathy, multiple myofascial trigger points, cannot rule out facet syndrome..lumbar epidural steroid injections.."

Medical Disability Certificate, 3/3/12, Andrew Davy, MD.

An interpretation of Electrical Studies, 3/9/12, Allan Wattenmaker, DC. *(There is no scientific validity for this form of testing.)*

History and Physical Form, undated, Allan Wattenmaker, DC. "... Displacement of Lumbar IVD without Myelopathy.. Lumbo-Sacral Radiculitis. Thoracic Spine Pain.." *(Prior to this manipulation there was no displaced disc, no thoracic pain and no documented "radiculitis".)*

Operative Report, 3/17/12, Allan Wattenmaker, DC. "...Manipulation under anesthesia of the Thoracic and Lumbar Spine.." *(There is no scientific validity for this form of treatment. Any manipulation of the spine under anesthesia without radiographic control is medically unfounded and unsafe.)*

Letter of Medical Necessity for continuing the MUA, /22/12, Allan Wattenmaker, DC. *(There is no scientific validity for this form of treatment. Any manipulation of the spine under anesthesia without radiographic control is medically unfounded and unsafe.)*

Operative Report, 3/24/12, Howard Past, DC, "...Manipulation under anesthesia of the Thoracic and Lumbar Spine.." *(There is no scientific validity for this form of treatment. Any manipulation of the spine under anesthesia without radiographic control is medically unfounded and unsafe.)*

Letter of Medical Necessity, 3/28/12, Allan Wattenmaker, DC. *(There is no scientific validity for this form of treatment. Any manipulation of the spine under anesthesia without radiographic control is medically unfounded and unsafe.)*

Operative Report, 3/31/12, Allan Wattenmaker, DC, "...Manipulation under anesthesia of the Thoracic and Lumbar Spine.." (*There is no scientific validity for this form of treatment. Any manipulation of the spine under anesthesia without radiographic control is medically unfounded and unsafe.)*

An interpretation of Electrical Studies, 4/5/12, Allan Wattenmaker, DC. *(There is no scientific validity for this form of testing.)*

A partly typewritten/part handwritten/part check-off/part circled word: note 4/5/12, Ranga Krishna, MD.

An interpretation of an electrodiagnostic study, 4/5/12, Ranga Krishna, MD. "..evidence of right L5-S1 radiculopathy.." *(The findings are minimal and not sufficient to diagnose radiculopathy.)*

Medical Disability Certificate, 4/30/12, Andrew Davy, MD.

An interpretation of the MRI of her lumbar spine, performed 1/20/2012, Michael Setton, DO, 9/3/12, "...Minimal bulging of the L4-5 and L5-S1 intervertebral discs with mild bilateral foramina stenosis. No disc herniation identified. Minor degeneration of the lower lumbar facet joints..minor degenerative changes of the lumbar spine unrelated to trauma.."

An interpretation of the MRI of her cervical spine, of 1/20/2012, Michael Setton, DO, 9/3/12, "..Straightening of upper cervical lordosis which may be positional or related to muscle spasm. No evidence of disc bulge or herniation..no abnormal bone marrow or paraspinal soft tissue signal to indicate recent injury to the cervical spine..

A series of Visit Notes, Vincent Vasile, RPT, PC, 12/28/11, 12/29/11, 12/30/11, 1/3/12, 1/04/12, 1/6/12, 1/9/12, 1/11/12, 1/12/12, 1/13/12, 1/16/12, 1/17/12, 1/18/12, 1/19/12, 1/23/12, 1/24/12, 1/25/12, 1/26/12, 1/27/12, 1/30/12, 1/31/12, 2/1/12, 2/2/12, 2/3/12, 2/6/12, 2/7/12, 2/8/12, 2/10/12, 2/14/12, 2/16/12, 2/17/12, 2/22/12, 2/23/12, 2/24/12, 2/28/12, 3/1/12, 3/5/12, 3/6/12, 3/9/12, 3/14/12, 3/15/12, 3/16/12, 3/20/12, 3/22/12, 3/27/12, 3/30/12, 4/3/12, 4/5/12, 4/10/12, 4/13/12, 4/17/12, 4/18/12, 4/25/12, 4/27/12, 5/3/12, 5/14/12, 6/7/12, 6/11/12, 6/20/12, 7/9/12

