

## FealGood Foundation list of those with cancer and those who died from cancer

This list was compiled from various unions, advocates, media, internet, public records and the FGF's client list. This list contains members of FDNY, NYPD, PAPD, EMT/EMS, Construction Workers/Trade & Volunteers.

269 Total with cancer and 189 Deceased

1-R. Alexander	Lung Cancer	Deceased
2	Cancer	
3	Thyroid Cancer	
4-V. Albanese	Cancer	Deceased
5	Liver Cancer	
6-	Lung Cancer	
7-Anspach	Esophageal Cancer	Deceased
8-Archili	Small Intestines	Deceased
9-Aviles	Brain Cancer	Deceased
10-Aviles	Lung Cancer	Deceased
11-	Testicular Cancer	
12-	Lung Cancer	
13-T. Brophy	Colon Cancer	Deceased
14-	Carcinoma	
15	Skin Cancer	
16	Red Cell Cancer	
17-F. Bolusi	Brain Cancer	Deceased
18-H. Brown	Lung Cancer	Deceased
19-F. Brinkworth	Laryngeal Cancer	Deceased
20-R. Burke	Lung Cancer	Deceased
21-Bassi	Non-Small Cell Lung	Deceased
22-Blovin	Small Cell Lung	Deceased
23-Boyles	Pancreatic Cancer	Deceased
24-Butler	Colon Cancer	Deceased
25-	Prostate Cancer	
26-Brown	Rectal Cancer	Deceased
27-R. Borcharding	Cancer	Deceased
28-K. Crzartoryski	Lung Cancer	Deceased
29-	Mesothelioma	
30-R. Chelsen	Multiple Myeloma	Deceased
31-J. Claude	Bone/Lung Cancer	Deceased
32	Prostate Cancer	
33-	Thyroid Cancer	
34-C. Clark	Lung Cancer	Deceased

35-D. Conroy	Lung Cancer	Deceased
36-J. Costello	Lung Cancer	Deceased
37-Cozza	Leukemia	Deceased
38-J. Colleluori	Brain Cancer	Deceased
39-Christianio	Multiple Myeloma	Deceased
40-Chiarantan	Non-Small Cell Carcinoma	Deceased
41-Collazo	Leukemia	Deceased
42-Casertano	Cancer	Deceased
43-	Lymphocytic Leukemia	
44-K. Cassidy	Cancer	Deceased
45	Digestive Cancer	
46-	Prostate Cancer	
47-	Tongue/Lung Cancer	
48-	Cancer	
49-K. Delano	Larynx Cancer	Deceased
50-J. Duffy	Leukemia	Deceased
51-Diamond	Cancer	Deceased
52-Damiano	Larynx Cancer	Deceased
53-Davidson	Lung Cancer	Deceased
54-Duffy	Lung Cancer	Deceased
55-Dunn	Gastric Carcinoma	Deceased
56-	Leukemia	
57-M. Debiase	Cancer	Deceased
58	Cancer	
59-R. Ehmer	Kidney Cancer	Deceased
60-Edwards	Colon/Lung	Deceased
61-B. Ellicott	Cancer	Deceased
62	Cancer	
63	Cancer	
64-	Brain Cancer	
65-	Multiple Myeloma	
66-	Cancer	
67	Non-Hodgkin's	
68-	Skin Cancer	
69-	Squamous Cell	
70-E. Ferraro	Brain Cancer	Deceased
71-B. Foss	Stomach Cancer	Deceased
72-W. Franklin	Cancer	Deceased
73-R. Ford	Cancer	Deceased
74-Fradella	Lung Cancer	Deceased
75-Folk	Lung Cancer	Deceased
76-Falu	Lung Cancer	Deceased

77-B. Galfano	Intestinal Cancer	Deceased
78-	Thyroid Cancer	
79-	Cancer	
80-	Non-Hodgkin's	
81-R. Grossman	Brain Cancer	Deceased
82-	Cancer	
83-j	Cancer	
84-	Thyroid Cancer	
85-M. Gajewski	Lung Cancer	Deceased
86-Gyuris	Leukemia	Deceased
87-Gorman	AML Leukemia	Deceased
88-J. McFarland	Brain Cancer	Deceased
89-R. Helmke	Cancer	Deceased
90-A. Herrmann	Cancer	Deceased
91-	Lung Cancer	
92-R. Hauber	Esophageal Cancer	Deceased
93-	Cancer	
94-K. Hawkins	Kidney Cancer	Deceased
95-W. Holfester	Non-Hodgkin's	Deceased
96-	Prostate Cancer	
97-Hubert	Lung/Brain Cancer	Deceased
98-i	Thyroid Cancer	
99-J. Hawe	Cancer	Deceased
100-G. Iacono	Brain Cancer	Deceased
101-A. Incarbone	Lung Cancer	Deceased
102-Isaac	Cervical Cancer	Deceased
103-J. Jones	Cancer	Deceased
104-S. Johnson	Cancer	Deceased
105-V. Johnson	Cancer	Deceased
106-Joseph	Lung Cancer	Deceased
107-M. Kendrick	Lung Cancer	Deceased
108-D. Knecht	Lung Cancer	Deceased
109-	Cancer	
110-T. Lockwood	Leukemia	Deceased
111-Lewis	Kidney Cancer	Deceased
112-G. Levy	Leukemia	Deceased
113-Lorenzo	Liver	Deceased
114-	Follicular Lymphoma	
115-D. Mahmoud	Cancer	Deceased
116-B. McCauley	Cancer	Deceased
117-T. McCaffrey	Throat Cancer	Deceased
118-J. McNamara	Colon Cancer	Deceased

119.	Lymphoma	
120-M. Mahoney	Cancer	Deceased
121	Cancer	
122.	Cancer	
123.	Cancer	
124.	Non-Hodgkin's	
125-F. Macari	Lung Cancer	Deceased
126-R. Manetta	Cancer	Deceased
127-W. Marzocchi	Blood Cancer	Deceased
128-R. McCormick	Non-Hodgkin's	Deceased
129-C. McMurray	Brain Cancer	Deceased
130.	Cancer	
131-J. Murray	Colon Cancer	Deceased
132-M. Morales	Lung Cancer	Deceased
133-S. McCarthy	Cancer	Deceased
134-S. Mosiello	Cancer	Deceased
135-V. Mauro	Colon Cancer	Deceased
136-Mazarese	Colon Cancer	Deceased
137-McAuslan	Lung Cancer	Deceased
138-Mungen	Lymphoma	Deceased
139-McCoy	Lung Cancer	Deceased
140-Melaniff	Lung Cancer	Deceased
141-Mollahan	Kidney Cancer	Deceased
142-Mucciola	Cancer	Deceased
143-Muligan	Lung Cancer	Deceased
144-C. Milosevich	Lung Cancer	Deceased
145-R. Natal	Pancreatic Cancer	Deceased
146-V. Navarra	Lung Cancer	Deceased
147-A. Nuccio	Melanoma	Deceased
148	Cancer	
149-W. O'Conner	Lung Cancer	Deceased
150-R. Oswain	Cancer	Deceased
151-O'Loughlin	Stomach Cancer	Deceased
152-Orsulich	Lung Cancer	Deceased
153-F. Paultre	Cancer	Deceased
154-G. Pennington	Lymphoma	Deceased
155.	Tongue Cancer	
156-D. Phillips	Cancer	Deceased
157-Pacheco	Gastric Cancer	Deceased
158-Pappalardo	Lung Cancer	Deceased
159-Perrotti	Renal Cancer	Deceased
160-Puma	Cancer	Deceased

