EXHIBIT E

WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL
NEW MILFORD HOSPITAL

CERTIFICATION OF RECORDS

The Undersigned hereby declares: Please note that these are billing records Only

1. That said is the person in charge of or an authorized assistant to the person in charge of the Health Information Services Department at Danbury Hospital / New Milford Hospital (circle appropriate hospital).

2. That the attached record is a true and complete copy of the record of

   Noah Pozner in said hospital.
   (Name of Patient)

3. That: (a) said record was made in the regular course of the business of said hospital; (b it was the regular course of business to make such record at the time of the transactions, occurrences and/or events recorded therein or within a reasonable time thereafter; and (c) said record was kept in the course of regularly conducted business activity.

I am familiar with the mode of preparation of, and have the authority to certify, the facility records. I declare under penalty of perjury that the foregoing is true and accurate.

Health Information Services Department

4/9/19
Date

APPROVED OMB NO. 0938-0279

DANBURY HOSPITAL ACUTE UB
PO BOX 5153
STAMFORD CT 06904
2037305800 2030000000

3 PATIENT CONTROL NO.

4 TYPE OF BILL: 111

5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 112006 THROUGH 112406 | 7 COV D. 004 | 8 N-C D. | 9 C-I D. | 10 L-R D. | 11

12 PATIENT NAME: POZNER, NBM A.

13 PATIENT ADDRESS: 3 KALE DAVIS ROAD SANDY HOOK CT 06482

14 BIRTHDATE	15 SEX	16 MS	17 ADMISSION DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	24-30 CONDITION CODES	31
11202006	M		112006	08	4	1	14	01	0821014	C5	

32 OCCURRENCE CODE/DATE | 33 OCCURRENCE CODE/DATE | 34 OCCURRENCE CODE/DATE | 35 OCCURRENCE CODE/DATE | 36 OCCURRENCE SPAN CODE FROM THROUGH | 37

38
POZNER, VERONIQUE
3 KALE DAVIS ROAD

SANDY HOOK, CT 06482

39 VALUE CODES CODE AMOUNT | 40 VALUE CODES CODE AMOUNT | 41 VALUE CODES CODE AMOUNT

	42 REV.CD.	43 DESCRIPTION	44 HCPCS/RATES	45 SERV.DATE	46 SERV.UNITS	47 TOTAL CHARGES	48 NON-COV'D CHRGS	49
1	170		710.00		4	2840.00		
2	250			112306	1	2.00		
3	259			112006	3	13.00		
4	270			112006	1	275.00		
5	300			112006	3	91.00		
6	301			112006	5	204.00		
7	636			112006	1	14.00		
8	001					3439.00		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	BCBS CONNECTICUT	024	Y	Y			

57 DUE FROM PATIENT

	58 INSURED'S NAME	59 P.REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	POZNER, LEONARD	19	XGN0066M49312		INB04529

63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION

67 PRIN.DIAG.CD.	68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM.DIAG.CD.	77 E-CODE	78
V3101	79099	V293							V3101		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE A CODE	DATE	B CODE	DATE
9	640	112306				

C OTHER PROCEDURE CODE DATE | D OTHER PROCEDURE CODE DATE | E OTHER PROCEDURE CODE DATE

82 ATTENDING PHYS. ID: 1154988 KELLER BARRY

83 OTHER PHYS. ID (A): 1423334 DAILEY CHRISTIN

OTHER PHYS. (B)

84 REMARKS
BCBS CONNECTICUT
P O BOX 1041
NORTH HAVEN CT 06473

85 PROVIDER REPRESENTATIVE: X MARY BRANNIGAN

86 DATE: 11/30/06

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 HCFA-1450 PAYER COPY

SELECTED DETAIL DATA SVC FAC: MOHE 04/09/19 1457

PT NO: [redacted] POZNER ,NOAH SAMUEL MR NO: 0821014 ACCT TYPE: A
REG: 11/20/06 DSCH: 11/24/06 FC: S PT: B EXP IND: ACCT BAL .00
PAGE NO: 1