Chiropractic Notes, Grand Concourse Chiropractic, PC, 12/28/11, 12/29/11, 12/30/11, 1/3/12, 1/04/12, 1/5/12, 1/6/12, 1/9/12, 1/11/12, 1/12/12, 1/13/12, 1/16/12, 1/17/12, 1/18/12, 1/19/12, 1/23/12, 1/24/12, 1/25/12, 1/26/12, 1/27/12, 1/30/12, 1/31/12, 2/1/12, 2/2/12, 2/3/12, 2/6/12, 2/7/12, 2/8/12, 2/14/12, 2/16/12, 2/17/12, 2/22/12, 2/23/12, 2/24/12, 2/28/12, 3/1/12, 3/3/12, 3/6/12, 3/9/12, 3/14/12, 3/15/12, 3/16/12, 3/20/12, 3/22/12, 3/27/12, 3/30/12, 4/3/12, 4/5/12, 4/10/12, 4/13/12, 4/17/12, 4/18/12, 4/25/12, 4/27/12, 5/3/12, 5/14/12, 6/11/12, 6/20/12, 7/9/12

PHYSICAL EXAMINATION

GENERAL APPEARANCE

On physical examination today Ms. Stanford appears a fully-developed, morbidly obese young woman who is no apparent acute distress. She says she is 5 feet 4 inches tall and weighs 220 pounds (our scale weighs her at 238 pounds - BMI 40.8). Her gait normal; it is neither antalgic nor camptocormic; neither spastic nor ataxic; neither slap-foot nor Trendelenburg. She exhibits normal hip sway when walking and normal, symmetric heel-to-toe progression during the stance phases of gait. She walks on her heels and the balls of her feet symmetrically with ease.

HEAD

Visibly - normocepahlic; Ms. Stanford does not report or exhibit scars, bruising of lacerations on her head and she does not report any head-strike. There are no visible asymmetries that would suggest major head trauma. She has black hair and blue eyes (?contact lenses).

CERVICAL SPINE

She does not exhibit torticollis. She turns her head left and right 75 degrees. She tilts her head backward 60 degrees and forward 50 degrees. She tilts side to side 30 degrees in extension. There is no tenderness, spasm or deformity about her cervical spine. There is no levator scapula, trapezial or periscapular spasm during head movements in any direction. Spurling's test is negative and Lhermitte's phenomenon is negative. There is no lymphadenopathy or supraclavicular fossa fullness or tenderness. *(In most humans the normal ranges of cervical motion are: Flexion - expected normal flexion is 50 degrees with a range of from 30 to 80 degrees, depending on age and habitus. Extension - expected*

normal extension is 60 degrees with a range of from 30 to 80 degrees, depending on age and habitus. Rotation -expected normal is 80 degrees with a range of from 45 degrees to 100 degrees, depending on age and habitus. Lateral bending – expected normal lateral bending 35 degrees with a range of from 20 degrees to 60 degrees. As regards the general issue of range of motion in the spine please see the note on pages 11 and 12.)

