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Public Comments on Developing an Unified Intercarrier Compensation:=====

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Proposed Rule Making (NPRM) D=FCC-2011-0078-0001
Dear Rulemaking:

I strongly object to the proposal to eliminate landlines. There are millions of citizens that are unable to use cell phones who depend on landlines to communicate.

Elimination of landlines is ill advised especially in light of volumnes of recent research showing biological damage from emissions from towers and cell phones.(see Bioinitiative at www.bioinitiative.org and many recent studies cited in the attached letter.

This action would violate these citizens constitutional rights and would also violate the Americans with Disabilities Act by effectively prohibiting access to these citizens to communications.
Please see proclamations of Govenors recognizing these Americans, tetimony given by experts and citizens to the Department of Justice January 18, 2011 on the topic and my letter with cites attached supporting this comment.

Please start looking at the recent research not vintage research that helps the industry attempt to avoid an "inconenient truth". The taxpayers of the country pay your salaries and we would appreciate a modicum of consideration to our health and wishes in this matter!

Sincerely , Barbara E. Schnier, Esq (113809 disabled inactive)

Honorary Proclamation



BILL RITTER, JR.
GOVERNOR

ELECTROMAGNETIC SENSITIVITY AWARENESS MONTH *May 2009*

WHEREAS, people of all ages in Colorado and throughout the world have developed the illness of Electromagnetic Sensitivity (EMS) as a result of global electromagnetic pollution; and

WHEREAS, Electromagnetic Sensitivity is a painful chronic illness of hypersensitive reactions to electromagnetic radiations for which there is no known cure; and

WHEREAS, the symptoms of EMS include, dermal changes, acute numbness and tingling, dermatitis, flushing, headaches, arrhythmia, muscular weakness, tinnitus, malaise, gastric problems, nausea, visual disturbances, severe neurological, respiratory, speech problems, and numerous other physiological symptoms; and

WHEREAS, Electromagnetic Sensitivity is recognized by the Americans with Disabilities Act, the US Access Board and numerous commissions; and

WHEREAS, this illness may be preventable through the reduction or avoidance of electromagnetic radiations, in both indoor and outdoor environments and by conducting further scientific research;

Therefore, I, Bill Ritter, Jr., Governor of Colorado, do hereby proclaim May 2009

ELECTROMAGNETIC SENSITIVITY AWARENESS MONTH

in the State of Colorado.



*GIVEN under my hand and the
Executive Seal of the State of
Colorado, this fifteenth day of May,
2009*

Bill Ritter Jr.

Bill Ritter, Jr.
Governor

FLORIDA GOVERNOR PROCLAIMS MAY 2009 AS ELECTROMAGNETIC SENSITIVITY (EMS) AWARENESS MONTH

Christiane Tourtet B.A.

April 28, 2009

Florida Governor Charlie Crist signed a proclamation declaring May 2009 as Electromagnetic Sensitivity (EMS) Awareness Month in Florida. As stated in the proclamation, people in Florida and throughout the world have developed Electromagnetic Sensitivity (EMS) as a result of global electromagnetic pollution.

Electromagnetic Sensitivity is a painful chronic illness of hypersensitivities reactions to electromagnetic radiations for which there is no known cure. The symptoms of EMS include dermal changes, acute numbness and tingling, dermatitis, flushing, headaches, arrhythmia, muscular weakness, tinnitus, malaise, gastric problems, nausea, visual disturbances, severe neurological, respiratory, speech problems and numerous other physiological symptoms.

The Governor also states that Electromagnetic Sensitivity (EMS) is recognized by the Americans with Disabilities Act and the U.S. Access Board and that the health of the general population is at risk from electromagnetic exposures that can lead to this illness induced by electromagnetic radiations, and that this illness may be preventable though the reduction or avoidance of electromagnetic radiations in both indoor and outdoor environments and by conducting further scientific research, and that people with EMS need the support of the Medical Establishment, understanding of family, friends, co-workers, and society as they struggle with their illness and have to adapt to new lifestyles.

[For additional information on Electromagnetic Sensitivity \(EMS\) and to view the Proclamation signed by Florida Governor Charlie Crist, please visit the website:](#)



**Transcript of January 10, 2011 Public Hearing
on Advance Notices of Proposed Rulemakings**

San Francisco, CA

9:30 AM PST

This text is being provided in a rough draft format. This transcription is provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

>> SARA WINSLOW: Good morning, everyone. I'm Sara Winslow deputy chief of the Civil Division at the U.S. Attorney office of the northern districts of California. I want to welcome you all here on behalf of U.S. Attorney Melinda Hague.

One of the many things that we do at the civil division of the U.S. Attorney's office is to work with the Department of Justice's Civil Rights Division, to help enforce civil rights laws such as the Americans with Disabilities Act.

We do that throughout the Northern District of California, which contains the coastal counties from Monterey and the south up to the border with Oregon in the north. And we are very happy that the Department Civil Rights Division is here in San Francisco today to receive comments from our community regarding proposed new rules to implement the ADA in the 21st century.

We would like to thank the Civil Rights Division and all of you who came here today. It's very important to hear from each and every one of you who wants to give comments, get your thoughts and your input on the proposed rules. So, we thank you very much for your participation, and we wish you a very productive hearing today. With that, I will turn it over to Mazen Basrawi from the Civil Rights Division.

>> MAZEN BASRAWI: Good morning, everyone. My name is Mazen Basrawi. I'm

Counsel to the Assistant Attorney General Tom Perez. On behalf of Assistant Attorney General Perez, I'd like to welcome you to our third and final hearing on our Advance Notices of Proposed Rulemaking.

Now, before we begin, the President has asked us to observe a moment of silence in memory of those who were killed this weekend in Arizona. So, we would like to do that at this time. (Pause)

Thank you. This morning, and throughout the day, we will be hearing from members of the public on our advanced notices of proposed rulemaking in the area of Internet websites, captioning and audio description in movies, next generation 911, and equipment and furniture.

And for those who have been following our very productive hearings in Chicago and Washington, D.C., we have gotten very helpful and very important comments throughout the public. From people with disabilities, organizations representing people with disabilities and advocates, representatives of industry, members of public entities, and a variety of others who have provided us with valuable feedback in order for us to take the next steps in producing regulations in these areas.

I don't want to take up much time this morning, since we have a very full schedule for the day. We ask that everyone proceed as efficiently as possible, given that we have a remarkable number of individuals, more than in both Chicago and Washington, D.C.

And now, I would like to turn to our presiding officer in this hearing, Acting Deputy Assistant Attorney General, Mr. John Wodatch, who has served as the Chief of the Disability Rights Section since its founding 20 years ago. And who brings a tremendous amount of wealth, of experience, and wisdom to this process, and will be our presiding officer for the day. So, John?

>> JOHN WODATCH: Thank you, Mazen. Good morning, everyone. We are delighted to be here and to see so many of you here with us in the audience. We'll try and move this hearing along as expeditiously as possible. We have a full day. People have filled in every slot that we have available.

We ask that when you are testifying that you stay within the five-minute allocation we have. We realize that only gives you the opportunity to hit the highlights of what you would like to tell us. We hope that you will supplement your testimony today with written comments.

You can file written comments with the Department through January 24. If you have them with you today, we will be happy to take them and enter them into the record.

There will be a light. When you are testifying, at the four-minute mark, the green light will turn to a yellow light. And there will be a beep. At the five-minute mark, the yellow light will turn to a red light and there will be another louder beep.

We ask that you stay within those parameters, so that the people who have signed up to testify later in the day can have their opportunity to testify as well.

There are a lot of staff here from the Department of Justice and from other agencies here in the Bay Area. And if you have issues or questions, they are available all around the room, and can assist you.

With that, I think we should just begin. Our first commenter this morning is Wayne Lesser. Mr. Lesser, please proceed.

>> WAYNE LESSER: Good morning. My name is Wayne Lesser. I am a lawyer. I'm a trial lawyer. I've been practicing law for 41 years. I was born with moderate to severe hearing loss, and didn't know it until I reached the Bay Area in the late '60s. I'm also the founder of Lesser Sound which will be the first consumer electronics store for the hearing-impaired.

I am an example of the need for the proposed rulemaking for captioning 100 percent of motion picture theaters now, not over five years, unless the theater or its owner can show cause why it should not be required.

I read the materials and found one of the key words is the undue, quote-unquote, "burden," which in my opinion and perhaps others, would justify not accelerating the process. I believe the term is unduly vague, and it is much like the definition of pornography that you, my fellow counsel, will recognize when Justice Stewart in 1964 said, "I know it when I see it."

Undue burden is just too vague. I would suggest the establish -- the presumption of no undue burden with the administrative proceedings to show cause otherwise.

I believe that all theaters should be covered with the requirement that closed captioning or open captioning be introduced as soon as possible, and not over five years, as there is no showing that the technology is not currently available.

I did a study and I found as you all know that the population of we hearing-impaired are at least 36 million and supposedly increasing by one million per year. Thirty-six million new potential customers to the movie industry would offset any undue burden for the industry, and would increase the ability of

my people, my hearing-impaired people, to enjoy the benefits of what you all enjoy without trouble.

We know that 25 to 30 million people who are hearing-impaired don't wear hearing aids, and need assistive devices but either cannot afford them, or are embarrassed to seek help.

Well, the real cost of compliance with the movie theaters introducing closed captioning can be offset by amortization of the cost, institutional loans and perhaps the sale of hearing glasses to what I call the HIP, hearing-impaired people, to offset the cost.

Finally I'd like to share one personal experience that I didn't find funny, others might. Recently I went to a local theater. I don't go much, neither does my wife, because she knows I have difficulty. That theater to my delight had the audio earphones, and I guess it would be a battery-powered sound augmentation device, which you would be able to adjust the sound for the theater. And I was very happy to see that my local theater did it.

I sat there, and the movie began. And I have the device, which looks like a pack of cigarettes with the earphones on, in my hand. And all of a sudden I said, uh-oh, because sound characters, scenes, change of scenes vary. And I found myself with this little cigarette device with the volume control up and down and around and looking up and every time the characters on the screen would look away, I wasn't able to see or hear what they did.

So even with current technology, even with these little battery packs that the theaters are mandated to carry, it doesn't work for people like me.

I wanted to share this personal experience, because I am really what 36 million other people are all about, except I'm here, they are not. But I speak not just for myself, but for them.

>> JOHN WODATCH: Thank you very much. We appreciate you taking the time and sharing your story with us today.

>> WAYNE LESSER: You're welcome and hopefully it will work and it will work for all of us.

>> JOHN WODATCH: Thank you. I'd like to also introduce the other members of the panel. You obviously met Mazen Basrawi, Counsel to the Assistant Attorney General. We are also joined on the panel, on my far right, by Kathy Devine, who is senior attorney in the Disability Rights Section in the Civil Rights Division, and Sarah DeCosse, who is a senior attorney in the Disability Rights Section, both of whom have responsibilities in the area

of developing regulations. I believe our next commenter is going to be by phone, and it's Susan Brinchman.

>> SUSAN BRINCHMAN: Thank you. My name is Susan Brinchman and I reside in La Mesa, California. I'm the director of a national educational 501(C)(iii) nonprofit, the Center for School Mold Help. And my comment is directed with regard to nondiscrimination pertaining to equipment and furniture although there may be some broader applications to what I say for ADA.

I have struggled to live with environmental disabilities for over the past ten years. My suggestions are based on personal experience, communicating with thousands of individuals with these disabilities over the past six-and-a-half years, speaking with experts in the area including doctors and scientists, my own physician recommendations, and use of peer reviewed research which exists in the thousands on this topic.

A large number of the population may be in a category with significant sensitivities that cause them to avoid environmental factors such as chemicals, indoor molds and dampness, or electromagnetic radiation or electric fields.

These people range in the millions. The chemical sector there is estimated to be at 15 percent of the total population. Those sensitive to indoor molds and dampness, 24 percent of the total population. With the electromagnetic and electric concerns, 9.8 million in the United States.

Millions of individuals within these categories are in the severe range, with regard to environmental disabilities, actually. They are designated as partially or totally disabled. And they may be unable to work and access public services and programs, as a result.

And the current status quo is unacceptable in the public services and program sector, and workplace, with regard to accommodating those with environmental disabilities. Even at the Department of Justice ADA office, there appears to be some confusion on the matter as to whether the ADA covers these individuals, even though I know that people are accommodated now and then throughout the United States, based on these disabilities.

A key concept that must be adopted is to provide these people, identified by their own treating physicians, with their recommended accommodations and alternatives in the workplace and in places where they go to receive services and programs. And when accessing services at home, by phone, Internet, or when they are accessing public utilities, that allows them to avoid the triggers for their own illnesses.

Do not force environmentally ill people to expose themselves to triggers to receive services or to work. These measures will in turn protect the general population, improve public health, and reduce the number of disabled people. Because the triggers for these environmental illnesses are not good for anyone.