ACCT BAL	062 V	PT BAL
.00	.00	.00

SVC	POST	SVC CD	INS CD-DESCRIPTION/COMMENT-REF DATE		AMOUNT
112006	112006	5030017	03	NEWBORN WELL	275.00
112006	112006	6023038	30	ERYTHROMYCIN 0.5% OPHTH OINT	2.00
112006	112006	6028219	40	PHYTONADIONE 1MG INJ	14.00
112006	112106	5553022	44	BILIRUBIN TOTAL	43.00
112006	112106	5553023	44	DIRECT BILIRUBIN	26.00
112006	112006	5559802	44	NEWBORN SCREENING (PKU)	49.00
112006	112006	5560401	49	COOMBS DIR EA ANTISERA	43.00
112006	112006	5560403	49		24.00
112006	112006	5560404	49		24.00
112006	112006	3415100	B	ROOM 3N02-11 B	710.00

! (PF14) SEL PT ! (PF3) SELECT DTL ! (PF11) ACCT CASH
! (PF15) RETURN TO PT OVERVIEW ! (PF10) ACCT CMNTS PF16 D/E
! (PF7) NEXT ! (PF9) LAST

PAQDTL01

DANBURY HOSPITAL

SELECTED DETAIL DATA SVC FAC: MOHE 04/09/19 1457

PT NO: [redacted] POZNER ,NOAH SAMUEL

REG: 11/20/06 DSCH: 11/24/06 FC: S PT: B EXP IND: MR NO: 0821014 ACCT TYPE: A

ACCT BAL .00

PAGE NO: 2

ACCT BAL .00 062 V .00

PT BAL .00

SVC	POST	SVC CD	INS	CD-DESCRIPTION/COMMENT-REF DATE		AMOUNT
112106	112106	5040003	03	OAE NEWBORN HEARING SCREENING		.00
112106	112106	5553022	44	BILIRUBIN TOTAL		43.00
112106	112106	3415100	B	ROOM 3N02-11	B	710.00
112206	112206	5553022	44	BILIRUBIN TOTAL		43.00
112206	112206	3415100	B	ROOM 3N02-11	B	710.00
112306	112306	6022411	30	ACETAMINOPHN 40MG/0.4ML LIQ UD		2.00
112306	112306	6029005	30	BACITRACIN OINT		9.00
112306	112306	6028150	40	LIDOCAINE 1% MDV 30ML		2.00
112306	112306	3415100	B	ROOM 3N02-11	B	710.00
120106	120106	80862	1	BLUECARE		-615.00

! (PF14) SEL PT
! (PF15) RETURN TO PT OVERVIEW ! (PF3) SELECT DTL ! (PF11) ACCT CASH
! (PF6) PREVIOUS ! (PF10) ACCT CMNTS PF16 D/E
! (PF7) NEXT ! (PF8) BEGINNING ! (PF9) LAST
PAQDTL01

DANBURY HOSPITAL

SELECTED DETAIL DATA SVC FAC: MOHE 04/09/19 1457

PT NO: [redacted] POZNER ,NOAH SAMUEL MR NO: 0821014 ACCT TYPE: A
REG: 11/20/06 DSCH: 11/24/06 FC: S PT: B EXP IND: ACCT BAL .00
-- PAGE NO: 3

ACCT BAL	062 V	PT BAL
.00	.00	.00

SVC	POST	SVC CD	INS	CD-DESCRIPTION/COMMENT-REF DATE	AMOUNT
120506	120706	129	1	BLUE CROSS PAYMENT	-2824.00

! (PF14) SEL PT ! (PF3) SELECT DTL ! (PF11) ACCT CASH
! (PF15) RETURN TO PT OVERVIEW ! (PF10) ACCT CMNTS PF16 D/E ____
! (PF6) PREVIOUS ! (PF8) BEGINNING
PAQDTL01

DANBURY HOSPITAL

EXHIBIT F

forgery noun

forg·ery | \ ˈfȯrj-rē, ˈfȯr-jə-\

plural **forgeries**

Definition of *forgery*

1 *archaic* : INVENTION

2 : something forged

3 : an act of forging

especially : the crime of falsely and fraudulently making or altering a document (such as a check)