UPPER EXTREMITIES

At the shoulders she demonstrates forward flexion and abduction to 150 degrees, bilaterally. She demonstrates external rotation of 90 degrees, bilaterally. She demonstrates internal rotation such that her fingertips reach L1, bilaterally. Both elbows demonstrate full, symmetric extension with full flexion to forearms compressing biceps. She demonstrates full, symmetric, normal supination and pronation of 90 degrees. At the wrists she demonstrates dorsiflexion of 90 degrees, palmar flexion of 90 degrees and radial and ulnar deviation of 15 degrees. All fingertips reach her mid-palmar crease and her thumb-tips reach the heads of her fifth metacarpals. There is no thenar, hypothenar or interosseous atrophy. Tinel's sign is negative and Phalen's test is negative. Finkelstein's test is negative. She does not report TFCC tenderness or snuffbox tenderness. There is no distal radial-ulnar instability. At maximal biceps girth (over shirtsleeves) her arms are symmetric at 14 ½ inches. Her forearms (shirtsleeves rolled up to elbows) are symmetric at 12 inches. All visible muscles are symmetric in texture and tone without fasciculation or wasting. In both hands sensation and sudomotor function is symmetric and normal. Manual motor testing is symmetric and normal in all major muscle groups of her upper extremities. Gross grip, chuck and key pinch are symmetric and normal. Finger abduction and finger adduction strength is symmetric and normal.

THORACIC SPINE

There is no tenderness, spasm or deformity in her thoracic spine. Ms. Stanford reports asymmetric perception of sensation in her thoracic spine. There is no tenderness, spasm or deformity in her thoracic spine.

LUMBAR SPINE

As noted above, Ms. Stanford's gait is normal; it is neither antalgic nor camptocormic, neither slap-foot nor Trendelenburg. She exhibits normal hip sway when walking and normal symmetric heel-to-toe progression during the stance phases of gait. Standing with her knees straight she comes within a foot of touching her toes with her fingertips with fluidity, alacrity and ease. The muscles of her lumbar spine demonstrate normal reciprocating function with side bending, rotational movement and with gait. She bends to the left and right a measured 40 degrees. There is no tenderness, spasm or deformity of her lumbar spine. Straight leg raising is negative; Lasègue's sign negative; McNabb's test is negative and the FABER maneuver is negative. *(As regards the issue of range of motion in the spine please see notes on pages 11 and 12.)*

LOWER EXTREMITIES

As noted above, Ms. Stanford's gait is normal; it is neither antalgic nor camptocormic, neither slap-foot nor Trendelenburg. She exhibits normal hip sway when walking and normal symmetric heel-to-toe progression during the stance phases of gait. Manual motor testing is symmetric and normal in all major muscle groups of her lower extremities. She wears tight pants. When measured 8 inches above the medial joint lines of her knees (over tight trousers) her thighs are symmetric at 25 inches. At maximal

calf girth (over tight trousers) her legs are symmetric at 17 ½ inches. All visible muscles are symmetric in texture and tone without wasting. At her knees she demonstrates full extension with flexion to 125 degrees bilaterally. The drawer signs are negative; Lachman's test is negative and pivot shift is negative. There is neither medial nor lateral instability. In her right foot she reports reverse sensing of toe position. She reports correct position in her left foot. She reports normal vibratory sensation on the right. She reports inability to perceive vibration at her left medial malleolus but intact vibration at her right medial malleolus and at both tibial tubercles. There is no interosseous muscle atrophy in either foot.

ORTHOPEDIC NEUROLOGIC

Deep tendon reflexes, including: biceps, brachioradialis, triceps, knee jerks and ankle jerks are 2+ and symmetric. Babinski's are plantar and Hoffmann's are negative. Because Ms. Stanford does not report a spinal cord injury I did not test the bulbocavernosus reflex. In both hands, sensation and sudomotor function are symmetric and normal. There is no thenar, hypothenar or interosseous atrophy. In her right foot she reports reverse sensing of toe position. She reports correct position in her left foot. She reports normal vibratory sensation on the right. She reports inability to perceive vibration at her left medial malleolus but intact vibration at her right medial malleolus and at both tibial tubercles. There is no interosseous muscle atrophy in either foot. Manual motor testing is symmetric in all major muscle groups of her upper and lower extremities.

All range of motion measurements are done with a standard goniometer when needed. All girth measurements are done with a standard ½ inch wide Dritz measuring tape. Vibration is tested with a Neurotone 5 vibration tester. Light touch testing is done with fingertips and, when needed, coin

recognition and with West filaments. Muscle tone is estimated via fingertip palpation. Reflex testing is done with a standard rubber mallet. There is a popular adage: "use it or lose it". Persons who are athletes correctly take this to mean if you do not exercise a muscle, it will get smaller. This is normal human physiology. The corollary of this statement is: "if you don't lose it – you are using it."