161-R. Pfiefer	Cancer	
162-G. Quibell	AML Leukemia	Deceased
163-B. Quick	Cancer	Deceased
164-P. Rooney	Leukemia	Deceased
165-	Cancer	
166-R. Ragucci	Cancer	Deceased
167-	Cancer	
168-	Liver/Abdominal Cancer	
169-P. Rodriguez	Thyroid Cancer	Deceased
170-	Cancer	
171-D. Reeve	Mesothelioma	Deceased
172-	Cancer	
173-T. Roberts	Esophagus Cancer	Deceased
174-J. Ryan	Cancer	Deceased
175-M. Ryan	Lymphoma	Deceased
176	Leukemia	
177-Regan	Pancreatic Cancer	Deceased
178	Multiple Myeloma	
179-H. Smith	Kidney Cancer	Deceased
180-M. Summers	Lung Cancer	Deceased
181-	Non-Hodgkin's	
182-F. Stuck	Throat Cancer	Deceased
183-	Thyroid Cancer	
184-R. Schor	Carcinoma	Deceased
185-M. Snadecky	Cancer	Deceased
186-W. St. George	Cancer	Deceased
187-J. Sullivan	Pancreatic Cancer	Deceased
188-	Brain Cancer	
189	Cancer	
190	Multiple Myeloma	
191-	Colon Cancer	
192-Scigliato	Esophageal Cancer	Deceased
193-Suweidan	Cancer	Deceased
194-M. Tom	Liver/Brain Cancer	Deceased
195-J. Thomas	Lung Cancer	Deceased
196-	Prostate Cancer	
197	Cancer	
198-W. Voight	Cancer	Deceased
199-C. Vidro	Multiple Myeloma	Deceased
200-B. Viania	Lymphoma	Deceased
201-Vincent	Liver	Deceased
202-	Non-Hodgkin's	

203-R. Wiebicke	Multiple Myeloma	Deceased
204	Leukemia	
205-R. Winter	Leukemia	Deceased
206-R. Williamson	Cancer	Deceased
207-J. Young	Cancer	Deceased
208-S. Yurek	Brain Cancer	Deceased
209-R. Zane	Cancer	Deceased
210	Leukemia	
211-	Cancer	
212-L. Heyward	Lymphoma	Deceased
213-A.Jurinko	Pancreatic	Deceased
214	Throat Cancer	
215	Lymphoma	
216-D.Otten	Cancer	Deceased
217-P.Pallas	Cancer	Deceased
218-G.Allen	Colon Cancer	Deceased
219-F. Ghussin	Cancer	Deceased
220-R. Graves	Cancer	Deceased
221-R. Burke	Cancer	Deceased
222-J.Daley	Cancer	Deceased
223-P.Farrenkopf	Cancer	Deceased
224-R.Hess	Cancer	Deceased
225-R.Hodges	Cancer	Deceased
226-E. Reilly	Cancer	Deceased
227-H.Wanamaker	Cancer	Deceased
228-P.Berger	Cancer	Deceased
229-C.Brown	Cancer	Deceased
230-C.Capobianco	Cancer	Deceased
231-F.Rosario	Cancer	Deceased
232-W.Moreau	Cancer	Deceased
233-W.Tropea	Cancer	Deceased
234	Sarcoma	
235-C.Cole	Brian Cancer	Deceased
236-J.Cortazzo	Blood Cancer	Deceased
237	Thyroid Cancer	
238	Leukemia	
239-S.Adrian	Brian Cancer	Deceased
240-R.Dunbar	Cancer	Deceased
241-D.Feser	Cancer	Deceased
242-E.Gilpin	Cancer	Deceased
243-J.Goosdbee	Cancer	Deceased
244-C.Hanarhan	Cancer	Deceased

245-G.Mausberg	Cancer	Deceased
246-E.Ortiz	Cancer	Deceased
247-C.Ocasio	Cancer	Deceased
248-A.Peluso	Cancer	Deceased
249-G.Rex	Cancer	Deceased
250-R.Rivera	Cancer	Deceased
251-E.Thompson	Cancer	Deceased
252-R.Weintraub	Cancer	Deceased
253-B.Mohammed	Cancer	Deceased
254-A.Baez	Cancer	Deceased
255-G.Wong	Gastric Cancer	Deceased
256-L.Johnston	Lung Cancer	Deceased
257-R.Jakubowsky	Cancer	Deceased
258-R.Nicosia	Cancer	Deceased
259-	Cancer	
260-	Cancer	
261-	Cancer	
262-	Leukemia	
263-G.Spinelli	Cancer	Deceased
264-	Non-Hodgkin's	
265-	Throat Cancer	
266-	Prostate Cancer	
267-	Thyroid Cancer	
268-A-Falco	Pancreatic Cancer	Deceased
269	Tongue Cancer	

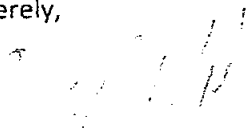


January 6, 2012

\_\_\_\_\_ is a patient at Memorial Sloan Kettering Hospital and currently under my care. He has a diagnosis of Primary CNS Lymphoma and has undergone a stem-cell transplant. Although the cause of his lymphoma is not certain, ~~it is possible that his disease may have been caused by environmental exposure while working at Ground Zero in New York.~~

If you require any additional information please contact my office at 631-623-4000.

Sincerely,

  
Craig Nolan MD



# North Shore LIJ Center for Advanced Medicine

450 Lakeville Road  
Lake Success, New York 11042  
Tel (516) 734-8900

North Shore-Long Island Jewish Health System

## Monter Cancer Center

Department of Medicine  
North Shore University Hospital

Don Monti Division of  
Medical Oncology  
Division of Hematology

Chief  
VINCENT VINCIGUERRA, M.D., FACP

Associate Chief, Hematology  
STEVEN L. ALLEN, M.D., FACP

Associate Chief, Oncology  
DANIEL R. BUDMAN, M.D., FACP

Director, Fellowship Program  
THOMAS BRADLEY, M.D.

Director, Leukemia Service  
JONATHAN KOLITZ, M.D., FACP

Chief, Breast Cancer Service  
LORA WEISELBERG, M.D., FACP

Director, Adult Hematopoietic  
Stem Cell Transplant Program  
RUTHEE-LU BAYER, M.D.

Director, Supportive &  
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JAMES D'OLIMPIO, M.D.

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JANE CARLETON, M.D.  
CRAIG DEVOE, M.D.  
LAURA DONAHUE, M.D.  
VEENA JOHN, M.D.  
BONNIE KINER, M.D.  
STEVEN SAVONA, M.D.  
IULIANA SHAPIRA, M.D.

August 8, 2008

Re: \_\_\_\_\_

To Whom It May Concern:

This is to confirm that \_\_\_\_\_ had Acute Myelogenous  
Leukemia. He had both an autologous and allogeneic stem cell  
transplant.

~~It is with a reasonable degree of medical certainty that his disease  
is related to his exposures at Ground Zero.~~

Ruthee-Lu Bayer, M.D.  
Medical Director of the Don Monti Division of Bone Marrow &  
Hematopoietic Stem Cell Transplantation  
Monter Cancer Center



*Mark Heaney, MD, PhD  
Leukemia and Hematology Services*

October 13, 2005

**RE:**

To Whom It May Concern:

\_\_\_\_\_ is a patient under my care with a diagnosis of Myelodysplastic syndrome that evolved into Acute Myelogenous Leukemia. I have learned from Mr. \_\_\_\_\_ that he worked at Ground Zero immediately following the World Trade Center attacks on 9/11/2001. ~~The timing between the onset of the bone marrow disease (2/10/2004) and his exposure to the toxins at Ground Zero raises the possibility that his leukemia may have been a result of this exposure.~~

If you have any questions or concerns, please feel free to contact my office at any time at 212-639-2275.