Some examples, some practical examples of needed furniture and equipment are as follows. For those with chemical sensitivities, or multiple chemical sensitivities, provide alternatives that avoid triggers, scent-free policies, low to no VOC policy for furniture and equipment, provision of appropriate air cleaners, no use of pesticides or herbicide in their presence or even when they are not there. Following the presence, they may be ill from it. Use of no scent green cleaners and just making use of the treating physician recommendations.

Those with mold related illnesses, sick building syndrome, building related illness, asthmatics, those with lung disease. The same as the chemical sensitivity and multiple chemical sensitivity people, they would need that same list, and we would add alternatives to avoid water damaged buildings and mold. The electro-sensitive, provide alternatives that avoid trigger. Especially with smart meters, allow them to opt out of wireless technologies that are placed on their home that radiate their entire home, and make it impossible to live within their own home and be healthy. This has come up just recently with the establishment of the smart meters by the public utilities.

Provide shielding and furniture that may be necessary in the workplace. Or even if they are going to put something on your home like that, have the utility company provide shielding.

I have such a smart meter which is making me sick on my bedroom wall right by my headboard. That is an egregious example of discrimination against me, I feel, but I need help from the ADA to implement my physician recommendations. Thank you very much.

>> JOHN WODATCH: Thank you, Ms. Brinchman. Next, we will hear from Diana Owrey.

>> DIANA OWREY: Good morning. My name is Diana Owrey. I'm a physical therapist from Long Beach Memorial Medical Center. And I work specifically with the spinal cord injured population, and as part of a community-based day treatment program. And this program's position is to bridge the gap between the acute inpatient world and transition patients into a productive lifestyle with activities that they were doing prior to their injury.

The majority of our population are young individuals that are into activities and exercise. And what we are trying to do is help identify ways that they

can keep going with those activities after rehab and after they finish with our program.

Typically our patients, they have doctors' appointments, they like to go to the gym, they like all kinds of activities. What we are addressing here is the equipment and the furniture for those type of activities.

Today's regular ADA regulations get people into gyms and hotels and things like that. But the new regulations that you are proposing are a great way to expand on that and allow them full and integrated access into fitness clubs, and helps them after they are finished with therapy to keep going. And the problem that we have is therapy benefits are becoming shorter and shorter. So what we want to do is set them up for success after they are finished with therapy.

Typically I see, when my patients come back, if they are not set up with accurate resources they gain ten to 25 pounds which as we all know is going lead to cardiovascular problems, obesity, diabetes, secondary causes that are going to be more and more expensive to the healthcare world.

So by setting them up with a nice maintenance program, that doesn't necessarily have to be with a physical therapist but somebody who is educated on how their bodies work, and how they can function with different machines and the right equipment that can help them. There's not a lot of these programs or area where I can take my patients. Regular clubs only have very limited equipment, it's usually stuck in a corner. They don't feel like they are integrated into a society just like everyone else.

Some of the programs I find in the L.A. area, there's Next Step Fitness Center, which is a great facility with accessible equipment. They feel like they are just going to the gym as anybody should.

Hospital programs, they do have a lot of accessible equipment. It is not as the high quality sport, gym-type equipment. So, we need to try and merge the two. Hospital rehab programs should have the same equipment that gyms have so they know how to use it, they're comfortable with it. The part of the problem with hospitals is it's an institutional feel which we're also trying to get off psychologically, we want these people to, people with disabilities should feel comfortable anywhere.

Gyms need to provide equipment that has simple changes like larger seats, swing away seats, things that can be operated from, from a wheelchair or with simple assistance. Color contrasted controls, treadmills with lower speeds, lifts. There should be a lift on every pool. Raised mats. If you want to be able to stretch out, it's a lot easier to get onto a mat than it is to get

onto the floor. And all of this, like I said earlier, should not be stuck into a corner.

One simple way to fix it is most gyms have multiple machines of the same muscle group. Change one of those machines out to an accessible machine, put a sign on it just like the one on the bus that says please give priority to persons with disabilities. And it's a simple way that everybody can just kind of integrate into that fitness world.

Staff trainers at gyms can be really easily educated. Maintenance programs, of course, are not covered under physical therapy benefits. So, with some consultation services and a little bit of education, trainers that know how to do exercise-based programs can help push these people with disabilities to keep going and keep up their fitness and reduce costs later on of the secondary problems.

Another simple thing that can go in gyms or, like we're talking about, doctors' offices, anywhere, gate belts, sliding boards, lift type mechanisms. All these things can just, really easy additions that can make a big difference.

So, what I'm almost talking about is like a collaboration between the rehab world and what I call the outside or non-rehab-based world, fitness clubs, things like that. If we do that, it's going to set up so much more success, because the critical period of time is right after rehab. We just want to keep going and have them on the same program that they were on before, and it will just make them so much more successful. And with the right tools, this can happen.

Because if you maintain that strength, they are going to maintain that functional independence, and prevent all that secondary injury, stroke, CVA. So, I think just the rehab world and outside world need to collaborate. And there is going to be a big change and a lot of helpful things for persons with disabilities. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your taking the time and your testimony as well. Our next commenter will also be via the phone. It's Cindy Sage of Sage Associates.

>> CINDY SAGE: Good morning, my name is Cindy Sage. I'm the owner of Sage Associates, an environmental consulting firm in Santa Barbara, California. I've been a professional environmental consultant since 1972 and taught at the University of California Santa Barbara for about a decade. My particular expertise is in the health and in the environmental aspects of electromagnetic fields, and radio frequency radiation, as they affect the human living environment.

I'm also a senior fellow at the Department of Oncology, School of Health and Medical Sciences at Orebro University Hospital in Sweden. And I have served as an expert witness on these matters in both federal and state courts.

I am here to speak to you today, and I thank you for this opportunity. I want to talk about the growing issue of mobility limitation and health risks that come from exposure to wireless technologies. And that is to radio frequency and microwave radiation. And I will have four recommendations to your board.

My particular concern is for those in this country who have medical sensitivity to electromagnetic fields and radio frequency radiation. And for those with medical implants, who are endangered by electronic interference or radio frequency interference in the environment, and so are unable to live a normal life due to wireless exposures. Such interference can come from every day things like cell phones, cordless phones, Wi-Fi installations and other wireless technologies as they proliferate.

These exposures can greatly restrict access for people to public places, like hospitals, libraries, public transportation of all kinds, the workplace, the school environment. And now with the rollout of wireless electric and gas meters, even in one's home, we have and expect to have increasingly high radio frequency and microwave exposures.

I have got a couple examples where we have been able to validate that even travel on a bus, a train or an airplane where it has installed wireless or heavy use of cell phones during transport can lead to radio frequency microwave levels that can shut down the proper operation of implanted electrodes, and implanted medical devices. In one instance, deep brain stimulators that are used by Parkinson's patients are sensitive to this kind of radio frequency interference and can either disrupt normal function or shut down these electrodes entirely.

So, for people who are using public transportation, the use of these wireless devices, not by the person, but by those around that person, can create a situation akin to secondhand smoke. You might think of it as secondhand radiation, and it can be a real limitation for people to live a normal life.

RFID scanners that are in wide use in hospitals may have the same effect in disrupting implanted electrodes and other medical implants. People who are electrically sensitive are already medically sensitive to these exposures, can be restricted from visiting loved ones in hospital situations or medical clinics, where wireless reporting systems are in operation.

Even the security gates that are large producers of radio frequency microwave radiation that bracket entry doors of many hospitals and stores and libraries and so on, government offices and public places, can be impediments to people.

So, I'd like to make the point to you that there is really just not enough recognition yet in this country at least of these risks. And let me then go directly to my recommendations to you, hearing that beep.

I would urge you to consider new ADA rules protecting people with medical sensitivity to electromagnetic fields and radio frequency radiation. And they need to be clearly addressed by the Department of Justice and rules governing Title I, Title II and Title III of the ADA.

Number two, I would encourage you to make explicit to utility companies in this country that there will need to be exemptions for people with radio frequency illness and electromagnetic sensitivities or medical implants, so they do not have to have the involuntary exposure from wireless utility meters placed in their homes.

Three, we need to have a place for citizens to register their complaints and problems with daily living environments where wireless exposures are limiting them. And to date the FDA and the FCC are not providing that service. We hope you will consider it.

And fourth, we need you to be proactive and communicate these concerns to the FDA Center for Devices and Radiological Health and to the FCC. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony this morning. Next we will hear from Rose Daly-Rooney, who is with the Arizona Attorney General's Office.

>> ROSE DALY-ROONEY: Our Civil Rights Division offers comments on movie theater captioning and video description.

The public and the courts would benefit from the Department's regulatory and interpretive guidance about the movie theater industry's existing obligation to provide captioning and video description for its customers with sensory disabilities. However, we urge the Department to change direction and offer guidance on how to apply the general undue burden factors to the movie theater industry instead of proposing a rule whereby movie theaters would have five more years to equip only 50 percent of their screens.

The ADA already provides a framework for analyzing the auxiliary aids and services requirement. The framework arose from debate and compromise in

Congress and now requires public accommodations to take the steps necessary to ensure that people with disabilities are not treated differently or denied services because of the absence of auxiliary aids and service. And to do so to the extent that it would not result in an undue burden. The auxiliary aids and services provision requires full and equal enjoyment. The undue burden general factors set out by the Department about undue burden provide the flexible individualized approach to determine the limit of that obligation for a particular entity.

The framework was built to last, and it can handle the changes of time including technological advances. The current proposal does not comport with that framework, and we offer four reasons to support changing direction.

First, the current proposal does not provide an individualized assessment of the net cost and financial resources of each theater as the undue burden analysis does. For example, net cost will vary based on the equipment the theater has. The theater industry has provided information that it will be cheaper to install on digital equipment. There is a various rollout among the theaters. So that will vary from theater to theater.

Additionally, the financial resources will vary, because as we know, the movie theater industry is comprised of entities from small independent theaters that operate in rural communities, all the way to huge wealthy corporate conglomerates and everything in between. So, as Congress intended, the undue burden defense is flexible enough to answer the question of how much an entity can do before it rises to an undue burden regardless of its size and therefore, no categorical exemptions are required.

Second, the 50 percent cap in the current proposal sets an arbitrary ceiling on full and equal enjoyment for people with sensory disabilities that is not directly tied to the financial resources of the theaters. By the very nature of services that a movie theater provides, a person can walk into a theater, choose any movie at any location, on any date and at any time the theater exhibits the movies.

Under the current proposal and five years from now, movie theaters would only be required to offer 50 percent of the choices to people with sensory disabilities, irrespective of their financial resources. That's like going into a restaurant and only being read half the menu items or only being read the menu items when it's not rush hour. The Second Circuit rejected that in a case, and we think the Department should also reject that kind of proposal.

Although in reality some movie theater owners and operators may not be financially able to equip all of its theater screens at this time, the largest, wealthiest movie theater operators who are already spending massive

budget amounts to upgrade to digital screens could provide access on a 100 percent of the screens for a de minimis additional cost to the upgrade.

Third, the five-year sliding compliance schedule in the current proposal conflicts with the existing statutory obligation to provide auxiliary aids and services. When the ADA was passed it required auxiliary aids and services. When the technology became available to do so, the movie theater industry had an obligation. They've had an obligation at least since 1997. And the current proposal will not adapt to change as would the undue burden. No matter how cheap it gets, it's still only 50 percent.

In changing directions, the Department should propose regulations and draft interpretation guidance that clarifies that captioning and video description in movie theaters are examples of auxiliary aids that all theaters, regardless of size, must do so, except to the extent of an undue burden. That it is not a fundamental alteration, and that it is a de minimis expense, not an undue burden, for movie theaters that undertake the significant expense or secure the significant funding to upgrade or to acquire screens with digital to add the equipment necessary to show the caption and descriptions in the digital file. Therefore, those theaters who can establish it as an undue burden to equip 100 percent, that they must take steps to maximize choice, and guidance on how to maximize choice. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony. We also appreciate your leadership on this issue in the past. Our next commenter is via videophone. And it's Tom Green from Para Quad. Mr. Green?

>> TOM GREEN: (through Interpreter) Hello, good afternoon. My name is Thomas Green, I'm deaf and hard-of-hearing systems change advocate at Paraquad, Inc. I'm from St. Louis, Missouri. My testimony today is about the ANPRM and its accessibility service information system for state and local government entities and public accommodation.

The Internet, a marvelous advance in technology, has brought forth many innovative innovations and designs for communicating information digitally to millions of people around the world. State and local government entities have seized the advancements of technology and Internet as a means of communicating with the constituents they serve and are representing.

Unfortunately, there are barriers that need to be removed for access to all individuals. On January 5, 2011, the Missouri General Assembly had opening ceremony that was live video streamed on their web page. Unfortunately, deaf individuals like me could not watch the video, because it was not captioned.

We are in the dark ages. We don't know what is going on in 2011 for the state legislative agenda. Removing those barriers will allow deaf individuals to be full participants of our governmental affairs and full-fledged citizens of this great country.

Next, ANPRM, NG 911, a new generation 911. When I drive on a busy freeway, I often see electronics signs that say, for emergency call star 55. And I wonder if I could send a text, since I don't use the phone.