Over the past near half century that I have examined patients I have seen many tables that are said to describe "normal motion". Most such tables are derived from examinations performed on young, healthy students and therapists. At best, they are useful for knowing what may be expected in that limited population. They may or may not be relevant to a given patient and are useless when it comes to the issue of determining disability. Most laymen can picture the difference in the physiques of Sumo wrestlers and gymnasts or heavyweight weight lifters and ballerinas. The differences in both joint and spinal motion are considerable. What may be normal for a Sumo wrestler may be totally disabling for a ballerina – and vice versa. What may be normal for a heavyweight weightlifter may be a career ender for a gymnast – and vice versa. The common lay terms "muscle-bound" and "double-jointed" reflect this common knowledge. The only way of determining a causal relationship of joint motion loss is to have measured it pre and post event as is common practice in joint replacement surgery. For any given individual, the best measure of loss of joint motion is to compare one side with the other. Comparison with a table of "normal" is medically meaningless. Conceptually it is the equivalent of saying normal eyes are blue and any other color is therefore, abnormal.

As regards range of motion in the spine: the 3rd edition of the American Medical Association Guides to the Evaluation of Permanent Impairment (which are no longer available but which are referenced in the

State of New York Workers' Compensation Board Medical Guidelines of June, 1996) suggest we may use range of motion as a guide but does not list any range of motion. The 4th edition of American Medical Association Guides to the evaluation of Permanent Impairment was published during June, 1993. These clearly state on page 112 that: "the range of motion model should be used only if the injury model is not applicable or if more clinical data on the spine are needed to categorize the individual's spinal impairment". The 5th edition of the American Medical Association, Guides to the Evaluation of Permanent Impairment, published during November, 2000, on pate 374 states: "The DRE method is the primary method used to evaluate individuals with an injury. Use the ROM method when the impairment is not caused by an injury or when an individual's impairment is not well represented by a DRE category". The current, 6th edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, page 558 states: "Range of Motion is no longer used as a basis for defining impairment."

DIAGNOSES

1) Normal examination without objective evidence of cervical spinal injury on examination or in the medical records.
2) Normal examination without objective evidence of lumbar spinal injury on examination or in the medical records.
3) Consider factitious disorder based on non-physiologic sensory examination in her feet.
4) Iatrogenic disability.
5) Morbid obesity, pre-existing.
6) Hypertension, pre-existing.

CONCLUSIONS

Ms. Stanford attorneys report she sustained injuries of her neck, her back as a result of the accident of December 17, 2011.

I have reviewed the above medical records in chronological order.

1) The first document, an FDNY Prehospital Care report of 12/17/11 2332h. This indicates a complaint of back pain. It does not mention any head strike or cervical pain. There were no objective findings to suggest significant injury such as neurologic deficits, deformity, bleeding, bruising or swelling. She did not complain of neck pain or extremity pain.

2) The next series of reports from the emergency room at New York Presbyterian Hospital on 12/18/11 from 0006h until discharge at 0254h indicate she had been brought in by ambulance after a low speed collision in which she was an unrestrained passenger in a taxi. She had been able to get out of the taxi without assistance and she was ambulatory at the scene of the accident. She complained of lower back pain. Her vital signs were normal. Except for reported lower back tenderness, her examination was normal and her spinal x-rays were also normal. She did not complain of neck pain or extremity pain. She was discharged without assistive devices an indication that there was no disabling condition present.

3) The next report, 10 days later, is an interpretation of an x-ray of her lumbar spine, 12/28/11 by Jacob Lichy, MD. He interprets these films as normal. Given that she had had a set of normal films a week prior, this represents unnecessary x-ray exposure. Most often when x-rays are

ordered, there is a referring doctor mentioned however there is none with this report.