Sincerely,

Mark Heaney, MD, PhD

*Memorial Sloan-Kettering Cancer Center  
1275 York Avenue, New York, New York 10021  
Telephone 212.639.2275 • FAX 212.772.8550  
E-mail: m-heaney@ski.mskcc.org*

*NCI-designated Comprehensive Cancer Center*



STONY BROOK  
UNIVERSITY  
**Physicians**

Division of Otolaryngology-  
Head and Neck Surgery

*David Schessel, MD, PhD*  
Chief and Associate Professor  
Medical Director of Speech and  
Hearing, Neurotology/Otology  
*Mark Marzouk, MD*  
Assistant Professor of Surgery  
Head and Neck Surgery  
*Elliot Regenbogen, MD*  
Assistant Professor of Surgery  
Head and Neck Surgery  
Voice and Swallowing Disorder  
*Ghassan J. Samara, MD, FACS*  
Associate Professor of Surgery  
Director of Rhinology/Research  
*Wasył Szeremeta, MD*  
Professor of Surgery  
Pediatric Otolaryngology

*Fran Tanzella, NP*  
Nurse Practitioner  
*Kristl Mohr, MA-CCC-A*  
Audiologist  
*Lori Gynizio, RN*  
Clinic Supervisor

January 07, 2011

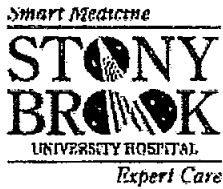
To Whom It May Concern:

This letter is regarding my patient, ~~\_\_\_\_\_~~ Mr. ~~\_\_\_\_\_~~ has been under my care for a squamous cell carcinoma involving his base of tongue, vallecula and epiglottis with node involvement. ~~In a nonsmoker, this is a highly suspicious tumor and may be related to his 10 months of working at Ground Zero.~~ The patient is suffering from sequelae of radiation therapy and cancer including chronic aspiration, neck stiffness, pain and difficulty swallowing.

If you have any questions or concerns regarding this patient, please feel free to contact me.

Sincerely,

Ghassan J. Samara, M.D.  
Clinical Associate Professor of Surgery  
Director of Rhinology/Research



*Department of Medicine  
Division of Neoplastic Diseases*

**Patient Name:**  
**Medical Record #:**

**Date: 1/10/2011**

To Whom It May Concern:

Mr. [redacted] has been under our care since April 2009 for cancer of the throat. [redacted] opinion that there is a [redacted] and his [redacted] exposure [redacted] working at [redacted] 17 [redacted]

Mr. [redacted] has undergone chemotherapy and radiation for extensive squamous cell carcinoma involving the base of tongue, vallecula, and epiglottis, with probable involvement of lymph nodes. His treatment has resulted in chronic aspiration and recurrent pneumonia, for which he has required multiple courses of antibiotics and steroids. He is currently receiving speech therapy for his swallowing impairment and is followed by an otolaryngologist, Dr. Ghassan Samara. He has also been referred to a gastroenterologist, Dr. Jonathan Buscaglia, for treatment of GI symptoms which have been exacerbated by his other treatment.

If I can be of any assistance in this matter, please contact me at (631)-638-1000.

Sincerely,



Roger S. Keresztes M.D.



Long Island Clinical Center  
WTC Medical Monitoring and Treatment Program  
State University of New York, Stony Brook

1345 Motor Parkway, 1<sup>st</sup> Floor, Islandia, NY 11749/ Tel. (631) 855-1200/ Fax (631) 630-6297  
380 South Broadway, Hicksville, NY 11801

September 3, 2009

To Whom It May Concern:

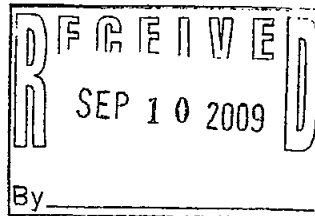
Mr. [redacted] is a patient at the Long Island World Trade Center Medical Monitoring and Treatment Program and was last evaluated and treated on 1/8/09 by Robert Goldstein, MD. Mr. [redacted] reports that he was working as an operating engineer at Ground Zero for approximately 10.5 months involved with removal of debris to aid in the recovery and restoration effort. During his time at Ground Zero, he states he was exposed to dust, toxins, debris and the psychological trauma of recovering human remains.

Prior to 9/11/01, Mr. [redacted] states he was in good general health. However, he states that after working at Ground Zero he developed acid reflux, breathing problems, a chronic sore throat, and difficulty eating and/or drinking. Mr. [redacted] was referred for further evaluations by an ENT. After further testing was completed, Mr. [redacted] was diagnosed with squamous cell carcinoma of the tongue. Mr. [redacted] reports that he never smoked and rarely drank alcohol. Mr. [redacted] does not have other risk factors that are found in people who develop this medical condition. Currently, he is under the treatment of an oncologist.

It is my medical opinion, with a degree of medical certainty, that it is more likely than not that Mr. [redacted] exposure to World Trade Center dust and debris contributed to the development of squamous cell carcinoma of the tongue. The World Trade Center Medical Monitoring and Treatment Program continues to research the linkage between the development of cancer and exposure to Ground Zero toxins and debris. If you need further information, please contact my office at (631) 855-1200.

Sincerely,

Benjamin Luft, MD  
Principal Investigator  
Long Island WTC Medical Monitoring and Treatment Program  
SUNY Stony Brook



Robin A. Sambur  
Edward T. McIntyre  
Richard W. Donohue  
James J. Accardi  
John J. Fiore  
...

Lisa C. Salmonson  
Marina Krikorian  
Scott T. Salmonson  
Sean P. Riordan  
Edward W. Guldi  
Nichell G. Schuman  
Lic. Representative



Sherman  
Federman  
Sambur &  
McIntyre LLP

Kenneth S. Beskin  
Social Security  
Disability & Veterans Law  
...  
Of Counsel  
Benson Sherman (Ret.)  
Paul R. Federman (Ret.)  
Barbara B. Levine (Ret.)

www.licomplaw.com  
Protecting Injured Workers for Over 50 Years.

...  
\*All correspondence  
to Bay Shore office.

May 14, 2010

Roger Keresztes, MD/  
Dr. Scimara

VIA FACSIMILE:  
Facility Billing: 631-444-4148  
Attn: Workers' Compensation Dept.

&

VIA FACSIMILE:  
Doctor Billing: 631-444-4919  
Attn: Workers' Compensation Dept.

To Whom It May Concern:

Please be advised that our office represents the claimant in the above referenced Workers' Compensation claim. The case was originally established for work related injuries arising out of our client's exposure to dust and debris following the cleanup efforts at the World Trade Center on September 11, 2001. These injuries include reactive airway dysfunction syndrome, chronic irritative bronchitis, asthmatic bronchitis, chronic sinusitis, tracheitis, gastroesophageal reflux disease syndrome, dyspnea, and rhinitis.

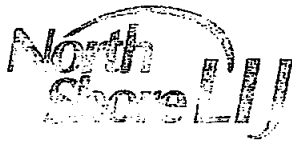
⊗ At a hearing held on January 19, 2010 the case was amended to include squamous cell carcinoma of the tongue.