Most citizens don't have to concern themselves about 911 or the star 55 choices. But as a deaf person, I am concerned. I pay for services for 911 that I cannot access directly. It is important that we have direct access any time there is an emergency. To have 100 percent communication access, I recommend SMS, and MMS, on a text pager be required. We should be able to access 911 any time, anywhere, with any concerns about how we might do that.

Also, it would be a wonderful breakthrough if deaf individuals could call 911 through their video phones and talk directly in their language of preference, American Sign Language, to get the services and rapid assistance that we need. Thank you.

>> JOHN WODATCH: Thank you very much, Mr. Green. We would also from the Department of Justice like to send our condolences to your organization for the loss of your leader, our colleague and friend, Max Starkloff. Next we are going to hear from Elizabeth Toumajian. I hope I didn't mess up your name.

>> ELIZABETH TOUMAJIAN: Close enough. Good morning. My name is Elizabeth Toumajian, and I'm the fitness director of the Goodwill Fitness Center located in Southern California and Santa Ana.

The Goodwill Fitness Center is a one of a kind facility that is specifically designed for people with disabilities, physical in particular, and chronic illness. We have been in operation for a little over two years, and we have currently over 300 members, all people with disabilities that utilize our facility.

The goal of the Goodwill Fitness Center is to promote fitness much like a mainstream gym. But in addition to promoting fitness, what we're really trying to promote is also independence and an increase in the quality of life. The members that I have the privilege of coming into contact with on a daily basis share numerous stories about changes that they have experienced as a result of fitness and exercise participation.

It goes much beyond fitting in a certain size dress or losing a certain amount of weight. The changes that my members are experiencing are real changes like reduction in pain, weight loss, which makes mobility easier, and changes in their independence, so that they can travel and go places and be with their grandchildren at the park and that sort of thing. These are very measurable goals and that they have managed to achieve.

The Goodwill Fitness Center features a complete line of Cybex equipment. They have a specific brand called Total Access, and the Total Access equipment has been tremendously helpful in working with many different types of disabilities, specifically for those people with spinal cord injuries, or people who are visually impaired or blind.

Accessible equipment is very important, as well as facilities that feature this equipment. But in addition to the equipment, I really feel strongly that there needs to be some sort of implements for mandating education and training.

Working with people with disabilities does require a specific knowledge base, not only about the disabilities themselves, but about disability etiquette, as well as appropriate terminology to use when working with people with disabilities

In addition to the education, there needs to be a component of sensitivity training, in that people with disabilities often feel as though they live their lives in a fishbowl, because in our society, they tend to get a lot of attention, mostly unwanted, and they are constantly being watched or stared at.

It is important that, to have a successful fitness center, you need to have an environment where people don't feel like they are living in a fishbowl. They need to feel comfortable coming in with their modality implements whether it be a walker, wheelchair, and exercising just like any of us would at a mainstream health club.

I thank you for your time and look forward to seeing some action in the near future. Thank you

>> JOHN WODATCH: Thank you very much. We appreciate your comments today. Next we will hear from Mr. Mike Garvey.

>> MIKE GARVEY: Thank you. My name is Michael Garvey, and I'm currently owner of the Dumbbell Man fitness equipment. (spells) I misspell it intentionally. I want to state for the record my parents are extremely proud of me.

Being involved in health and fitness industry for the last 30 years, I've been able to walk in and out of numerous environments, and was only recently as

the owner of a business that is in the supply of exercise equipment, facility design and equipment maintenance, that I came across the opportunity to provide inclusive fitness environments in a variety of locations.

I have in the past worked with Ms. Toumajian at the O.C. Goodwill Fitness Center. And, as of late, I've tried to become a proponent of inclusive fitness as I see as an opportunity as a private business owner, it's good for business. And it also, obviously, has a significant impact in creating inclusive fitness environments for those who don't have opportunities to exercise, mainstream individuals who really want to work out where everybody else works out.

So my testimony today is only to provide the DOJ with some examples of equipment as the aforementioned Cybex Total Access equipment. Manufactured in the United States, the Cybex brand has aesthetically pleasing club-looking equipment which a club owner or a nonprofit facility or taxpayer-based funded facility could purchase. And create environments within the main part of the exercise area within their facility, as opposed to sticking equipment in the corner or purchasing equipment that looks rehabilitative in nature.

The equipment today from brands like Cybex, New Step, the Cross Trainer, Cyfit, the Total Body Trainer, the Marpo Kinetics Rope Trainer, the Matrix Crank Cycle, all exist. And the unique thing about the types of equipment that exist from these brands is that they can be utilized by the disabled and most able-bodied individuals as well.

These manufacturers, I think, are ahead of the curve in terms of creating fitness equipment that will enable disabled individuals to not only utilize exercise equipment but also do it within a quote-unquote, "inclusive" fitness environment. And I think that is extremely important.

I think it's an opportunity not only again for nonprofits or tax-enhanced facilities that they can create these environments. But also for the private business owner to understand that there is a market out there that is probably underserved and an opportunity for them to create new marketing and new programs and new revenue streams that they may or may not know exist today.

I do have a submittal with examples of some of the exercise equipment. And I have outlined a sample of some pricing structures that, if upon your perusal, you will see that the costs of purchasing said equipment doesn't really differ that much from standard exercise equipment, if you will, and I'll present that today.

That's it. That is the Dumbbell Man, I think you for your time.

>> JOHN WODATCH: We appreciate your coming today and look forward to the information you are going to provide for us. Thank you. Next we are going to hear from Kristina Ripatti.

>> KRISTINA RIPATTI: Thank you. My name is Kristina Ripatti. I am a former police officer with LAPD. And I'm here to share my personal experiences on some of the issues that were just discussed regarding making fitness centers and gyms accessible.

I personally was paralyzed four years ago on the job. I was a police officer. I was shot. As a result, I am a T2 paraplegic, so I'm paralyzed from the chest down.

My lifestyle before I got hurt, working out and fitness was an extremely important and huge part of my life and not just for my job, but it was my hobby, my lifestyle. So, when I was shot and in the hospital, my life was completely up ended by this injury.

I didn't know exactly how I was going to deal with this. It affected every aspect of my life. But in the hospital, I was just like, let me get out of here and get back into the gym. Because I knew mentally and physically, that's what I was going to need to help get me through this. I knew I was going to need now my strength especially to move my body around with just my arms. And I knew how important the mental aspect of dealing with the injury was going to be, because it had been before I was injured.

I went back to my gym and, Gold's Gym, so it was a big national gym, with a lot of equipment. And of course, I had never realized before, but ADA accessible now meant a ramp going into the gym, and that's where it stopped. Except for maybe some bars in the bathroom.

And I was looking around at all the fitness, cardio vascular equipment, rows upon rows of treadmills, stationary bikes, elliptical machines, cardiovascular equipment that you had to use your legs for everything. There was not a single piece of equipment in there for your arms, whatsoever.

And then upon looking at all the weight training machines, most of them were not accessible for me as far as transferring onto the seats. The seats were small. Because I'm paralyzed from the chest down, I have no balance. I required a great deal of assistance in order to do a workout.

I'm fortunate, because of my insurance, I have worker's comp. And I realize that I get a lot more benefits than many of the people in my same situation. I do have a trainer now that helps me. And I haven't let these road blocks stop me from working out. I've been able to adjust my workouts and still

come up with a routine. However, these simple things are often enough of a roadblock to keep most people from going into the gym.

I think we all know now the importance of fitness. I don't really need to hit on that. But for people with disabilities, spinal cord injuries, especially, it is extremely important for warding off secondary issues related to the injury.

Most of the disabled population, as far as spinal cord injuries, are young people, and many of them are active. And they get disabled, get spinal cord injuries, as a result of an active lifestyle. And especially with war veterans coming over now, more and more it's going to be increasing more and more – amputees, spinal cord injuries.

I can't reiterate how important it is to return to your active lifestyle once you are injured with such a catastrophic injury. But like it was already said by the Dumbbell Man and Elizabeth, there is equipment that exists out there already.

Cybex does have inclusive line of fitness that will serve the able-bodied population and disabled body. New Step is a recumbent trainer that allows me to use my entire body, simply by adding a leg stabilizer. Crank Cycle allows people with disabilities to be in a group class environment. And just a side note, many of these fitness centers have pools, yet most of them don't even have a simple lift, which is a very easy remedy to fix.

You don't need to have a ton of specialized training. The Inclusive Fitness Coalition is working on certification programs, so trainers can have a simple certification program to assist people with disabilities.

I can't emphasize enough, inclusive and integration. Don't put the equipment into a corner. We want to feel like we are human still, and a part of the everyday population. And to be able to have that would be so huge. Thank you for considering this.

>> JOHN WODATCH: Thank you very much for your public service, first of all, and for coming forward and sharing your story with us. We appreciate it. Our next commenter is going to be on the telephone. And it's Marilyn Piepho.

>> MARILYN PIEPHO: Yes, this is Marilyn Piepho. I would like to speak to the issues of vision loss.

And the main thing, like the lady who was just speaking, is just to be part of the mainline, and not to be excluded from things that everybody else takes for granted.

I have just lost my vision in the last ten years. So, it's been quite a change. Going to the movies, I always thoroughly enjoyed. And I find audio description is being resisted so much in the movie theaters. There's very few houses that even have equipment so people with vision loss can enjoy movies also.

One comment I want to make. The ones who do, they tell me that they have to almost disassemble half of the projector to put the audio description disk in, which of course I can see why they are resistant to having it. The receivers they have often don't work, have dead batteries. When the movie starts, you find out it doesn't work. By the time you get out, get a new receiver, get new batteries, the movie is half an hour into it. A test pattern, before the movie actually starts, would be fantastic if that could be embedded in the film somehow, so you know whether your receiver works or not.

Going to forms, I have found several of the forms in the State of Ohio with my retirement plan; none of the forms are accessible to fill out on the computer. You have to print them out and fill them out in print. That would be really fantastic if forms were actually doable on the computer, so they could be filled out.

Some other issues I would like to speak to also is, I call it a disability penalty. Everybody else goes and buys the cell phone for maybe \$50. To get one that is accessible at least double that price. Maybe triple that price. I call that a disability penalty. So much equipment you have to pay double and triple what everybody else pays to get something usable. That would be really great, if accessibility was automatically built into electronic equipment like cell phones, like caller I.D., et cetera.

Those are just some things that I took for granted, before I lost my vision. And now I find it's either not available or so expensive to get it available.

TV menus. When they are selling things on TV, this is another electronic format. Most of the time, the numbers on the screen, they never verbalize it, or they say, call the number on your screen. So many things I would have liked to buy there is no access. This is just on simple TV.

Even the converter boxes that came out, all visual menus. DVD movies that have audio description, the menus to get to audio description are all visual. So, even though there is audio description, you cannot even get to it.

Most remotes do not have the SAP button, which would get you automatically to audio description. You again have to go through a visual menu. So that would be fantastic if even TV and DVD movies would be accessible.

Just some other things. The lady before me spoke of exercise. I have tried to go to our community center. They won't even unlock the door so my guide dog and I can come in safely. The door they have is automatic. I've already been hit in the face with it, I've been injured, my dog has been injured. The flanking doors which are regular doors they refuse to unlock, so you can walk in safely.

I've tried to join an exercise gym. Their initial response was you can't come unless you pay for someone to come with you to assist you. But I'm working with them, and I think they are coming around.

It is just a challenge to do the things I used to do without even thinking about it. It would be so fantastic if accessibility was just in the mainline, and accessible, the accessibility itself be accessible instead of starting with the need for vision.

I really appreciate you considering updating the ADA to the electronic age. Without electronics, I could not have even kept working. My speaking cell phone, my computer makes that possible. But I so much want to do all the things I did for so many years that now I am barred from. But I'm still trying!

Again, thank you so much for your interest. And that is it. If there are any questions, let me know.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony. I think one thing that it's clear to us that the ADA is about, is opening up every day American life for people with disabilities in this country. And I think you are giving us some ample food for thought.

>> JOHN WODATCH: Next we are going to hear from Jeff Hansen from the corporate counsel of Troon Golf.

>> JEFF HANSEN: Thank you for the opportunity to be here today. I'm here to talk about the equipment and furniture issue and, in particular, the issue of golf course accessibility to golfers with disabilities.

Troon Golf has been in the golf business for over 20 years and is the largest third-party management company in the world. Troon Golf manages over 150 golf course facilities, including public daily fee, resort and private club courses located in 24 countries and 31 states in the United States.

Troon has become a leader on this issue of providing accessibility of disabled golfers to courses. We provide instruction when necessary, tee times. We allow golfers with disability to use standardized carts by driving them on tees and greens when that assists. We provide a staff person to chauffeur golfers if that helps.

And we also provide single-rider carts at various facilities, either through ownership or pooling. Troon has attempted to make significant efforts on this issue by meeting with the manufacturers of single-rider carts and testing themselves ourselves, to determine what is the best fit. Troon has had numerous conversations with golfers with disabilities to see what we can do to assist, and we also have participated in conference calls conducted by the NGCOA with other owners and operators of golf courses.