4) The next document from the same date, 12/28/11 is a physical therapy report of Vincent R. Vasile, RPT. This too, does not indicate a referring physician. It also indicates she was ambulating without assistance. The attached pages from the same practitioner suggest this practitioner ordered the x-rays. If so, his is beyond the scope of practice of a Physical Therapist. This therapist does not describe a single objective finding and adds neck pain to her complaints.

5) The next document, a week later, from Debra Goldman, Ph.D., a Psychologist, states she was thrown forward and backward with considerable force and became hysterical. This too, does not have referring doctor. The description of the event defies the laws of momentum and contradicts both the EMS and Emergency Room records.

6) The next document is titled "Initial Examination Report", by Okon Umana, MD, Internal Medicine dated 1/17/12. This is the first Medical record. Although no objective findings are reported Dr. Umana attaches a list of checked off "diagnoses" that are not supported by a single objective finding on physical examination.

7) The next document is a "Medical Disability Certificate" from Okon Umana, dated 1/31/12, that states she is totally incapacitated from 12/17/11 through 6/1/12. Given that there are no objective findings this is simply not true. *(In a real spinal cord injury center, as the one where I once served both as a fellow and later as a chief of service, a person who is quadriplegic – paralyzed*

from the neck down routinely takes up to 6 months of in-hospital rehabilitation by which time they are independent unless C3 and above which requires a respirator. A person who is paralyzed from the waist down becomes independent and frequently back to work in 3 months. For someone who has no objective findings of any injury, the above statement is ridiculous.)

8) The next document, a "Medical Disability Certificate" from Andrew Davy, dated 2/3/12, three days after the one above, indicates she is "totally incapacitated" from 2/3/12 through 3/3/12 because of post traumatic cervical spine and post traumatic lumbar spine. Given that there are no objective findings this is simply not true.

9) The next document, "Medical Disability Certificate" from Ranga Krishna, dated 3/3/12, indicates she is "totally incapacitated" from 3/3/12 through 4/2/12.

10) The next document, "Medical Disability Certificate" from Allan Wattenmaker, DC, dated 4/30/12, indicates from 12/17/ 11 through 4/30/12. This does not indicate any degree of disability.

11) The next document, a "Balance Center Report" of 1/19/12, has neither, clinical indication, scientific validity nor any scientific relevance to the claimed injury.

12) The next document, an interpretation of an electrodiagnostic study by R.C. Krishna, MD is said to show carpal tunnel syndrome (not related) and cervical radiculopathy. In my opinion based on

my experience with electrodiagnostic studies which I first experienced and studies as a medical student the findings as presented are not sufficient to diagnose any condition.

13) The next two reports are interpretation of MRI studies of her cervical spine and lumber spine on 1/20/12 by Jacob Lichy, MD. These films have been reviewed by two different radiologists as noted above. Neither one describes any indication of recent injury.

14) The next document is a note of 1/30/12 with illegible signature that says orthopedic surgery and concludes: prn. Indicating there was not need for further orthopedic treatment.

15) The next document is a "Preliminary Medical Report" of 1/30/12, by Stanley Liebowitz, MD. Dr. Liebowitz does not describe a single objective finding and cites a JTECH derived, Whole Person Impairment of 25%. (This equipment has long since been found to have no scientific validity as relates to the spine. Please see comments on pages 11 and 12.)

16) The next series of reports from Vincent Vasile, RPT, PC of 1/30/12, Andrew Davy of 2/3/12 and the documents of Allan Wattenmaker, DC of 3/9/12 demonstrate not one single objective finding and presents electrical studies that have no scientific validity and document a series of unsafe manipulations of Ms. Stanton's spine with anesthesia but no radiographic control.

17) The final documents are interpretations of MRI studies of her cervical and lumbar spine by Michael Setton, DO on 9/3/12. As noted above under item 13, there are no objective findings to

indicate any injury.

Today's clinical examination demonstrates:

1) Morbid obesity.
2) Normal gait and station.
3) Normal cervical examination.
4) Normal lumbar examination.
5) Normal extremities with no atrophy, muscle weakness or reflex asymmetry.
6) A feigned foot sensory abnormality that is not consistent with any known neurologic condition.