Suffolk County Office  
8 East Main Street  
Bay Shore, NY 11706-8807  
(631) 665-0609  
Fax (631) 665-7409

Nassau/Queens Office  
175 Fulton Avenue  
Suite 510  
Hempstead, NY 11550  
(516) 564-7791  
Fax (516) 564-7833

Manhattan Office  
15 Maiden Lane  
Suite 1305  
New York, NY 10038  
(866) 557-7500  
Fax (631) 665-7409

Riverhead Office  
737 Roanoke Avenue  
Riverhead, NY 11901  
(631) 665-0609  
Fax (631) 665-7409



Center for  
Advanced Medicine

450 Lakeville Road  
Lake Success, New York 11042

North Shore-Long Island Jewish Health System

Monter Cancer Center

Department of Medicine  
North Shore University Hospital

Don Monti Division of  
Medical Oncology  
Division of Hematology

December 21, 2007

Chief  
VINCENT VINCIGUERRA, M.D., FACP

Associate Chief, Hematology  
STEVEN L. ALLEN, M.D., FACP

**RE: GREGORY QUIBELL**

Associate Chief, Oncology  
DANIEL R. BUDMAN, M.D., FACP

To Whom it May Concern:

Director, Fellowship Program  
THOMAS BRADLEY, M.D.

Mr. Gregory Quibell is under my care for acute myelogenous leukemia. This type of leukemia can be caused by exposure to various toxic chemicals and radiation. Mr. Quibell informs me that he spent 242 hours working at Ground Zero participating in search and recovery activities.

Director, Leukemia Service  
JONATHAN KOLTZ, M.D., FACP

Chief, Breast Cancer Service  
LORA WEISELBERG, M.D., FACP

Director, Adult Hematopoietic  
Stem Cell Transplant Program  
RUTHIE-LU BAYER, M.D.

[REDACTED]

Director, Supportive &  
Palliative, Oncology  
JAMES D'OLIMPIO, M.D.

Yours truly,

Attendings  
JANE CARLETON, M.D.  
CRAIG DEVOE, M.D.  
LAURA DONAHUE, M.D.  
VEENA JOHN, M.D.  
BONNIE KINER, M.D.  
STEVEN SAVONA, M.D.  
JULIANA SHAPIRA, M.D.

Steven L. Allen, M.D., FACP  
Associate Chief, Division of Hematology  
North Shore University Hospital

Professor of Clinical Medicine  
Albert Einstein College of Medicine  
Yeshiva University

CERTIFICATE OF DEATH

STATE FILE NUMBER

RESIDENCE

REGISTER NUMBER 1618

1. NAME: FIRST MIDDLE LAST GREGORY CLIFFORD Quibell 2. SEX: MALE FEMALE 3A. DATE OF DEATH: MONTH DAY YEAR 08 27 2008 3B. HOUR: 7:30 7:30 p.m.

4A. PLACE OF DEATH: HOSPITAL OOA ER HOSPITAL OUTPATIENT HOSPITAL INPATIENT NURSING HOME PRIVATE RESIDENCE HOSPICE FACILITY OTHER 4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR 08 27 2008

4C. NAME OF FACILITY: (If not facility, give address) GOOD SAMARITAN HOSP. 4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN ISLIP 4E. COUNTY OF DEATH: SUFFOLK

4F. MEDICAL RECORD NO. 082400003 4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO YES 5. DATE OF BIRTH: MONTH DAY YEAR 08 30 1954 6A. AGE IN YEARS: 53 yrs. 6B. IF UNDER 1 YEAR ENTER: months days 6C. IF UNDER 1 DAY ENTER: hours minutes 7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) QUEEN'S N.Y. 7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO YES 9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. 10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be.

11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of schooling completed at the time of death. 12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED SEPARATED 14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name. GENEVIEVE F. WILDES

15A. USUAL OCCUPATION: (Do not enter retired) CORRECTION OFFICER 15B. KIND OF BUSINESS OR INDUSTRY: DEPT OF CORRECTIONS 15C. NAME AND LOCALITY OF COMPANY OR FIRM: NEW YORK, N.Y.

16A. RESIDENCE: (State or Country if not USA) N.Y. 16B. County or Region/Province if not USA SUFFOLK 16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN NORTH BABYLON 16E. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES NO IF NO, SPECIFY TOWN:

16D. STREET AND NUMBER OF RESIDENCE: 12 STAR COURT 16E. ZIP CODE: 11703 BABYLON

17. NAME OF FATHER: FIRST MI LAST CLIFFORD Quibell 18. MAIDEN NAME OF MOTHER: FIRST MI LAST EDNA MAI RING

19A. NAME OF INFORMANT: SUSAN ZAVALA 19B. MAILING ADDRESS: (include zip code) 2557 ASTER PLACE, S3 WESTBURY, N.Y. 11550

20A. 1 BURIAL 2 CREMATION 3 REMOVAL 4 HOLD 5 DONATION 6 EXHUMATION 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION 20C. LOCATION: (City or town and state) L.I. CREMATION CO. W. BABYLON, N.Y.

21A. NAME AND ADDRESS OF FUNERAL HOME: NOCE FUNERAL HOME INC WEST BABYLON, N.Y. 21B. REGISTRATION NUMBER: 01304

22A. NAME OF FUNERAL DIRECTOR: VINCENT J. NOCE 22B. SIGNATURE OF FUNERAL DIRECTOR: Vincent J. Noce 22C. REGISTRATION NUMBER: 02696

23A. SIGNATURE OF REGISTRAR: Regina V. Duffley 23B. DATE FILED: MONTH DAY YEAR 8 29 08 24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Irene Couette 24B. DATE ISSUED: MONTH DAY YEAR 8 29 08

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. Certifier's Name: ANSER LONE, MD License No.: 219416 Signature: [Signature] Month Day Year 08 28 08

25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Address: 1000 MONTAUK HWY W. ISLIP N.Y.

25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Address:

26A. Attending physician attended deceased: FROM Month Day Year 08 27 08 TO 08 27 08 26B. Deceased last seen alive by attending physician: Month Day Year 08 27 08 26C. Pronounced Dead ON Month Day Year 08 27 08 AT Time 7:30 p.m.

27. MANNER OF DEATH: NATURAL CAUSE ACCIDENT HOMICIDE SUICIDE UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 29A. AUTOPSY? 29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH?

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) Cardiorespiratory arrest, Bacterial pneumonia / acute (B) DUE TO OR AS A CONSEQUENCE OF: Hospice patient (C) DUE TO OR AS A CONSEQUENCE OF: PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): DID TOBACCO USE CONTRIBUTE TO DEATH? 0 YES 1 NO 2 PROBABLY 3 UNKNOWN

31A. IF INJURY DATE: MONTH DAY YEAR 31B. INJURY LOCALITY: (City or town and county and state) 31C. DESCRIBE HOW INJURY OCCURRED: 31D. PLACE OF INJURY: 31E. INJURY AT WORK?

DECEASED INT: Quibell, Gregory DATE OF DEATH: 08-27-08



**Gregory C. Quibell**  
**12 Star Court**  
**North Babylon, N.Y. 11703**  
**516-547-5656**  
**Cell-347-386-8753**

To: Billing Department

Please be advised that on [REDACTED]

[REDACTED] are all bills will be sent to and paid for by the  
New York State Insurance fund.