We have recommended to all our facilities that the owners either purchase a single rider cart or make it available through pooling. Several owners have purchased the carts but the majority have not based on the economic conditions of the industry. It's just not feasible at this time. But we have kept statistics over the last year that I want to share with you.

In Arizona, we've had seven rounds of golf where a single rider cart has been used out of a total of 217,300. That's outside of Arizona. It hasn't been used very much. In Arizona, we have had six requests out of 411,900 rounds for a single-rider cart. An exception to that is we have two golfers with disabilities that have used the carts 35 times between the two of them. But outside those 35 uses, there's only been six other requests for usage.

We have never had a situation where a golfer with a disability has requested a single-rider cart and we have not been able to fulfill that request. Through pooling generally, we make sure that every region that we have a cart available. And if we get a call and somebody requests it, we make sure that the cart is there and available.

The position on the proposed ADA regulation requiring every owner to have a cart doesn't really fit with the historical statistics that I've just commented on. The cost to owners of these carts is anywhere between 8,000 and 20,000 dollars per cart. In this climate where very few courses are able to make a profit, the owners just simply can't justify the expenditure at this time.

The other issue is the safety concerns. There's been no ANSI safety test or certification on the single rider carts. And until that is done, we have a difficult time sending them out. Although we do, because if something happens, obviously there is going to be some issues that we will have to deal with.

So based on our historical statistics, what we are recommending, that we support the ADA's continued efforts to make golf available to everyone. That helps support our industry in the future. We obviously want everybody to play that can. Pooling does work, as I mentioned. Nobody has been unable to use a cart when they have wanted it. But we just don't think that the requirement of requiring every course to own one is practical at this time.

Until the safety standards are certified and met, we believe that the pooling issue will continue to serve the golfers with disabilities, and that is what we would encourage the panel to continue to promote.

>> JOHN WODATCH: Thank you very much, Mr. Hansen. We would hope if you provide written comments, you would give us some information on how pooling has worked in the past. Next commenter is Regina Dick-Endrizzi.

>> REGINA DICK-ENDRIZZI: Hello. Good morning. Regina Dick-Endrizzi. I'm the director of San Francisco's Office of Small Business and Small Business Commission. I'm here to speak to you primarily on the web access components that you are considering.

First, the Small Business Commission really supports that businesses make their businesses accessible, and that it's good for business. Recently, we have seen a high number of lawsuits for small businesses around accessibility. And what I've come to learn in listening to the businesses and these are your very small businesses who don't have access, they don't have lawyers and retainers. Many of them are business owners where English is not their first language. The laws around accessibility with the federal and state is very confusing and they don't understand it. There is a sense of frustration that there's not better communication around it.

What I am here to say is, in terms of the considerations for web accessibility, I'm not able to right now speak on the specific questions that you have. But a big broad perspective is that we look at the web community as part of a community that helps educate our small businesses on the accessibility.

So, that we have our Internet service providers, they sell business packages. That when they sell their business package, they are also providing information on the requirements that businesses may in the future may need to do to make their sites accessible. To engage technology sectors such as Google or YouTube. Many businesses use YouTube as part of providing video information on their websites, as well as Yelp and those types of Internet service providers that many businesses are using to market their business to help provide that education and information.

Also, the federal government funds our neighborhood, our business economic development organizations. And they receive the HUD dollars. And many, they are training and developing our entrepreneurs, and many of them are on marketing. So, I think it would be a great thing to make it a requirement of our economic business development organizations to also provide education and information, both on accessibility for the business organization and their physical structure, but then as we move forward into the technology structure as well.

So, I'm just here to say from hearing from the business community, I really think that we as government can really take a look at some of our other institutions that are intersecting with businesses to help educate them on what's good for accessibility so they don't find themselves in court and finding it very expensive to defend themselves, even with what is readily achievable.

>> JOHN WODATCH: Thank you very much. We appreciate your coming here today and sharing your information. Next we are going to hear from Fred Nisen.

>> FRED NISEN. (through Interpreter) Thank you, my name is Fred Nisen. I'm an attorney at Disability Rights California, a private nonprofit law firm designated as California's protection and advocacy system for people with disabilities.

All of the issues addressed in the Department of Justice 2010 Advance Notices of Proposed Rulemaking regarding Title III of the ADA are extremely important to people with disabilities, because regulations in these areas will help ensure that people with disabilities will have equal access to all aspects of community life, which is the premise on which the Americans with Disabilities Act was based. In particular, the accessibility of medical equipment is vitally important.

Regulations in these areas are desperately needed. Most medical examination and diagnostic tables tend to be too high. These tables need to be adjustable, to allow people with disabilities to transfer as independently as possible.

Since the average height of the seat of a wheelchair is 19 inches high, the minimum height should be between 17 inches and 19 inches high. Notwithstanding these standards, these regulations need to remind covered entities to provide other reasonable modifications to ensure access, including transfer assistance, to ensure that all people with disabilities have access to the services.

In addition to a standard height, there should also be standard table surface width, 28 inches and length 68 inches. Most tables are too narrow for people with movement disorders, such as cerebral palsy or people with obesity. Many tables are also too short, creating a problem for people with balance issues because their feet hang down. For example, my doctor has an accessible table for people with disabilities, because it's lower. But because of how narrow and short it is I cannot get onto it. Tables also should be required to have extensions to allow them to be made wider or longer if necessary, by persons with disability.

With regards to transfer assistance in medical facilities which utilize mechanical lifts, we feel the use of mechanical lifts should not be the only form of transfer assistance offered.

Generally, the person with the disability knows what type of assistance they need. Some people with disabilities cannot be transferred safely using a mechanical lift. The ANPRM regarding medical equipment and furniture inquiries as to whether the Department should require medical facilities to have lower hospital beds.

We think there should be a requirement that hospital beds be adjustable and that the lowest possible height should be no higher than 16 inches high. People who use mobility devices such as canes and walkers would have to leap or jump down to get in or out of bed. The same is true for people who use wheelchairs, who do a pivot transfer or use a sliding board. They are also adjustable. So, if a person is tall, the bed would be accessible to them as well.

Disability Rights California urges the Department to include a section in its new regulations requiring hotels and other entities providing sleeping rooms, ensure that they have beds that are accessible to people with disabilities. As mentioned in the ANPRM, there should be space to accommodate a mechanical lift.

There should be enough room under the bed for the base of a lift to fit under the bed. In addition, the pillow top mattresses are too high for a person with a mobility disability to transfer onto with or without assistance and hard to transfer out of because of how far the mattress indents.

We know of people with disabilities, including myself, who had harrowing experience with these beds. We recommend the new regulations require that at least half of the accessible rooms have a mattress other than a pillow top mattress.

Disability Rights California urges the Department to include a section in its new regulation explicitly requiring freestanding non-fixed furniture and equipment to be accessible to persons with disabilities. Using ATMs as an example, there is no difference to the public between a fixed ATM and a freestanding ATM. The public uses both types for its banking needs. Our clients have pointed out numerous examples of freestanding furniture items, including ATMs that are inaccessible. However, in order to ensure flexibility in innovations, we encourage the Department to opt for a general accessibility requirement for these items rather than specific details, technical standards.

As the Department notes, many EIT items such as ATM, points of sale devices and electronic kiosks contain touch screen interfaces that are inaccessible to persons with a visual impairment, as well as persons with disabilities that limit use of their hands. Many touch screen systems may be made accessible to large numbers of persons with disabilities, solely by including voice command systems and tactical key pads. Disability Rights California urges the Department to require that all EIT items be accessible to persons with disabilities with the caveat that programs' access and barrier removal be stressed as the operative requirements rather than specific technical standards in order to ensure flexibility as technology evolves. Thank you for allowing me to comment about these ANPRMs. We will be submitting detailed written comments within the next two weeks.

>> JOHN WODATCH: Thank you very much. We look forward to your written comments as well. Thank you for being here. Next we are going to have another telephone commenter, Jackie Hunt Christensen.

>> JACKIE HUNT CHRISTENSEN: Yes, good morning. Thank you for this opportunity to testify. I will be speaking to the issue of nondiscrimination on the basis of disability by state and local governments and places of public accommodation, and also furniture.

I'm a 46-year-old author and volunteer environmental health activist. At age 33, six months after the second of my two sons was born, I was diagnosed with Crohn's disease, and at age 34 with Parkinson's disease.

I'm the author of two books about Parkinson's disease, with a third on the way. And while I'm involved with several organizations, the views I present today are my own.

Parkinson's disease is a progressive neural degenerative disease second only to Alzheimer's in prevalence. Average age of onset is 55 but five to ten percent of patients are diagnosed before age 40. Major signs are tremors, slowness of movement, muscle rigidity and poor balance. But there can be cognitive impact such as memory and decision-making problems as well.

Stress makes these things worse. Dyskinesia, an uncontrollable writhing movement that is caused by medication used to treat Parkinson's, can induce a lot of sweating. For example, if I am at an ATM, I may not be able to choose quickly enough before the session times out. For me it is helpful to have buttons to push and a few seconds longer to make my choice. When I'm having trouble with dyskinesia my fingers are too sweaty and won't work on the touch screens.

By the way, this is a problem with many places. Information kiosks at museums and stores, on smart phones, music players and many other new

widgets that are becoming available every day. To cope with some of my motor symptoms, I underwent deep brain stimulation surgery, or DBS, in January of 2006. I have an electrical lead going into each side of my brain that is connected to a neural stimulator on each side of my chest.

DBS has greatly reduced my rigidity and dyskinesia, but I have a whole new set of issues to deal with. There are magnetic switches in the neural stimulators which can be shut off by large magnets, such as those in the doors of grocery store refrigerator and freezer sections.

And also stores are sources of electromagnetic interference such as health protection systems or surveillance systems. At Target or other stores I need to walk straight down the middle between security pylons or my system will be turned off. When I'm off, I stiffen up and my dyskinesia will return within about 15 minutes. For people with tremors, the effect is almost immediate, and there is a risk that Parkinson's symptoms will worsen temporarily after the device is turned back on.

Hilton hotels in particular seem to have hidden surveillance systems. I have been turned off in many places, including a local emergency room, or a nurse was reaching across my body to scan my wrist band. A scary, most expensive incident was when some unknown source of electromagnetic energy put one of the neural stimulators back to factory settings, which is zero. Checks of the system showed that it was on. It took a few months of doctor visits and finally a trip from Minneapolis back to Cleveland Clinic where I had my surgery, to find the problem. We never did identify the source of the electromagnetic interference.

None of these sources of large magnets or electromagnetic interference have any signage to warn to people with implanted medical devices, or those with sensitivity to electromagnetic radiation. I had my DBS done because I had begun to feel like a prisoner in my own home. Now I'm finding that possibly this treatment could return me to that prison. I think the ADA should address this.

In addition to public notification at each source, I would like the DOJ and other federal agencies to examine the growing body of evidence from Europe about hazards of EMR from cell phones, Wi-Fi, smart meters, et cetera.

Lastly, I have read the testimony from previous hearings. And as someone with Crohn's disease, I want to echo the ADA to formally adopt and implement the Restroom Access Act. I will be submitting materials, a section of my book *Life With a Battery-Operated Brain*, and with information from Dr. Gary Olhoeft about electromagnetic interference and implanted medical devices. Thank you for this opportunity to testify.

>> JOHN WODATCH: Thank you very much. We look forward to your written testimony. Next we will hear from Mr. Walter Park.

>> WALTER PARK: Thank you very much, ladies and gentlemen, for coming to hear us today in the provinces. We have a lot to say to you. And I can't speak in a place where we are doing the public's business today without mentioning the destructive violence that happened to all of us in the public and to the public's government in our House in Congress last week. Like all of us here, I feel just terrible about that, and I hope that we can move on in some positive kind of way.

I'd also like to say at this very hour, Governor Jerry Brown is about to announce a Draconian budget for the State of California, which is not allowed to go bankrupt. Unfortunately, which is just going to be extremely disruptive to people with disabilities, particularly those trying to live at home independently, without state services, which are going to disappear in the next fiscal year.

My name is Walter Park, I'm a resident of San Francisco. I'm a person with a disability, HIV AIDS. I've had it for 26 years. I'm one of those very strange people who didn't get sick, despite not taking any medications for 25 years. Although my friends did. The effects of that on me are, the salient conditions I have are low vision, pretty much vision in one eye. I now have learned to appreciate striped stairways in a way that was only academic ten years ago.

Of course we don't stripe them, or we do it very irregularly. Also, my disabilities include depression and probably a lack of stamina. I have a slide presentation here, if we can get to it. San Francisco has a lot of cutting edge experience with accessible technology.

Over ten years ago, we insisted that the JC deco street furniture, the automatic toilets be accessible and they are. We created the first accessible ATM in the country here in City Hall in San Francisco. We created the first talking ATM in San Francisco. We created the first talking door entry system with Viking Electronics which are now at every public housing project in San Francisco. And all of our public buildings where you use a push button door entry system. There are 280 talking signs in City Hall which have actually already become obsolete perhaps.