It is my opinion after reviewing the medical records and today's examination that Ms. Stanford did not sustain any serious injury as result of this accident. I base my opinion on several factors:

In regard to the claimed cervical injury:

In my opinion, Ms. Stanford has no disability with respect to her cervical spine.

1) Although the records indicate Ms. Stanford was unrestrained, she did not report head strike or loss of consciousness and none is described in any medical record.
2) Based on the described mechanics of injury, no significant force was applied to the muscles, ligaments, discs or bones of neck. At most her head would have tilted backwards slightly with respect to her torso.
3) In spite of her interacting with several different EMS and Emergency room staff members, not

one mentions cervical pain or extremity pain and she was discharged without assistive devices. With reasonable medical certainty, had any serious cervical injury occurred this would not be so.

4) Not one of the subsequent records describes any cervical spinal injury or pathologic finding indicative of injury.
5) The first report that mentions neck pain is that from a physical therapist of 12/28/11. This report does not mention any objective findings.
6) Although several subsequent documents suggest cervical complaints, not one describes a single objective finding of cervical pathology.
7) The electrodiagnostic studies not consistent with any significant cervical pathology.
8) The MRI of her cervical spine, as read by two radiologists does not describe any finding that would indicate recent injury. With reasonable medical certainty, had any serious cervical injury occurred this would not be so.
9) Her cervical examination today – including all appendages – is normal.
10) She has resumed her usual work without restrictions.

In regard to the claimed lumbar injury:

In my opinion, Ms. Stanford has no causally-related disability with respect to her lumbar spine.

1) The records reflect that Ms. Stanford was able to get out of the taxi and was ambulatory at the scene. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
2) She did complain of lower back pain to the EMS and Emergency room staff, however not one clinical finding of injury was identified on any examination or x-ray. It is plausible that she had a

bruise type injury from something behind her seat although this or objective findings related to such an event are not described in any medical report.

3) Although she interacted with several different emergency room staff members and had x-rays of her lumbar spine in the emergency room, not one objective finding to suggest spinal injury is described. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
4) She was discharged without assistive devices. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
5) Her subsequent x-rays do not indicate a single finding to suggest recent injury.
6) Her MRI studies as reported by two different radiologists do not indicate a single finding to suggest recent injury. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
7) Not one medical report describes any mechanism of lumbar spinal injury.
8) Her electrodiagnostic studies do not indicate any spinal injury.
9) Her lumbar examination today is normal. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
10) She is performing her regular work without restrictions. With reasonable medical certainty, if she had a serious thoracic or lumbar spinal injury, this would not be the case.
11) I do not know if her manipulations changed her spine in any way.

In my opinion, she may perform all activities of daily living and her usual and customary work as she is doing at this time.

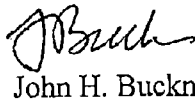
There is no permanency as a result of this accident documented on any examination, test or today's physical examination.

I am licensed to practice medicine in the State of New York, pursuant to CPLR 2106, that the foregoing is true and accurate under the penalties of perjury.

The opinions expressed in this report are my own opinions and are based on my examination and my review of the medical documents that have been submitted with the assumption that the material is true and correct. If more information becomes available at a later date, I shall be delighted to review it and submit an addendum. New information may or may not change the opinions as expressed in this report. The opinions expressed in this report do not constitute recommendation for specific claims or administrative function. This report concerns the injuries for which I have been asked to evaluate this patient. It also considers other conditions that may have impact on her overall condition to the extent to which they can be discerned from the medical records.

The above captioned claimant was examined in accordance with the restrictive rules concerning an independent medical examination. No Doctor/Patient relationship exists or is implied by this examination. No treatment was given or suggested to the claimant. A photo ID was presented before the examination.

Thank you very much for the opportunity to evaluate this claimant. If there are any further questions, please feel free to call at any time.



John H. Buckner, M.D.

TESTIMONY AVAILABILITY: Upon request, given four weeks notice.