Please send all invoices to:

The New York state Insurance Fund  
199 Church Street  
New York, N.Y. 10007-1100

My Worker's Comp. Case # is WCB # 00753836

Thank you,

Gregory C. Quibell

**CASE INFORMATION**

CLAIMANT NAME: Gregory C Quibell  
12 Star Court  
North Babylon, NY 11703

CARRIER NAME: State Insurance Fund  
199 Church St  
New York, NY 10007-1100

SOCIAL SECURITY: [REDACTED]

CARRIER CASE:

WCB CASE NUMBER: 00753836

CARRIER ID: W204002

DATE OF ACCIDENT: September 12, 2001

EMPLOYER: Queensboro Correctional Facility  
47 - 04 Van Dam Street  
Long Island City, NY 11101-3081

PART OF BODY: Leukemia / Pleurisy Fibrosis

ATTORNEY OR REPRESENTATIVE:

ADDITIONAL PARTY OR PARTIES:

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD  
EMPLOYEE'S CLAIM FOR COMPENSATION

ANSWER ALL QUESTIONS  
FULLY - PRINT OR TYPE  
CLEARLY

IMPORTANT: Your Social Security Number Must Be Entered:  
 IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

WCB Case No.: (If known) Carrier Case No.: (If known)

A. Injured Person	1. Name <u>MR. GREGORY QUIBELL</u> <small style="display: block; text-align: center;">First Name Middle Name Last Name</small> 2. Mailing Address <u>12 STAR COURT NORTH BABYLON, NY 11703</u> <small style="display: block; text-align: center;">Number and Street (include Apartment No.) City State Zip Code</small> 3. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ Date of Birth: <u>August 30, 1954</u> Telephone No.: _____ 4. Do you speak English? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, what language do you speak? <u>ENGLISH</u> 5. Name of Union and local number, if member: _____ 6. State what your regular work/occupation was: <u>SENIOR INVESTIGATOR</u> 7. Wages or average earnings per day, including overtime, board, rent and other allowances: _____ 8. Were you paid full wages for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Your work week at time of injury was: <input checked="" type="checkbox"/> Five day <input type="checkbox"/> Six day <input type="checkbox"/> Seven day <input type="checkbox"/> Other: _____
B. Employer(s)	1. Employer: <u>NYS DEPT. OF CORRECTIONS</u> Telephone No.: _____ 2. Employer's Address: <u>247 HARRIS ROAD BEDFORD HILLS, NY 10507</u> 3. Were you employed by any other employer or employers at the time of your injury/illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. If yes, did you lose time from work at this time other employment as a result of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Place/Time	1. Address where injury occurred: <u>GROUND ZERO</u> County: _____ 2. Date of injury: <u>September 11, 2001</u> at _____ o'clock, AM PM <input type="checkbox"/> <input type="checkbox"/>
D. The Injury	1. How did injury/illness occur? <u>WORKED AT GROUND ZERO: SEARCH &amp; RESCUE, ID OF BODIES, MORGUE, GROUND ZERO SITE CLEAN-UP, TRANSPORTAION OF FIREFIGHTERS, EQUIPMENT, AND SUPPLIES TO &amp; FROM ZERO. WORKED THE BUCKET LINE, FRESH KILLS SITE - AT FIRE MARSHAL'S DISPOSAL FOR TASKS</u>
E. Nature and Extent of Injury/ Illness	1. State fully the nature of your injury/illness, including all parts of body injured <u>LEUKEMIA, PULMONARY, CELLULITIS, GOUT AND PNEUMONIA</u> 2. Date you stopped work because of this injury/illness? <u>10/29/07</u> 3. Have you returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, on what date? 4. Does injury/illness keep you from work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 5. Have you done any work during period of disability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6. Have you received any wages since your injury/illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2. Are you now in need of medical care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 3. Name of attending doctor: <u>DR. PAUL KUPERSCHMID, DR. STEVEN ALLEN, AND DR. GERRY RUBIN</u> Doctor's address: <u>LSQ MEDICAL COMPLEX 6 OHIO DRIVE, SUITE 201 LAKE SUCCESS, NY 11042, 450 LAKEVILLE ROAD, LAKE SUCCESS, NY 11042 AND 180 EAST MAIN STREET, STE 5, BAY SHORE, NY 11706</u> 4. If you were in a hospital, give the dates hospitalized: Name of hospital: Hospital's address:
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Do you claim further workers' compensation payments? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2. If yes, notice was given <input checked="" type="checkbox"/> orally <input checked="" type="checkbox"/> in writing, on to SUPERVISOR

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Signed by *Gregory Quibell* Dated December 14, 2007  
(Claimant)

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.  
 LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

ATTENDING DOCTOR'S REPORT AND  
CARRIER/EMPLOYER BILLING FORM

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER THE PRIVATE  
PROVIDER ORGANIZATION PROGRAM (PPO)

45 NRC INITIAL	15 DAY INITIAL	45 DAY PROGRESS	AND OTHER 7 OR MORE DAYS FOR FILING INSTRUCTIONS	PROVIDER	PROVIDER	PROVIDER
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WORKER CASE NO.	CARRIER CASE NO. (IF APPLICABLE)	DATE OF WORKER'S INJURY	ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE)	SOCIAL SECURITY NUMBER
01753836	0264402	4-12-01	WFC SITE NY NY	085463909
CLAIMED PERSON	EMPLOYER	ADDRESS (CITY, STATE AND ZIP)	ADDRESS (CITY, STATE AND ZIP)	DATE OF BIRTH
Gregory C Rubell	Queensboro Correctional Facility	12 St of N Babylon NY 11703	47-04 Van Dam St LIC NY 11001	6-1-53
ADJUSTER	INSURANCE COMPANY	ADDRESS (CITY, STATE AND ZIP)	ADDRESS (CITY, STATE AND ZIP)	INDICATE DATE OF BIRTH & SEX (M or F) when past 65 available to verify.
State Ins Fund		199 Church St NY NY 10003-1100		8-30-54

If treatment was under the VFDL or VAWBL, show as "Employer" the liable political subdivision and check one:  VFDL  VAWBL  
 If you have filed a previous report, setting forth a history of the injury, enter its date and complete items 3-12. If not, complete ALL items.

1. How did injury occur? Also include description of an occupational disease, including a description of the nature and extent of the exposure.  
 2. If there is any history or evidence of pre-existing injury, disease or physical impairment, describe specifically.

3. Dates of occupational exposure which this report is based: 11/2/07 - 12/19/07  
 4. Describe treatment rendered and planned future treatment. If no authorization request is required (see items 6 & 9 on reverse), check box  and explain below. If additional action is necessary, attach request.  
 Pt. was hospitalized @ N.Y. University Hospital in November 2007.

5. Was the injury caused by permanent retention, loss or partial loss of function of a part or member, or permanent loss, loss of use or disfigurement?  
 6. Was any part of patient's work due to impairment, if so, specify:  
 7. Is patient working?   
 8. Is patient unable to perform regular work?  
 9. If yes, degree of impairment is:  TOTAL  PARTIAL

10. Can patient do any type of work?  YES  NO If yes, describe work capacity.  
 11. Was the occurrence or development of any disease described above (on your previous report when this information is available) the cause of the injury or disease and treatment (if any) described?  
 12. Can patient do any type of work?  YES  NO If yes, describe work capacity.  
 Pt. is suffering from leukemia & has chronic lung disease he is unable to work at the present time.