But we did everything we could to try to make those work for orientation of people who are blind or have low vision. The next Muni system we have here, which is the Muni Transit Alert System, provides talking signs in each of the transit shelters, so that not only can a person see the sign, but you can also hear the sign. And we now have hundreds of APSs, accessible pedestrian signals downtown in particular. They have lots of operational

problems, and if I had more than five minutes I'd love to talk to you about them more.

We now have, as a result of a lawsuit, we have visual paging as well as auditory paging at SFO, at the airport which you probably came in at. Before that, you had to pick up the white courtesy telephone to find out where the accessible information was, which didn't work of course if you did not hear.

And more recently, we have adopted accessibility standards for destination-based elevators. These are the new elevators that I have some photos, but maybe you won't see them right now. I will give you a copy of the PowerPoint presentation. In fact, I've already e-mailed it to your staff.

Instead of an up and down button, these elevators have a telephone style control pad, and you need to know where you are going. It will tell you which elevator to get into. The interaction is more complex than up and down. If you get on the wrong one you may have to come back to the lobby again and start all over. People with no disabilities have trouble using them at first. People with disabilities have quite a few problems using them.

We just spent two years going through a public hearing process to create about a ten-page document which we call Administrative Bulletin 090. We started by reading ANSI and ADAAG and found it was entirely lacking, did not provide accessibility either visually, tactilely, auditorily, voice, in any way that we cared about, even positioning of keys and so on. So, we basically invented our own standard. I'd like you to incorporate that into your work, of course.

We have a working model. It's already being used in buildings throughout San Francisco. So there is no technological impediment. There is no cost impediment. They are on the grounds. We would like you to incorporate them. I and others who worked on that in the last two years will give you all the details about that, not during these five minutes.

Touch screen building security is also extremely important. Linked to those elevators and increasingly to others are touch screen security systems in high-rise buildings. Twenty years ago I could walk into any high-rise building in San Francisco, simply go to the office I needed to go to and see the person I needed to. Now, I call in the day before, they can put my name into their computer through a normal web browser. When I get there, there is a kiosk, which uses a touch screen, which does not talk to me, which has no tactile feedback, which simply does not work for a disabled person. That's how I get into the building.

So, there is no root there. Those kiosks must be made accessible. There is a card reader there, which ought to have Braille on it and so on. The touch screen, of course, doesn't work. I could go through all of that. Ticket machines and so on, present the same kinds of problems, although we are doing well now on transit.

There are pervasive EITs for commercial transactions for transit, for security and various paths of travel which are both in the public area and in public accommodations. We now have ill-formed ideas on the smart city, which is going to require much more of this including use of our cell phones. I would like you to do four things, if I have another minute or two.

>> JOHN WODATCH: A minute, please.

>> WALTER PARK: First I'd like you to make your scope extremely broad. I think one reason why you initiated this ANRPM is to broaden your existing scope. Make it apply to portable EITs, like kiosks in malls. Make it apply to those that are fixed. ATMs it already does. Security kiosks I just mentioned we would like it, too. Make it apply to mobile EITs. My mobile EIT is right here in my hand. It is the best possible interface device I can have as a sighted or unsighted person with the devices around me because I have already personalized it entirely to myself. It has its own memory. It communicates with me and other devices through Blue Tooth. It has all the radios in it, it's got everything in it.

Make this work for everyone. This is a part of the system now. You must make these accessible for everyone. We did it with telephones by making them work for people with magnetic assistance. We need to do this now for people who need any kind of assistance. We can't do it with technologies here. It is cheap and in front of us, and everybody's got one.

I'd also like you to go further in depth in what you're doing today. As I said, the ANSI standards didn't help us with DBEs. It looked to me like they were written by industry with not a lot of other input. I'm sure that's not true. I know you had 150 meetings with 1,000 people inputting. You have to do better on this round. We did not like reinventing this here in San Francisco because we don't want 50 different jurisdictions reinventing this stuff. We'd like you to do it with our help.

And we'd like you to be quick. Two years is plenty of time to do this. If it takes you five years to do the next round, you can stop this morning because the technology will have moved on ten years in the next five years. You will still be regulating something that would have been nice in the 1990s. Please don't do that.

I'd like you to be ambitious. What we can do we must do. Particularly in the area of technology, we now can do all kinds of things we couldn't begin to do before because of cost, because of technical infeasibility and so on. I'd like to you do those things.

Looking at the cost curves, we have Moore's Law on our side. No matter what you propose right now, we will be told that it's too expensive, and that it can't be done. Well, we found with elevators, it not too expensive. It can be done. We did a couple of things. First of all, we said, well, if we don't want you to manufacture it for a year or two, could you do it then? And people said yes. They couldn't do it today. They couldn't do it in six months but they can do it in a year.

I would rather have stronger regulations that go in effect in a couple years than weaker regulation that would work today because we are already beyond today. Move hardware cost to software cost, move installation and maintenance cost to manufacturing. Because there's nobody to do the installations, nobody to do the maintenance. Those individual costs don't work. They get undone by people in buildings.

>> JOHN WODATCH: Mr. Park--

>> WALTER PARK: One more second. We had a destination-based n elevator in L.A. which did talk. It was one of the first gen of elevators. But the building management simply turned down the volume because people didn't like having the thing talk to them. You have to automate such things. You can do that. I have a few more things to say which I'll talk to you about later. Thank you very much.

>> JOHN WODATCH: Mr. Park, you obviously have a wealth of information that would be helpful to us. We hope that your written comments will provide some of that information for us. Thank you.

Next we are going to hear from Michael Fiorino.

>> MICHAEL FIORINO: Good day. My name is Michael Fiorino. And I am the co-chair of the captioned movies committee of the Connecticut Association of the Deaf.

We are an independent nonprofit organization that serves the needs of deaf and hard-of-hearing individuals in Connecticut through advocacy, education, and referral. Most of our members of the commission are deaf or hard-of-hearing. I'm here to speak on behalf of the deaf and hard-of-hearing community in Connecticut.

Movies are an integral part of the cultural landscape today in the United States of America.

Movie themes, movie stars, and movie characters permeate our national discourse and are part of our shared national experience. Therefore, the issue of providing captioning of movies in public theaters throughout the United States is of critical importance to the deaf and the hard-of-hearing community in Connecticut.

Just like everyone else, we want to see and enjoy the next blockbuster movie along with our families and our neighbors and more importantly, in our local movie theater.

To be able to do so requires equal access to any showing in any theater of the same movies available and offered to the general public. The Department of Justice in its proposed regulations is proposing that only 50 percent of movies or 50 percent of movie theater auditoriums be equipped to display captions in five years. This is unacceptable. This is not equal access under the law.

This proposal would actually permit, perpetuate and legalize the discrimination against people who are deaf or hard-of-hearing.

Movies can currently be accessed by available technology and the time is now. The members of the deaf and hard-of-hearing community in Connecticut are united in asserting the technologies and formats now exist to make the movie soundtrack accessible for all movies and in all movie theaters.

For example, on demand screen captions are now available to movie theaters through a system developed by digital theater systems and it's known as DTSCSS, or cinema subtitling system.

They only show on the movie screen when the movie projectionist activates the captions. The other showings of the movie are unaffected. Also, as movie theaters switch to digital cinema technology, they will be able to select and display the captions at no cost. Zero cost to movie theaters. Zero cost means undue, no undue burden.

Upon approval of the proposed regulations for captioning of movies in public theaters, the implementation should be effective within one year after adoption. I believe this is a reasonable time frame for implementation. Five years is simply too long, especially considering that since the advent of the talking pictures, we have been waiting to enjoy like everyone else any showing of a movie in any theater and at any time.

Thank you for your time, and again, I am Michael Fiorino.

>> JOHN WODATCH: Thank you very much Mr. Fiorino. Next we will hear from Bonnie Lewkowicz.

>> BONNIE LEWKOWICZ: Yes. Thank you.

>> JOHN WODATCH: Please proceed.

>> BONNIE LEWKOWICZ: First let me express my deepest gratitude to the Department of Justice for this opportunity and to apologize for reading my statement quickly. My name is Bonnie. I'd like to address the issue of bed heights in places of lodging. I'm here as a consumer as well as the director/founder of Access Northern California, a nonprofit accessible tourism organization. Let me start with a little history. I've worked in the travel industry for more than 25 years in various capacities from '92 to '98, I was a travel agent specializing in accessible travel. During that time, I never once heard a complaint from clients or my friends with disabilities that they couldn't get into their hotel bed. I also traveled extensively for work during that time period and looked and stayed at over 200 hotel rooms.

Because I could independently transfer into all of these beds, and 23 inches is my maximum transfer height, I'm going to give an educated assessment that the bed heights during this time period were between 20 and 23 inches.

Then in 1998, I founded Access Northern California. And, one aspects of my work is to survey hotels for accessibility, not in terms of compliance with access codes, rather to take an inventory of a hotel's access features, and present this information in an access guide or website. Bed heights was not one of the survey questions.

Around five years ago I noticed a curious trend. Hotel beds were growing in height and correspondingly myself and other people with disabilities were having difficulties accessing these taller beds so I started to include bed heights on my surveys. At first what seemed like a few isolated instances was quickly becoming pervasive across the spectrum of lodging categories, from high end to budget.

In 2007, we conducted a bed campaign. For this project, we sent an educational piece and letter explaining the bed height issue to more than 200 properties in San Francisco and said that we were to create a registry of hotels whose bed heights were less than 24. In this letter, I asked hotels to contact us with their bed heights. I got zero responses so we followed up with a phone call.

Not one property could tell us the height of their bed, so they said they would get back to us. We eventually got two responses both of which were greater than 24 inches. While the lack of responses doesn't necessarily indicate that all beds were higher than 24, it does imply that the issue wasn't taken seriously. I then learned that J.D. Powers had conducted a customer satisfaction survey for the lodging industry and one of the must-haves in a lodging experience was a comfortable bed. The lodging industry responded by installing new beds and in some cases worked with bed manufacturers to develop their own branded premium beds. These new beds range in height from 25 inches to 30 inches, and are notably higher than the beds previously found in hotels and in countless instances pose a significant barrier to people with mobility disabilities including people with paralysis, polio, CP, short stature and seniors.

It's important to note at this time that people travel for a variety of reasons, pleasure, work, medical appointments, family gatherings and it's not just a simple matter of finding a hotel that doesn't have a tall bed because in some instances the hotel is chosen for you.

An example of this would be if someone has a work conference to attend and all the conference hotels have tall beds. If the only alternate hotel they can find with a lower bed is miles away and there is no accessible transportation available, they probably have to forego the trip. In my own case, I planned a trip for Thanksgiving to my brother's in Chico, three hours north of here. When I contacted the same hotel I stayed at for the past 15 years, I learned that their new beds were 27 inches high. I proceeded to call five other hotels and not one had a bed that measured less than 24 inches.

There are no other cities nearby so this meant that me and my husband who also uses a wheelchair and needs a low bed could not visit our family. In fact, we haven't been able to travel for two years now because of this problem with high beds. And, I'm afraid if this issue doesn't get addressed, we won't be able to take another vacation. These high beds have also forced me to travel for work with a companion that can help me into bed should I need it. This has doubled my travel expenses and limited my ability to be spontaneous. Tall beds are no longer just a trend. They have become the standard. And what is most disturbing to me about this is that rooms that were once accessible have become inaccessible once again. It's a step backwards.

I'm confident that this practice is not an intentional act to keep people with disabilities from staying at hotels. Rather, it's a response to the perception and marketing strategy by the bed industry that bigger beds equates to greater comfort. But where is our comfort when we are being forced to sleep in our wheelchairs because we can't get in a bed or move around in it because we've sunk so far into the pillow-top. On the positive side, there is

an easy remedy and one that would not pose an undue burden on the lodging industry. Require places of lodging to have beds that measure 20 to 23 inches as they previously did from the floor to the top of the mattress in at least some of their accessible rooms. These beds already exist on the market. In fact, the micro hotel chain uses a lower bed in their accessible rooms that does not compromise comfort for access. And, I will submit my other specific recommendations because I've run out of time.

>> JOHN WODATCH: Thank you very much. We appreciate your comments. We are going to switch several of our panelists right now. Joining us on the panel are Bob Mather, who is an attorney in the Disability Rights Section and Christina Galindo-Walsh, another attorney in the Disability Rights Section in the Civil Rights Division at the Department of Justice.

Our next Commenter is going to be on the phone, and it's Luciana Profaca

>> LUCIANA PROFACA: Hello. Thank you. My name is Dr. Luciana Profaca. I am the Chief Deputy Director for the California Department of Rehabilitation. And, first I would like to applaud the efforts of the U.S. Department of Justice to update and strengthen the regulations implementing the act. This is a very important move and I'm extremely grateful.