13. List the names of workers by names of injury (include items 1, 2, 3 or 4 to item 12) by sex. Enter date and nature of injury.  
 1. 476.0 COPD  
 2. 138.6 Lymphadenopathy

Date of Injury	Date of Report					Name of Worker	Nature of Injury	Sex	Degree of Impairment	Occupation	Progress Date	Changes	Date of Last Exam	Date When Exam was Referred
	MM	DD	YY	MM	DD									
<del>Table content is crossed out with a large X.</del>														

14. Period for 18 months:  18M  12M  6M  3M

15. THE INJURED WORKER SHOULD NOT PAY THIS BILL.  
 16. Signature of Doctor: Paul Kuperchak, MD  
 17. Address: 6010 47th St, Lake Success, NY 11042

# Unusual Ciliary Abnormalities in Three 9/11 Response Workers

James T. McMahon, PhD; Rizwan Aslam, DO; Stephen E. Schell, MD

After the 9/11 terrorist attacks on the World Trade Center in New York in 2001, thousands of response workers were exposed to complex mixtures of toxins, pollutants, and carcinogens. Many developed illnesses involving the respiratory tract. We report unusual ultrastructural ciliary abnormalities in 3 response workers that corresponded to their respiratory and ciliary functional abnormalities. Each patient had respiratory cilia biopsies that were evaluated for motility and ultrastructural changes. Impaired ciliary motility was seen in 2 of the 3 patients. Each of the patients showed monomorphic ultrastructural abnormalities. Two of the patients showed identical triangular disarray of axonemal microtubules with peripheral doublets 1, 4, and 7 forming the corners of the triangle and doublet 9 always more medially displaced than doublets 2, 3, 5, 6, and 8. Two workers had cilia in which axonemes were replaced by homogeneously dense cores. One of these also had cilia with triangular axonemes as previously described. The other had cilia with a geometric triangular to pentagonal shape. The ciliary abnormalities described here may represent a new class of primary ciliary dyskinesia in which abnormalities may have a genetic basis and a phenotypic expression that is prompted at the cellular level by local environmental conditions.

**Key Words:** 9/11, abnormal cilia, environmental pollution, World Trade Center.

## INTRODUCTION

When the World Trade Center (WTC) buildings burned and collapsed after terrorist attacks on September 11, 2001, the United States suffered a human and environmental disaster of unprecedented proportions. Pulverized and vaporized, along with thousands of people, were an estimated 1.2 million tons of concrete, plus metal, asbestos, glass, and other construction materials, creating massive clouds of dust and debris<sup>1-3</sup> that had a toxic alkalinity capable of searing the soft membrane linings of the lungs and respiratory tract. Also, at the time of the attack, combustion of 20,000 gallons of fuel from two jet airplanes spewed dense plumes of black smoke containing volatile organic compounds, including benzene and polycyclic aromatic hydrocarbons,<sup>4</sup> both known to be potent carcinogens. As the rubble continued to smolder, thousands of men and women continued to breathe the toxins, pollutants, and carcinogens as they participated in the rescue, recovery, and cleanup operations at the WTC site and at the Staten Island landfill that became the repository of the WTC wreckage. Many of these workers developed symptoms, mostly involving the respiratory tract. Although most have recovered, it appears that there exists a subset of these workers who were more sensitive to the toxins than their coworkers and continue to have debilitating symptoms that have persisted years after their exposure.<sup>5-13</sup>

We describe in this report three 9/11 response workers who suffered respiratory and other symptomatic ailments that began shortly after their exposure to the fumes and that have persisted long after cessation of their responder operations. We wished to investigate whether their symptoms were attributable to ciliary dysfunction related to changes in ciliary ultrastructure.

## MATERIALS AND METHODS

*Patients.* Three previously healthy, unrelated female patients were included in this study. All were members of a Family Services outreach team of the American Red Cross Disaster Services from the same region of northwestern Pennsylvania. All served near the WTC site between October 2001 and February 2002 and were later referred to one of the authors (S.E.S.) at the Otolaryngology Service of Hamot Medical Center in Erie, Pennsylvania. Each patient presented with symptoms of an upper airway infection, including cough, dysphonia, rhinitis, postnasal drainage, and generalized fatigue. Each has had periodic exacerbations of sinonasal and laryngotracheal symptoms that were variably responsive to empirical antibiotic treatment. Each patient had negative findings on sinus and chest radiographs that did not indicate further computed tomographic scans. All patients presented with single or multiple lesions of the aerodigestive tract that required bi-

From the Department of Anatomic Pathology, Cleveland Clinic Foundation, Cleveland, Ohio (McMahon), and the Division of Otorhinolaryngology, Hamot Medical Center, Erie, Pennsylvania (Aslam, Schell).

Correspondence: Stephen E. Schell, MD, Division of Otorhinolaryngology, Hamot Medical Center, 201 State St, Erie, PA 16550.

Journal of Clinical Endocrinology and Metabolism

James F. Horowitz, PhD; Richard A. Anderson, D.O.; Stephen E. Jensen, PhD

ANNALS OF THE ENTOMOLOGICAL SOCIETY OF AMERICA  
JANUARY 1991

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- (A) Sally Hightes -
- (B) Barbara Richardson -

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**North Shore LIJ Center for Advanced Medicine**

450 Lakeville Road  
Lake Success, New York 11042

North Shore-Long Island Jewish Health System

**Monter Cancer Center**

Department of Medicine  
North Shore University Hospital

Don Monti Division of  
Medical Oncology  
Division of Hematology

December 21, 2007

Chief  
VINCENT VINCIGUERRA, M.D., FACP

Associate Chief, Hematology  
STEVEN L. ALLEN, M.D., FACP

**RE:**

Associate Chief, Oncology  
DANIEL R. BUDMAN, M.D., FACP

**To Whom it May Concern:**

Director, Fellowship Program  
THOMAS BRADLEY, M.D.

Mr. \_\_\_\_\_ is under my care for acute myelogenous leukemia. This type of leukemia can be caused by exposure to various toxic chemicals and radiation. Mr. \_\_\_\_\_ informs me that he spent 242 hours working at Ground Zero participating in search and recovery activities.

Director, Leukemia Service  
JONATHAN KOLTZ, M.D., FACP

Chief, Breast Cancer Service  
LORA WEISELBERG, M.D., FACP

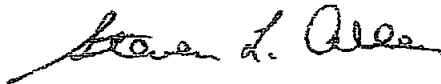
Director, Adult Hematopoietic  
Stem Cell Transplant Program  
RUTHEE-LU BAYER, M.D.

~~There is a significant possibility that Mr. \_\_\_\_\_ has developed acute myelogenous leukemia due to his Ground Zero exposure.~~

Director, Supportive &  
Palliative, Oncology  
JAMES D'OLIMPIO, M.D.

Yours truly,

Attendings  
JANE CARLETON, M.D.  
CRAIG DEVOE, M.D.  
LAURA DONAHUE, M.D.  
VEENA JOHN, M.D.  
BONNIE KINER, M.D.  
STEVEN SAVONA, M.D.  
JULIANA SHAPIRA, M.D.