In your request for input on web accessibility, you ask about which standards to apply. We encourage the Department of Justice to craft regulations which will support the work of the U.S. Access Board to harmonize the updated Section 508 requirements with web content accessibility guidelines 2.0.

It is our understanding that in partnership with the Department of Justice, and the U.S. Access Board, the accessibility committee of the chief information officer's council is developing best practices guidance and resources for the federal sector. We would encourage broadening this to include other governmental entities, higher education, and the private sector.

We strongly encourage the Department to develop a portal providing web accessibility resources.

It would be burdensome to require public agencies to retroactively make all documents on their websites accessible, especially the many millions of older paper documents which we have converted to scanned images.

Even some materials which were originally created in electronic form a few years ago do not meet current accessibility standards. The same general principles that govern physical access should apply. All new or substantially

modified websites and content must be fully accessible. But, even existing sites and content should be made accessible to the extent this is readily achievable.

New challenges emerging in terms of digital accessibility that should be specifically addressed include access to social media sites, mobile devices, mobile apps, and secure health information systems.

We also wish to comment on regulations related to equipment and furniture. Standards for equipment and furniture, especially in the medical setting, should be put in place as soon as possible. Features to be required for medical equipment and furniture should include at least the following. Greater height adjustability, for example, for wheelchair users, wider chairs with flip-up arm rests, gurneys with rails, and bed rails that allow flexibility and positioning and facilitate transfers.

Scales that can be used to weigh those who are in a wheelchair or in bed, the controls on patient's controlled equipment such as insulin pumps and thermometers and on furniture such as hospital beds need to be usable by individuals who are blind or visually impaired.

Transfer options should include independent transfers, use of a lift, and staff assisted transfers. Staff who train patients in the use of a lift or staff who perform transfers need to be trained appropriately.

Adjustable beds are not necessary in all accessible hotel rooms, but a substantial percentage of such rooms should provide them. There should be an acceptable height range for nonadjustable beds, similar to the height range for toilets.

The access features in a particular room should be clearly identified, and the reservation system must allow guests to select and reserve a room that meets their needs.

Devices employing electronic or information technology displays and controls including appliances, video and audio equipment, and thermostats should be usable by persons who are visually impaired.

Whenever one or more information kiosks are provided, at least one should be accessible. I thank you for your attention to these matters. We will provide more detailed input when we submit written comments. Thank you very much

>> JOHN WODATCH: Thank you very much, Doctor Profaca. We look forward to your written comments. Next, we will hear from Steven Mendelsohn. Mr. Mendelsohn, please proceed.

>> STEVEN MENDELSON: Good morning. And, thank you very much for the opportunity of speaking here today. I wish to commend the Department for this initiative. It's a compliment that on the procedure it has adopted for obtaining broad-based input from the public as to the important proposals now before us.

I think it's important to put the question in context of what it means to update the ADA Title II and Title III regulations to meet the exigencies of the 21st century. And, what's important to remember in that regard is that what it means is nothing less than the ability to participate in society in all aspects and contexts. For, consider that without accessibility to the Internet and to electronic communication resources, without accessibility to equipment and furniture, without accessibility to the emergency next generation communication services that are being evolved, the possibilities for full participation are limited, so that we have not merely an inaccessibility in itself but we have without these opportunities an essential meaninglessness to all the other civil rights and all the other programs that have been developed to try to bring about equality for people with disabilities in our society.

What for example is the value of the legal right to access to government information if that information is provided on inaccessible websites or through inaccessible kiosks? What is the value of the right to use a gymnasium if the equipment in that gymnasium is inaccessible? What is the value of equal access to medical treatment if many of the diagnostic instruments are inaccessible, if many of the treatment modalities are unavailable by reason of the fact that they are inaccessible to people with one or another disability?

What are the value of employment programs if the technology that people increasingly need to use to work are not accessible? And, what is the value of educational equality as a legal principle if the educational system more and more is mediated through technologies, which are not accessible?

So, when we speak of accessibility, we are not speaking of something isolated. We are not speaking of something which matters only in its own life. We are speaking of something which increasingly in the 21st century is a predicate to any kind of participation in society. If any of the efforts we make, any of the values we espouse, any of the expenditures we undertake on behalf of equality of people with disabilities, on behalf of the creation of equal or nearly equal playing fields for people with disabilities are to have any real meaning, that meaning will be mediated by the accessibility of the electronic communications media, by the equipment, by the furniture and by the communications modalities that are necessarily involved in their utilization.

Now, I want to explain or express a concern that I have in that regard. It seems to me the Department, while we understand and appreciate its concern with anticipating concerns that may arise on the part of covered entities, its concerns that may arise with the burdens undue or otherwise that these new regulations may entail, that the Department has to be very careful to avoid going too far and anticipating difficulties that may not exist, in preempting the genius of the ADA in one respect, which is the way in which the existence of undue burdens can be asserted and identified, and if necessary litigated but at least addressed on an individual case by case basis. And, I'm very concerned that some of the proposals here, some of the proposed rules by tending to anticipate distinctions or problems that may or may not exist, will in fact introduce complexity into the system and indeed opportunities for gaming the system which are neither necessary nor productive.

I have every confidence that entities which find themselves aggrieved or burdened by one or another of their regulations will have ample opportunity to express their concerns, and as such, some of the questions which for example ask about whether or not in a couple cases in the regulations, proposed regulations, whether small entity should be exempted or given special exemptions, provisions in the descriptive video and audio acceptability NPRM, which involve for example the question of giving a blanket five-year exemption for 50 percent of the screens involved, that these, in an effort, in a good faith effort to be sure to anticipate problems, preempt the normal application of law and create opportunities for gaming the system, which may not exist. And in fact, reflect a degree of timidity, which is not warranted by evidences that are available to us. And, which if warranted, we can pretty well guarantee that affected entities will present on an individualized case by case basis where appropriate. Thank you very much.

>> JOHN WODATCH: Thank you very much Mr. Mendelsohn. We appreciate your comments. Next we are going to hear via the phone from Michelle Miller

>> MICHELLE MILLER: Hi, I'm Michelle Miller with Safer Building. And, my company has conducted hundreds of unbiased tests on nontoxic building materials and methods. And, as such, we hear from people all over the country that are interested in healthy home and office environments. Many of whom want a healthy life and many of whom are also chemically sensitive.

And, there are simple changes that will make a huge, huge difference to many people. Chemical sensitivity for the most part is an invisible disability. And so, if it were appropriate, leaders of various organizations could put together brochures that could help, brochures, people could carry cards that

were signed by physicians so that if somebody were stopped by a police officer or ambulance or some other 911 responder, the person would immediately be able to identify that this is one such person with this disability via a card signed by a physician, and they would have brochures to indicate protocols that would be more helpful. For example, the exhaust from fumes of ambulance and police cars and tow trucks is an issue. People who have been injured by chemicals frequently will have a severe reaction to toxins at much lower levels, levels than most people. And so, even though those fumes are harmful to everybody if they're closed in a garage and harmful to everybody at the low level, the reaction at the low level is what the difference is.

And so, it's important for example for ambulances and police officers and tow trucks to turn their engines off, because the fumes are so harmful. And, if it's not appropriate and that maybe they need it for a generator or something like that, at least they should be aware that, be aware of the wind direction and put the person in the car such that the person is not downwind of the fumes.

Another situation that comes up is fragrance-free personnel. And I've heard many, many times from people in the service industry. They feel fragrance is a personal choice. And, it would be if it only affected them, much like cigarette smoke. If cigarette smoke only affected the person doing the smoking it would be a personal choice. However, when people wear perfume, body wash, cologne, heavily scented deodorants, scented oils, hair gel, or if they wash their clothes in fabric softener, it has harmful effects upon other people.

At a minimum, since some people will likely refuse to be fragrance-free, there should always be somebody designated on staff that is fragrance free, an ambulance driver or police officer, so that if the issue comes up and the chemically sensitive person needs assistance, that designated fragrance-free person can come and assist and write the ticket or handle the person in the ambulance or do whatever is required.

The next thing that comes up is when we are stopped by police officers, the typical thing is people are asked to open their windows. However, it's frequently not safe for a chemically sensitive person and not only not safe, it could be very dangerous. For example, if there is a pesticide application that is nearby, if we are near a factory with fumes or a gas station and somebody opens the window, it could, the toxins would likely come in. It could cause a severe reaction.

Of course, the police officer needs to do his or her job, and so perhaps a solution, there is a lot of solutions but one solution would be once again, if a chemically sensitive person carried a card to show the officer and the

emergency responder had a brochure, they could designate, for example, a safer area with fresh air, and have the designated fragrance-free person meet there so they could do their business in an area that doesn't put the chemically sensitive person at risk.

And, the most difficult part of overcoming all these obstacles is with people that don't discover the affliction; it is extremely difficult to understand how dangerous it might be. For example, fumes bother everybody and they just think well just ignore it, it's not that much because they don't understand, and it's difficult for someone to put themselves in someone else's shoes, how severe the reaction is. And, sadly because of that, a lot of people will take it upon themselves to do a test. So again, long-term having training, long term training would be great. Short term, brochures with an outlined procedure would be effective.

Fragrance-free hospital staff, the same applies as what I said earlier. And, lastly, a lot of hospital rooms and nursing home rooms are not maintained in a toxic-free way. And, I'm not trying to plug my own company because that happens to be our area of expertise, not hospital rooms per se but nontoxic maintenance. But, aside from my organization, there is a lot of organizations that have protocols and procedures. And of course not every hospital room needs to be like that. But, at least if there were some in every hospital, or every nursing home, one or two rooms that were designated as safe, that would go a long way toward making it so chemically sensitive people could receive the services that they need. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your comments today. Next we are going to hear from an old friend of the Department, Richard Skaff

>> RICHARD SKAFF: Good morning John and members of the panel. Am I on? I'm on. First I'd like to thank and I understand it's called the Department, so thank you for the hearing today. I guess my only request would be, well I have other requests, but my first request would be that we have more of this type of hearing out on the left coast. We have a very large population, an active population of people with disabilities and seniors who are not only intellectually stimulating, but knowledgeable in issues related to their function in the built environment, whether it's physical things or programmatic issues, or whatever.

So, I would hope that we could have you back soon. But again, thank you all for being here and taking the day to have this hearing. I hope you are enjoying your stay at the most accessible city in the country, San Francisco. I should first say that I, for those of you that don't know me, I started in this business, I guess you could say, over 30 years ago when I was trimming a tree at home and fell and became a paraplegic. I opened an independent

living center after leaving my vocation and avocation, the restaurant business, because I was told I wouldn't be able to come back as the manager and be in the dining room or the bar when the public was there, because in 1978, people didn't feel comfortable seeing people like me in restaurants.

In any case, moving along, I would like to read the slides and describe the visual portions of the slides. I felt it was necessary to do a power point, a visual power point. I apologize for those of you that can't see it. I'll try to do a good description of it but I felt it was necessary to be able to understand visually what I'm talking about.

Very quickly, the first slide talks about issues related to accessibility and equipment and furniture and whether they meet the needs of people with disabilities. Can individuals using large electric wheelchairs access non-fixed tables in restaurants, libraries, or other public buildings and accommodations with knee clearance of 27 inches? What about the accessible bar sections in restaurants and sinks in public bathrooms that are required to have knee clearances of 27 inches from the finished floor to the underside of the sink? Are those accessible bars and sinks and tables really accessible to people with disabilities?

And, I'll get to the table portion of this in a moment based on what ADAAG has said for years. Can persons who are blind or have limited vision operate mechanisms like telephone entry systems and kiosks and do we have any way of assuring that they will be able to? Can persons who have a disability that precludes them from grasping, twisting or pinching manipulate operating systems like fire alarm pull stations and some door locks or dispensing systems like women's sanitary napkin dispensers? Can everyone with a disability function in the newly created elevator system called Destination Elevators, which are a computer operated system that Walter Park spoke to and not only eloquently but with 2-1/2 years of experience in developing those guidelines, and I hope the Department of Justice will see what can be done to create those same guidelines on a national level.

Although we love it being the most accessible city in the country, we would like to bring along other cities and states throughout the country to do similar kinds of good work.

Can everyone including those in our aging population operate all doors in an accessible route including exterior doors? Presently, ADAAG requires interior doors to have a maximum force to operate of five pounds, which is considered accessible. Should exterior doors that can't meet the five pounds force requirement be required to use power operators to make them accessible? I was part of a very small group of people, three people that created new code a number of years ago, requiring exterior doors to be

accessible at five pounds, if they weren't able to, for various reasons, they are required to put in a power operator. Are there other systems that should be required that would be, that would make the built environment more accessible to seniors and people with disabilities? That is what I'm going to talk about now.

If tables, presently if tables are attached to the wall or affixed, then 5 percent of the tables or at least one if fewer than 20 are provided must be wheelchair accessible. This, as I said earlier, and all other shelf like systems including tables, dining and other in libraries, or systems like sinks, now require the 27 inches. In California, we have a requirement that the front lip underneath should be 29, going back eight inches to 27 inches.