Steven L. Allen, M.D., FACP  
Associate Chief, Division of Hematology  
North Shore University Hospital

Professor of Clinical Medicine  
Albert Einstein College of Medicine  
Yeshiva University

1. NAME: FIRST MIDDLE LAST GREGORY CLIFFORD Quibell 2. SEX: MALE FEMALE 3A. DATE OF DEATH: MONTH DAY YEAR 08 27 2008 3B. HOUR: 7:30 7:7 m

4A. PLACE OF DEATH: HOSPITAL DOA ER HOSPITAL OUTPATIENT HOSPITAL INPATIENT NURSING HOME PRIVATE RESIDENCE HOSPICE FACILITY OTHER (Specify): 4B. IF FACILITY, DATE ADMITTED: MONTH DAY YEAR 08 27 2008

4C. NAME OF FACILITY: (If not facility, give address) GOOD SAMARITAN HOSP. 4D. LOCALITY: (Check one and specify) CITY VILLAGE TOWN ISLIP 4E. COUNTY OF DEATH: SUFFOLK

4F. MEDICAL RECORD NO. 0824000003 4G. WAS DECEDENT TRANSFERRED FROM ANOTHER INSTITUTION? (If yes, specify institution name, city or town, county and state) NO YES

5. DATE OF BIRTH: MONTH DAY YEAR 08 30 1954 6A. AGE IN YEARS: 53 yrs. 6B. IF UNDER 1 YEAR ENTER: months days 6C. IF UNDER 1 DAY ENTER: hours minutes 7A. CITY AND STATE OF BIRTH: (If not USA, Country and Region/Province) QUEENS N.Y. 7B. IF AGE UNDER 1 YEAR, NAME OF HOSPITAL OF BIRTH:

8. SERVED IN U.S. ARMED FORCES? (Specify years) NO YES 9. DECEDENT OF HISPANIC ORIGIN? Check the boxes that best describe whether the decedent is Spanish/Hispanic/Latino. 10. DECEDENT'S RACE: Check one or more races to indicate what the decedent considered himself or herself to be.

11. DECEDENT'S EDUCATION: Check the box that best describes the highest degree or level of schooling completed at the time of death. 12. SOCIAL SECURITY NUMBER: 13. MARITAL STATUS: NEVER MARRIED MARRIED WIDOWED DIVORCED SEPARATED 14. SURVIVING SPOUSE: Enter name if married or separated. If surviving spouse is wife, enter maiden name. GENEVIEVE F. WILDE

15A. USUAL OCCUPATION: (Do not enter retired) CORRECTION OFFICER DEPT OF CORRECTIONS 15B. KIND OF BUSINESS OR INDUSTRY: 15C. NAME AND LOCALITY OF COMPANY OR FIRM: NEW YORK, N.Y.

16A. RESIDENCE: (State or Country if not USA) N.Y. 16B. County or Region/Province if not USA: SUFFOLK 16C. LOCALITY: (Check one and specify) CITY VILLAGE TOWN NORTH BABYLON 16D. STREET AND NUMBER OF RESIDENCE: 12 STAR COURT 16E. ZIP CODE: 11703 16F. IF CITY OR VILLAGE, IS RESIDENCE WITHIN CITY OR VILLAGE LIMITS? YES NO

17. NAME OF FATHER: FIRST MI LAST CLIFFORD Quibell 18. MAIDEN NAME OF MOTHER: FIRST MI LAST EDNA MAI RING

19A. NAME OF INFORMANT: SUSAN ZAVALA 19B. MAILING ADDRESS: (include zip code) 2557 ASTER PARCE. SO WESTBURY, N.Y. 11590

20A. 1 BURIAL 2 CREMATION 3 REMOVAL 4 HOLD 5 DONATION 6 ENTOMBMENT 20B. PLACE OF BURIAL, CREMATION, REMOVAL OR OTHER DISPOSITION: L.I. CREMATION CO. 20C. LOCATION: (City or town and state) W. BABYLON, N.Y.

21A. NAME AND ADDRESS OF FUNERAL HOME: NOCE FUNERAL HOME INC WEST BABYLON, N.Y. 21B. REGISTRATION NUMBER: 01304

22A. NAME OF FUNERAL DIRECTOR: VINCENT J. NOCE 22B. SIGNATURE OF FUNERAL DIRECTOR: Vincent J Noce 22C. REGISTRATION NUMBER: 02696

23A. SIGNATURE OF REGISTRAR: Reyna V. Supply 23B. DATE FILED: MONTH DAY YEAR 08 29 08 24A. BURIAL OR REMOVAL PERMIT ISSUED BY: Diane Courte 24B. DATE ISSUED: MONTH DAY YEAR 08 29 08

25A. CERTIFICATION: To the best of my knowledge, death occurred at the time, date and place and due to the causes stated. Certifier's Name: ANJER LONE, MD License No.: 219416 Signature: [Signature] Month Day Year 08 28 08

25B. If coroner is not a physician, enter Coroner's Physician's name & title: License No.: Signature: Address: 1000 MONTAUK HWY W. ISLIP N.Y.

25C. If certifier is not attending physician, enter Attending Physician's name & title: License No.: Signature: Address:

26A. Attending physician attended deceased: FROM MONTH DAY YEAR 08 27 08 TO MONTH DAY YEAR 08 27 08 26B. Deceased last seen alive by attending physician: MONTH DAY YEAR 08 27 08 26C. Pronounced Dead ON MONTH DAY YEAR 08 27 08 AT 7:30 P.

27. MANNER OF DEATH: NATURAL CAUSE ACCIDENT HOMICIDE SUICIDE UNDETERMINED CIRCUMSTANCES PENDING INVESTIGATION 28. WAS CASE REFERRED TO CORONER OR MEDICAL EXAMINER? 29A. AUTOPSY? 29B. IF YES, WERE FINDINGS USED TO DETERMINE CAUSE OF DEATH?

30. DEATH WAS CAUSED BY: (ENTER ONLY ONE CAUSE PER LINE FOR (A), (B), AND (C).) PART I. IMMEDIATE CAUSE: (A) Cardiorespiratory arrest, 2nd decompensation / acute (B) DUE TO OR AS A CONSEQUENCE OF: Hospice patient (C) DUE TO OR AS A CONSEQUENCE OF:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (A): DID TOBACCO USE CONTRIBUTE TO DEATH? 31A. IF INJURY DATE: HOUR: 31B. INJURY LOCALITY: (City or town and county and state) 31C. DESCRIBE HOW INJURY OCCURRED: 31D. PLACE OF INJURY: 31E. INJURY AT WORK?

DATE OF DEATH: 08-27-08 AM 7:30 Quibell, Gregory



To: Billing Department

Please be advised that on ~~2/27/08~~ ~~the State of New York Workers Compensation Board has deemed that many diseases/illnesses have been classified as Occupational Diseases and they are job related~~ therefore all bills will be sent to and paid for by the New York State Insurance fund.

Please send all invoices to:

The New York state Insurance Fund  
199 Church Street  
New York, N.Y. 10007-1100

My Worker's Comp. Case # is

Thank you,

**CASE INFORMATION**

CLAIMANT NAME:

CARRIER NAME:

State Insurance Fund  
199 Church St  
New York, NY 10007-1100

SOCIAL SECURITY:

~~095-46-3400~~

CARRIER CASE:

WCB CASE NUMBER:

CARRIER ID :

W204002

DATE OF ACCIDENT:

September 12, 2004

EMPLOYER:

Queensboro Correctional Facility  
47 - 04 Van Dam Street  
Long Island City, NY 11101-3081

PART OF BODY:

Leukemia / Pulmonary Fibrosis

ATTORNEY OR

REPRESENTATIVE:

ADDITIONAL PARTY OR  
PARTIES:

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD  
EMPLOYEE'S CLAIM FOR COMPENSATION

ANSWER ALL QUESTIONS  
FULLY - PRINT OR TYPE  
CLEARLY

IMPORTANT: Your Social Security Number Must Be Entered:  
 IMPORTANTE: El Numero de su Seguro Social Debe Ser Indicado:

WCB Case No.: (If known) Carrier Case No.: (If known)