Although I don't understand that, because I haven't seen anyone, oh, my goodness, I'm all through. I have a number of visuals. Can I take a moment or two to go through them?

>> JOHN WODATCH: Can you take, just sort of summarize them in a minute and then would you submit those to the record so we can include them in the record?

>> RICHARD SKAFF: I will. Thank you very much. The first one is the picture that is used and clearly defines what a fixed table is, in whatever occupancy.

There is a massive failure here, because we have restaurants throughout the country that have non-fixed tables, which aren't accessible because of the table bases.

Some examples of tables with accessible bases, and here's another accessible base, a flat foot, and tables that are not accessible because of the type of support system they use.

The next slide shows bathroom fixtures and the requirement, I'm sorry, for the lack of clarity on this but this is taken from California building code, which is the same as an ADAAG, the requirement for 27 inches clear underneath. Based on the type of equipment people with disabilities are using now, the historical 27 inches just does not make it so we have people sitting sideways. Same thing with drinking fountains. And then, if we can go to the next slide, something clearly needs to be done because the two on the right photographs show two different restaurants, one in Marin county, one in San Francisco, and two restaurants again, one in San Francisco, and one in Marin county with two different types of accessible bars and I say that tongue in cheek. The two pictures on the right show a lowered section of the bar that goes completely from the customer side to the employee side at 34 inches.

The two on the left have either attached shelf or no accessible section. This needs to be clarified. We also again have the five-pound door pressure need for exterior doors, which this next slide shows. We are also having the problem of older styles of hardware still being installed throughout the country that are not accessible like pinched locking systems.

Just recently, we had the state fire marshal decertify most of the fire alarms that they had approved to this point. This has happened within the last month. This picture shows what has been allowed that is now not going to be allowed. But I've got to say, one company has come forward, Simplex, they have now taken out this little pull lever and they have actually designed a lever to replace it at less than 50 cents a piece. They are going to go back and replace once they are feeling that it is truly accessible. They will replace all the existing.

I'll say the last slide shows multiple systems that are available and are accessible that aren't being used. We have a garbage chute which is powered by air, an air compressor in multi story buildings. We have kiosks that sell product that use a touch screen, not accessible. This is the picture that Walter Park talked about, the accessible telephone entry system. We have a brand-new, a month or two old female sanitary napkin dispensers that doesn't require grasping, twisting and pinching. The industries that deal with operating mechanisms have been trying to find a definition so they would not have to remake their systems. So they have tried to redefine what tight grasping, twisting, and pinching means in order to find a way to not have to rebuild their systems. The problem is we have people that will never be able to operate those systems. Here are some that are the problem.

We have throughout the country, one back; we have portable equipment like the toilet I'm showing on the slide, the portable toilet that outside of California is not used. Lastly, I would suggest that the Department of Justice in some way has to find a way to do additional research.

We need to look at the built environment and actually do some research in a greater and more extensive way to assure that the products we are getting today don't just have the ISA on their marketing product but are truly accessible.

The other thing I would like to ask from the Department of Justice is more help with enforcement. We have a huge failure by the licensed folks, the architects and contractors. We have a huge failure by building departments throughout the country, not just in California. I'm fighting, finding what is called a pattern and practice in non-complying enforcement from building departments across the state. And, I would ask the DOJ start looking into that. Thank you for allowing me to speak.

>> JOHN WODATCH: Thank you very much. Next we are going to hear from a long time associate of the Department as well, Lainey Feingold. We're honored to have you here.

>> LAINEY FEINGOLD: I'm honored to be here. Thank you. My name is Lainey Feingold. And, I've worked on issues of web access with the blind community since the 1990s. Along with co-counsel, Linda Dardarian, who will be testifying next and blind organizations and individuals including the ACB and AFB, I've negotiated web accessibility agreements with some of the largest ADA covered entities in the United States. I also maintain a website for my own small law firm with the URL, LFlegal.com. I'm here today to talk fast and comment on the ANPRM, as fast as I can, talk, comment on ANPRM regarding web access. And, I thank the Department for providing me this opportunity. I'd like to speak about two principles that I hope will guide the Department as it drafts regulations on this critical issue. The first principle is, please do not, and you don't need to, reinvent the wheel as you are drafting these regulations. And, the second principle is, please remember that every limitation, every month of delay, every exception that you build into these regulations can serve as a do not enter sign on the side of the information highway.

What do I mean when I say please don't reinvent the wheel? First, robust internationally recognized technical standards already exist to ensure that websites work for people with disabilities. I urge the Department to adopt those standards, the web content accessibility guidelines 2.0 level double A as a technical standards for Title II and III web access. Second, the Department already has shown that performance and technical standards can work together. I urge the Department to adopt a generalized performance standard in addition to, not instead of, in addition to the technical standards of WCAG 2.0 AA. This two pronged approach has a proven track record in the built environment and it is going to work in the virtual environment as well.

Another recreate the wheel issue, WCAG is already being used by covered entities and has been so for many years. Examples from my own work and that of my co-counsel, Linda Dardarian include the following. In 2000, Bank of America with the California counsel of the blind signed the first agreement in the country referencing WCAG. That's 2000, over 10 years ago. Many other banks followed suit. In 2008, the three United States credit reporting agencies began using WCAG to guarantee accessibility of free online credit reports. Online financial information involves heightened security and privacy, including captchas. WCAG has worked well as a technical standard in these environments. In 2009, we worked with CVS and Rite Aid and got signed agreements to use WCAG on those complex retail sites. And, in 2010, Major League Baseball began using WCAG 2.0 level AA for both MLB.com and the websites of all 30 major league baseball teams. WCAG is

already rooted in the public and private sector in the United States and abroad. And, the Department should not recreate the wheel and develop a new or use a different technical standard.

Another recreate the wheel issue, the Department already has detailed undue burden regulations that take into account an entity's size, financial resources, number of employees and other factors. The Department should not develop new defenses or carve out exceptions based on website or entity size or type. And, that brings me to the second principle, which is as you're drafting these regulations, please remember that any exception to full accessibility of all content on the Internet is a do not enter sign for people with disabilities.

Do not exempt small businesses. I can tell you from personal experience, a business size is not a predictor of the ability to build an accessible website or maintain it as accessible. I encourage you to visit my site at LFlegal.com, which is a WCAG AAA site that was included in the 2.0 implementation report. Do not have blanket exemptions for social networking sites, on-line marketplaces, or any other category of website. Remember, Uncle Joe may want to sell his old fishing rod on e-bay, but Title III entities also use a site to conduct businesses.

Aunt Ann may use Facebook to share recipes but universities and colleges that are already covered entities are using Facebook to conduct classes. Just yesterday, the New York Times had a story that classes use twitter and improve the GPA of students sanctioned tweeting during classes. 19 million people are friends with Starbucks, a covered entity on Facebook. Please remember that people with disabilities might well be the occasional seller or private individual who wants to share photos that you talk about in the ANPRM. Aunt Ann may be blind and Uncle Joe may have a different disability. You are writing these regulations in part for them. One of the biggest do not enter signs potential is delay in implementing these regulations. Your two year proposal in the ANPRM is just too long. Implementation should be swift and immediate.

In 1997, Tim Burners Lee, widely considered the inventor of the Internet announced a launch of the web accessibility initiative with these words. "The power of the web is in its universality, access by everyone regardless of disability is an essential aspect." Every single day since this iconic statement was made, Title II and III entities have provided increasing amounts of service program and information online in every context imaginable.

1997 was 14 years ago. In many ways, the Department is playing catch up with these regulations. Today in 2011, the Department has a historic

opportunity to make the promise of the Internet a living, breathing reality. I urge you not to let the opportunity pass. Thank you very much

>> JOHN WODATCH: Thank you, Lainey. Next we will hear from Linda Dardarian.

>> LINDA DARDARIAN: Good morning. My name is Linda Dardarian. I'm a partner at Goldstein, Demchak, Baller, Borgen, and Dardarian, one of the oldest private civil rights law firms in the country. And, I'm the other half of the Feingold-Dardarian team. For the past 15 years, Lainey and I have been representing the blind community in negotiations with the largest financial institutions in the country to create and implement talking ATMs and have worked on making other flat screen kiosks and information technology accessible to people with visual impairments.

I thank you for the opportunity to address you today on the equipment ANPRM and I ask you to not delay in requiring that all electronic and information technology be accessible to people with disabilities now.

Two decades ago when enacting the ADA, Congress expressed its intent that the accommodations and services provided to individuals with disabilities would, "keep pace with the rapidly changing technology of the times."

We are here today because that has not happened. What has happened in the past two decades is that businesses and institutions have moved away from having live personnel provide services to customers, patients, students and others, and switched instead to touch screen self-service kiosks and ATMs which have allowed businesses and institutions to cut back on staff, and save significant personnel costs and increase operational efficiencies.

These machines are commonly used for everything from banking transactions, ticketing, bill-paying, grocery purchases, and appointment registration as well as hotel check-in, class registration, medication dispensing and other every day services.

But touch screen machines are inaccessible to people with visual impairments and others who cannot read the information and instructions that are on the touch screen, or cannot locate and touch the place on the screen to input information or select options.

People with disabilities are therefore either shut out of these services, or they are required to become dependent upon other people to input their private and confidential personal identification numbers, and other sensitive financial, health or personal information at the risk of their safety and their dignity.

This should not be the case 20 years after the ADA. This should not be the case because as the Department recognizes, the law already requires the provision of accessible equipment. This also should not be the case because accessible equipment already exists on the market.

For more than ten years, major ATM manufacturers have been making talking ATMs that deliver all instructions and information for use privately through an earphone jack and have tactile controls for all inputs.

These talking capabilities are part of the standard ATM package these days, and there are more than 100,000 talking ATMs in place throughout the country.

Major equipment manufacturers like IBM also make self-service kiosks that are similarly accessible to people with visual impairments, as evidenced by the easy access self-service kiosks that are in place in post offices throughout the country.

The same hardware and software that make these kiosks accessible to people with visual impairments can be applied to other electronic information technology at minimal to no extra cost.

Accordingly, we urge the Department to issue regulations that clearly stress the urgency of installing accessible self-service kiosks, ATMs and similar equipment. As detailed further in the written comments that we will be submitting, we ask the Department to adopt technical and performance standards for these types of equipment that are similar to those in section 707 of the 2010 standards for accessible design, as well as the technical standards in Section 508 of the Rehabilitation Act.

And, we ask that these standards be made effective without delay. Moreover, accessible EITs should be required everywhere. Every machine should be accessible. That should be the norm. That should be the standard. If meeting this 100 percent requirement would be an undue burden for any individual entity, the entity can demonstrate undue burden on a case by case basis.

But the expectation 20 years after the ADA should be access now, access everywhere. This will ensure that people with disabilities keep pace with emerging technology, as Congress intended. Thank you

>> JOHN WODATCH: Thank you very much. That was exactly five minutes. (Chuckles). Our next commenter is going to be on the phone, and it's Dr. Sean McCloy.

>> SEAN McCLOY: Hi, this is Dr. McCloy. I'm a family physician in Portland, Maine. I see a number of different varieties of medical conditions, one of which is electromagnetic sensitivity. And, I just wanted to speak a few minutes on that, and this relationship to smart meters.

I was fairly skeptical of the existence of electromagnetic sensitivity when I first heard about it and when I got my first few patients coming to my practice. But, I did a little reading and a little research and it seemed there was some biological plausibility in the data out there and it just hasn't really been well studied. So, I kind of took the problems with the grain of salt and treated my patients with the best compassion I could.

But as I started to see these patients, and read more and more, I think there is some emerging evidence that demonstrates that this is a real phenomenon, and is still poorly understood. The way I kind of explain it in my own brain is that there is a wide spectrum of susceptibility to the environment, different environmental factors. Some of us on one end of the spectrum are ironclad and bulletproof and we can take in any toxin and have any exposure and not really feel the health effects. At the other end of the spectrum are very sensitive individuals who are vastly affected by small doses of a prescription medication, for instance, or who just are very sensitive to their environment.

And, I think that electromagnetic sensitivity probably falls into this range of the spectrum. Now we're understanding the genetics and biology behind this a little better. I recently spoke before a public hearing on smart meter installation in Maine. There's a large initiative to replace the regular meters, the analog meters with the smart meters. And, we are seeing the emergence of some people who are having health problems as a consequence of the smart meters. And this is in lieu of other medical conditions that have been ruled out, including psychological ones.

So, my overall point is to approach this new technology using the precautionary principle in that any new technology which is going to be rolled out I think should be proven to be safe before it is initiated. Whereas currently, we seem to have a general standard of bring the new technology forward, and then wait for harm to happen, and try to accrue enough information about harm to take that technology off of the market.

A good example is prescription medications where you have to have a new drug come out and hit the general population before rare side effects show up to the point where that drug is taken off the market. I think it would be better for the public health to prove safety absolutely first, before the new technology is put in place. Many countries around the world are beginning to take this precautionary principle to heart when approving new technologies. I think the same should apply to smart meters.