A. Injured Person	1. Name <u>MR.</u> <small>First Name Middle Name Last Name</small> 2. Mailing Address _____ <small>Number and Street (include Apartment No.) City State Zip Code</small> 3. Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Age: _____ Date of Birth: _____ Telephone No.: _____ 4. Do you speak English? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no, what language do you speak? <u>ENGLISH</u> 5. Name of Union and local number, if member: _____ 6. State what your regular work/occupation was: <u>SENIOR INVESTIGATOR</u> 7. Wages or average earnings per day, including overtime, board, rent and other allowances: _____ 8. Were you paid full wages for the day of injury? <input type="checkbox"/> Yes <input type="checkbox"/> No 9. Your work week at time of injury was: <input checked="" type="checkbox"/> Five day <input type="checkbox"/> Six day <input type="checkbox"/> Seven day <input type="checkbox"/> Other:
B. Employer(s)	1. Employer: <u>NYS DEPT. OF CORRECTIONS</u> Telephone No.: _____ 2. Employer's Address: <u>247 HARRIS ROAD BEDFORD HILLS, NY 10507</u> 3. Were you employed by any other employer or employers at the time of your injury/illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 4. If yes, did you lose time from work at this time other employment as a result of your injury/illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
C. Place/Time	1. Address where injury occurred: <u>GROUND ZERO</u> County: _____ 2. Date of injury: <u>September 11, 2001</u> at _____ o'clock, AM PM <input type="checkbox"/> <input type="checkbox"/>
D. The Injury	1. How did injury/illness occur? <u>WORKED AT GROUND ZERO: SEARCH &amp; RESCUE, ID OF BODIES, MORGUE, GROUND ZERO SITE CLEAN-UP, TRANSPORTAION OF FIREFIGHTERS, EQUIPMENT, AND SUPPLIES TO &amp; FROM ZERO, WORKED THE BUCKET LINE, FRESH KILLS SITE -- AT FIRE MARSHAL'S DISPOSAL FOR TASKS</u>
E. Nature and Extent of Injury/Illness	1. State fully the nature of your injury/illness, including all parts of body injured <u>LEUKEMIA, PULMONARY, CELLULITIS, GOUT AND PNEUMONIA</u> 2. Date you stopped work because of this injury/illness? <u>10/29/07</u> 3. Have you returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, on what date? 4. Does injury/illness keep you from work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 5. Have you done any work during period of disability? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 6. Have you received any wages since your injury/illness? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
F. Medical Benefits	1. Did you receive or are you now receiving medical care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2. Are you now in need of medical care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 3. Name of attending doctor: <u>DR. PAUL KUPERSCHMID, DR. STEVEN ALLEN, AND DR. GERRY RUBIN</u> Doctor's address: <u>LSQ MEDICAL COMPLEX 6 OHIO DRIVE, SUITE 201 LAKE SUCCESS, NY 11042, 450 LAKEVILLE ROAD, LAKE SUCCESS, NY 11042 AND 180 EAST MAIN STREET, STE 5, BAY SHORE, NY 11706</u> 4. If you were in a hospital, give the dates hospitalized: Name of hospital: Hospital's address:
G. Comp. Payments	1. Have you received or are you now receiving workers' compensation payments for the injury reported above? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2. Do you claim further workers' compensation payments? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
H. Notice	1. Have you given your employer (or supervisor) notice of injury? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 2. If yes, notice was given <input checked="" type="checkbox"/> orally <input checked="" type="checkbox"/> in writing, on _____ to SUPERVISOR

I hereby present my claim to the Chair, Workers' Compensation Board, for compensation for disability resulting from an accidental injury or occupational disease arising out of and in the course of my employment and not occasioned by my willful intention or solely through intoxication, and in support of it I make the foregoing statement of facts.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO, OR BY AN INSURER, OR SELF INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Signed by \_\_\_\_\_

Dated December 14, 2007

SEE OTHER SIDE FOR IMPORTANT INFORMATION - VEASE AL DORSO PARA INFORMACION DE IMPORTANCIA

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.  
 LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

ATTENDING DOCTOR'S REPORT AND  
EMPLOYER/EMPLOYEE BILLING FORM

STATE OF NEW YORK  
WORKERS' COMPENSATION BOARD

SERVICES PROVIDED UNDER WORKERS' COMPENSATION PROVIDER ORGANIZATION PROGRAM (WCP)

45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL	45 DAY RETRAL
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WORKER'S NAME: WAGNER DATE OF BIRTH: 4-12-01 ADDRESS WHERE INJURY OCCURRED (CITY, TOWN OR VILLAGE): WFC SITE NY NY

EMPLOYER'S NAME: Queensboro Correctional Facility ADDRESS: 47-04 Van Dam St LIC NY 11431

EMPLOYER'S ADDRESS: State Trns Fund ADDRESS: 139 Church St NY NY 10007-1100

IF INJURY OCCURRED UNDER THE VFDL OR VAWBL, CHECK THE APPROPRIATE BOXES:  VFDL  VAWBL

1. How did injury occur? Also reason for injury. If an accident, describe the accident. If a disease, describe the disease. If a fall, describe the fall.

Partly by release to exposure during 9/11 2001 at the world trade center of site.

2. If there is any history of previous injury, disease or physical condition, describe it.

3. Date of examination: 11/2/07 - 12/19/07 Date of injury: 11/2/07

4. Describe the injury and disease and describe the treatment. If a disease, describe the disease. If an accident, describe the accident. If a fall, describe the fall.

It was hospitalizated @ NY university hospital in November 2007.

5. Was the injury caused by contact with a substance?  Yes  No

6. Was the injury caused by contact with a machine, tool or equipment?  Yes  No

7. Is patient contact?  Yes  No

8. Was the injury caused by contact with a vehicle?  Yes  No

9. Was the occurrence or development of injury caused (a) in your previous report which gave the attending physician producing cause of the injury or disease and (b) in your previous report which gave the attending physician producing cause of the injury or disease and (c) in your previous report which gave the attending physician producing cause of the injury or disease?

10. Can patient do any type of work?  Yes  No

Pat. is suffering from leukemia & has chronic lung disease he is unable to work at the present time.

11. Was the occurrence or development of injury caused (a) in your previous report which gave the attending physician producing cause of the injury or disease and (b) in your previous report which gave the attending physician producing cause of the injury or disease and (c) in your previous report which gave the attending physician producing cause of the injury or disease?

12. Description of injury or disease of body part: 1. LYMPH. G LYMPHADENOPATHY

DATE	TIME	PLACE	DURATION	NATURE OF INJURY	CAUSE OF INJURY	TREATMENT	RESULTS	DATE	PLACE	DURATION	NATURE OF INJURY	CAUSE OF INJURY	TREATMENT	RESULTS	DATE	PLACE	DURATION	NATURE OF INJURY	CAUSE OF INJURY	TREATMENT	RESULTS	DATE	PLACE	DURATION	NATURE OF INJURY	CAUSE OF INJURY	TREATMENT	RESULTS
<del>Table content is crossed out with a large X.</del>																												

14. Number of days lost:  None  Less than 14  14 or more

15. Was injury caused by:  Fall  Contact with object  Contact with machine  Contact with vehicle  Contact with substance  Contact with electricity  Contact with radiation  Contact with noise  Contact with vibration  Contact with heat  Contact with cold  Contact with light  Contact with sound  Contact with motion  Contact with other

16. Was injury caused by:  Fall  Contact with object  Contact with machine  Contact with vehicle  Contact with substance  Contact with electricity  Contact with radiation  Contact with noise  Contact with vibration  Contact with heat  Contact with cold  Contact with light  Contact with sound  Contact with motion  Contact with other

17. Signature of Doctor: Paul Kupfermann, M.D.

18. Signature of Employer: State Trns Fund