There is a growing body of evidence of potential harm of smart meters. Nothing has really been proven to be safe or proven to be harmful. But applying the precautionary principle to this, I think the smart meters need more research before they are broadened to general use and expose the public to them.

That's it. Less than five minutes. How's that? Not bad. Thanks very much.

>> JOHN WODATCH: Thank you, Doctor McCloy. We appreciate your testimony and its brevity as well. Next we will hear from Sheri Farinha from the NorCal Services for the Deaf and Hard of Hearing. Welcome.

>> SHERI FARINHA: Hello, it's good to see you all again today.

My name is Sheri Farinha. I'm CEO of NorCal Services for the Deaf and Hard of Hearing. We are a nonprofit community-based organization serving deaf and hard-of-hearing people in 24 northeastern counties in the state of California.

I'm also Chair of the EF 911 stakeholder's council, under TDI, Telecommunications for the Deaf, Inc., and also the secretary for the National Association of the Deaf. Thank you.

I'm pleased to have the opportunity to come and provide feedback to the ANPRM. Thanks so much for doing that, by the way. Specifically, I'd like to address direct communication access to 911 via Internet-based telecommunications.

You've already mentioned in your ANPRM that we have access via TTY or text, captioned telephone, but TTYs are being so much more less used today, and more people are using Internet-based telecommunications.

So, we are asking that, let's pave a road for the next generation 911 no matter what kind of device, that any individual who is deaf or hard-of-hearing uses, that that access has to happen. To pick which device is better over another doesn't seem to make sense at this time. It needs to have access to all devices. That is what is important to us. We are advocating for indirect versus direct communication. Indirect means video relay services, or IP relay, or captioned phone calls via Internet.

It's a type of Internet call that does take place. What we have right now is not an ideal situation. We would ideally advocate for direct services. Now video phones would be able to be supportive in doing direct services with having a split screen with a certified, qualified interpreter at the same time showing the PSAP call taker. So, they could access the emergency services.

Also, we are in support of the need for an interim service to be in place while working towards the next generation 911. Right now, in Sacramento County, we have the SAC PD offers 911 pager services for deaf constituents in the county.

It's critical and it has served as a lifesaver on many occasions. We were able to e-mail directly to 911 services to get assistance when needed. Oftentimes, deaf people find themselves in a threatening situation and have no access while on the road.

So, what we, any mobile device is able to access that 911. So I understand SAC PD is going to be coming here today and that pager service can be used as a model for an interim purpose. Ideally, it would be real-time text with the next generation 911, because that would allow for interactive, instantaneous interactive mobile devices to 911, as well as video. More and more mobile devices are including video devices at this time.

So, I understand that we do have access to use that service. I want to also mention that the reverse is true. If the 911 pager is set up, it's cost efficient, and we suggest that you use that, as an approach. The reverse is also true. 911 can reach the deaf community for emergency notifications in a given area. That would be something else to consider.

Now, for video interpreters, it's important that you receive your certified qualified interpreters that are to be used, not only the existing systems that are in place with video relay services. You might consider hiring deaf people to be call takers at the 911 center as an option.

There is a lot more that I want to say. But I understand time is short. And, I just wanted to hit on some basic points that are important to the deaf and hard-of-hearing individuals and make access happen, and do not let history repeat itself and leave us behind. Thank you so much.

>> JOHN WODATCH: Thank you very much. We appreciate you coming today and sharing your testimony with us.

Next we will hear from Silva Yee from the Disability Rights Education and Defense Fund. Welcome.

>> SILVA YEE: Yes. Thank you, I'm happy to be here. John, I would like to thank the Department for the issuance of the ANPRMs and for the opportunity to speak. While I will be specifically addressing the medical equipment and furniture ANPRMs, later in the month we will be submitting comments to the Department for the entire ANPRM on equipment and furniture.

DREDF does strongly support the Department's issuance of detailed technical accessibility requirements for medical equipment and furniture in all medical facilities. Today I would like to provide just a couple of reasons for why such regulation, including scoping requirements, is necessary and three overarching recommendations for the content of that regulation.

First, outpatient healthcare services in non-hospital settings are extremely significant for people with and without disabilities. The national ambulatory medical care survey found that ambulatory medical care in physician offices is the largest and most widely used segment of the American healthcare system. In 2006, over 900 million visits to office based physicians took place. And, over 50 percent of these were made by patients who had one or more chronic conditions such as hypertension, arthritis or depression.

Outpatient physician services ranged from primary care to highly specialized surgical and medical consultations and care. And approximately four-fifths of these services took place in a range of physician offices such as private practices, urgent care centers, public health centers, family clinics, mental health centers, community health centers and family practice plans.

In addition, 83.4 percent of the visits surveyed were to practices either owned by a physician or a group of physicians. While inpatient medical facilities are explicitly addressed in Title II and Title III regulations, outpatient facilities are not addressed in so far as architectural equipment or policy elements.

As the National Council on Disability has noted, it is critical that offices involved in delivering ambulatory care for physically and programmatic, be physically and programmatically accessible given the wide ranging types and amounts of service delivered in these offices and clinics.

The second reason is that accessible medical equipment is profoundly absent from outpatient offices and clinics. There is in fact very little hard data to support this, because not much is known about what is actually in those private physician's, doctor's offices, the policies that are going on or the fact that there may be no policies.

However, disability advocates in California have worked with a few health plans in California to administer a 55 item questionnaire designed to assess disability access. The questionnaire was administered to their primary care provider networks and was administered between 2006 and 2010.

This recent study used, and I will be handing you a power point later on that details more of what is in the study. The study used 2,389 reviews of primarily urban sites, primary care providers. The primary care providers surveyed had specialties in general medicine, internal medicine, family

practice, pediatrics or obstetrics and gynecology. The questions addressed a variety of elements, including architectural ones but I'm going to be focusing on the questions relating to exam tables and weight scales and examination rooms space. The findings on the availability of accessible equipment are stark. Across all primary care specialties and locations surveyed, 8.4 percent have an accessible exam table and 3.6 percent have an accessible weight scale.

The percentage of practices that have an examination room with sufficient clear floor space for a person using a wheelchair and with no door that swings into the space is a little more encouraging. 89.6 percent in urban offices and 97.6 percent in rural offices.

General medicine practitioners consistently had the lowest, the smallest percentage of accessible tables – 8.4 percent. And accessible scales – 2.2 percent. OBGYN was a little better, 18.4 percent accessible tables and 10.3 percent accessible scales. These findings were made 16 to 20 years after the passage of the ADA. The surveys were administered in California, arguably a state that has a higher degree of architectural accessibility, greater awareness of accessibility needs and a lengthier history of accessibility legislation than many other states. It would be very surprising if the numbers on accessible equipment are any better in any other state.

Also keep in mind that the accessible equipment being surveyed consisted only of exam tables and exam and weight scales. Two of the most basic tools used in medical care, and both of which existed in readily available accessible versions of the time. I'll finish my paragraph if I could.

The logical conclusion is that providers, even those who may be well-intentioned about providing accessibility are disinclined to take concrete steps to provide access unless the required actions are clearly defined, explicitly regulated, and incentivized either through the stick of enforcement and/or the carrot of tax breaks or deductions. I see I have not gotten to my three recommendations. However, they will definitely get to you. I will hand the slides to –

>> JOHN WODATCH: We look forward to looking at the information you are providing us today and the comments that you will be providing us. We will take special care to look at your recommendations.

>> SILVA YEE: Yes. They are very detailed. Thank you.

>> JOHN WODATCH: Thank you very much. I believe our next commenter will be via the telephone. This is going to be Alexis Kashar.

>> ALEXIS KASHAR: Hello. Good afternoon, everyone. My name is Alexis Ander Kashar. I've been a civil rights attorney for over 17 years. Thank you for this opportunity to provide comments today.

I'm testifying today on behalf of the National Association of the Deaf, the NAD, as chair of its civil rights committee. And, I will provide comments with respect to the NAD's position on movie theater captioning.

The NAD really appreciates the Department of Justice's efforts to bring the law up to date. Movie attendance has become a big part of American culture.

Just like everyone else, we want to attend any movie, in any theater, at any time. Of course, this means equal access through high quality and reliable captioning.

The NAD on behalf of the deaf and hard-of-hearing communities respectfully request that the Department require movie theaters to provide captioning for 100 percent of the movies shown in 100 percent of audience-driven theaters of the auditory experience in their facilities. The Department's proposal to require only 50 percent of movies or 50 percent of movie theater's auditoriums to be equipped with display captioned in five years is unacceptable.

Even with today's technology, available, has been available for a long time, many large theater facilities do not have a single theater with captions. A famous American actress, the youngest Oscar winner to win for the best actress, and one of only four women to win the Oscar for their first time on film, Marlee Matlin, completely agrees with this position.

Can you imagine even she herself does not have full access to the movies? Her own profession. I want to share some personal experiences of mine.

During a recent trip to Orlando, Florida, I went to two major movie theater complexes, the AMC at Downtown Disney, and the AMC at City Walk.

Both complexes had over 20-plus theaters, and neither had any captioning equipment available at all. The technology exists. So, the day has come for movies to become accessible to all. Not providing access is equivalent to posting a "no deaf people allowed" sign, equivalent to not requiring bus lifts, because, simply because they are inconvenient to all others involved.

Technology has evolved. Movie studios had movies captioned for years. The accessible product is there, and has been there in front of us. The movie theaters are not showing them. Department guidance must recognize

the difference between limited captioning technology that existed in the '90s, and the captioning technology that is available today.

New technology often requires new terminology, and the NAD respectfully requests that the Department adopts the following terminology: Opened captions to refer to captions that cannot be turned off. Closed caption refers to captioning that may be turned on and off. That includes existing caption projection systems and new digital cinema systems that can select the display of captions and other features.

I want to give you an example of how this specific type of closed captioning is already being used. For example, the Universal Studios in Orlando, they have a remote type of clicker that is given out to those who require captioning, to allow us to turn on the captioning on the TV screens that are part of the attractions.

This captioning is then seen by everyone in the room. The third term I wanted to describe is individual captions that refer to captions that require the use of ancillary equipment by the individual viewer. This includes system such as rear window captioning, RWC, and other systems in use and under development

>> JOHN WODATCH: Ms. Kashar, could you summarize the rest of your comments for us please?

>> ALEXIS KASHAR: Okay. While I appreciate the frequency and the flexibility of the RWC, we have to be aware that that is not the answer. It is not easy to use and it has a high failure rate. There are so many times to find out that I go that it's not working. So imagine the thrill of going to the theater and buying popcorn with your pop sitting down only to find that you can't enjoy the movie. And, that has happened countless times, that I have become too familiar with the movie managers for this reason. Okay.

Not only am I affected but my family and my children and their friends are impacted by this as well. Therefore, in closing, the NAD encourages the Department to require compliance with the ADA and that movie theaters provide captioning as defined in my testimony, at all times. Thank you for allowing us, The National Association for the deaf and the deaf community to be heard with respect to this life-altering issue. It's time to liberate the deaf and hard-of-hearing. Thank you again.

>> JOHN WODATCH: Thank you very much. We appreciate your comments today. Next we will hear from Ann Cupolo-Freeman.

>> ANN CUPOLO-FREEMAN: Hello.

>> JOHN WODATCH: Good morning.

>> ANN CUPOLO-FREEMAN: Good morning. Good morning. I am a retired medical social worker. I have worked in hospital-based rehabilitation programs at the Berkeley Center for Independent Living since 1976.

My comments today are based upon my own experiences trying to access certain services and those of the clients and of my friends, but the clients with whom I work in particular.

I thank the Department of Justice for recognizing that all of these topics would benefit from additional regulation. And, I'm here today to talk specifically about the need for additional regulation regarding medical equipment and bed heights in hotels.

We wouldn't tolerate people in any other segment of the population. We wouldn't expect people in any other segment of the population to tolerate not being able to book a hotel room because their bed was too high or to accept an inadequate medical exam because they could not get onto a table.

But it seems that people with disabilities are being expected to accept or to deal with the lack of access in these areas.

Regarding medical equipment and furniture, regulations are definitely needed for equipment including but not limited to exam tables and chairs, wheelchair accessible scales, radiological diagnostic equipment, dental chairs, infusion recliners and mammography chairs.

I'm aware of many situations where many people with disabilities absolutely do not even have access to providers of the community unless their provider has some inaccessible equipment. For example, tables: When I worked at the hospital, we made referrals to a variety of independent healthcare providers. The most common question asked of me by patients was to help them find a primary care physician or gynecologist with a height adjustable exam table.

I can rarely help them with this request because virtually none of the physicians in our community had or even have height adjustable tables. Or the staff willing or able to significantly help many of them get onto the exam tables that were too high. Many people were told to bring their own assistants to put them on the table. We had an accessible wheelchair scale in our rehab department. Our scale was well used because wheelchair users who weren't even our clients came to us to get weighed because no one in the local medical community had one. My own physicians did not have a height adjustable exam table or scale. Patients who couldn't transfer to a too high table were again here told to bring someone to lift them.