Synonyms

Example Sentences

Learn More about *forgery*

Synonyms for *forgery*

Synonyms

counterfeit, fake, hoax, humbug, phony (*also* phoney), sham

Visit the Thesaurus for More

Examples of *forgery* in a Sentence

// that is a cheap *forgery*, not an authentic Ming Dynasty vase

Recent Examples on the Web

// Other charges included burglary, tampering with evidence, and *forgery* for allegedly forging child custody documents.

— Kris Maher, *WSJ*, "Ohio Officials Charge Family in 'Execution' of Another Family," 13 Nov. 2018

// The Florida Supreme Court Referee's report found Marcellus knew his ex-wife's signature had been forged on a loan modification document, stopping just short of saying Marcellus engineered the *forgery*.

— David J. Neal, *miamiherald*, "The lawyer fought for the house in his divorce. He's been suspended," 11 June 2018

These example sentences are selected automatically from various online news sources to reflect current usage of the word 'forgery.' Views expressed in the examples do not represent the opinion of Merriam-Webster or its editors. Send us feedback.

See More

First Known Use of *forgery*

1583, in the meaning defined at sense 1

History and Etymology for *forgery*

FORGE entry 2 + -ERY

Learn More about *forgery*

Share *forgery*

Resources for *forgery*

Dictionary Entries near *forgery*

forged

forgeman

forger

forgery

forgery bond

forget

forgetful

Statistics for *forgery*

Last Updated

7 Apr 2019

Look-up Popularity

Bottom 40% of words

Time Traveler for *forgery*

The first known use of *forgery* was in 1583

See more words from the same year

COMPARE US TO THE OTHERS & Judge for Yourself. Compare Us Now! TOTAL TAX, INC

WORD OF THE DAY

accolade

an award or expression of praise

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TEST YOUR VOCABULARY

April 2019 Words of the Day Quiz

Which is a synonym of propitious?

dubious |
profound | heartening

Can you spell these 10 commonly misspelled words?

TAKE THE QUIZ

Test Your Knowledge - and learn some interesting things along the way.

TAKE THE QUIZ

TRENDING NOW

1 surveillance
Comey comments on Barr's ...

2 cavalier
Virginia wins men's champio...

3 redact, redacted
Barr discusses release of re...

SEE ALL

BVLGARI Eau Parfumée au thé vert Available at NORDSTROM Shop Now

SINCE 1828

forged

DICTIONARY THESAURUS

forged *adjective*

\ forjd \

Definition of *forged*

1 : formed by pressing or hammering with or without heat
especially : made into a desired shape by heating and hammering
// *forged* blades
// a cold *forged* sword

2 : made falsely especially with intent to deceive
// *forged* signatures
// a *forged* document

Synonyms & Antonyms for *forged*

Synonyms

bogus, counterfeit, fake, false, inauthentic, phony (*also* phoney), queer, sham, snide, spurious, unauthentic

Antonyms

authentic, bona fide, genuine, real, unfaked

Visit the Thesaurus for More

First Known Use of *forged*

15th century, in the meaning defined at sense 1

History and Etymology for *forged*

Middle English, from present participle of *forgen* "to FORGE entry 2"

WORD OF THE DAY

accolade

an award or expression of praise

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Shutterfly

Learn More about *forged*

Share *forged*

Resources for *forged*

Dictionary Entries near *forged*

forgat
forgather
forge
forged
forgeman
forger
forgery

Statistics for *forged*

Look-up Popularity
Bottom 10% of words

Time Traveler for *forged*

The first known use of *forged* was in the 15th century

See more words from the same century

More from Merriam-Webster on *forged*

Thesaurus: All synonyms and antonyms for *forged*
Nglish: Translation of *forged* for Spanish Speakers
Britannica English: Translation of *forged* for Arabic Speakers

Comments on *forged*

What made you want to look up *forged*? Please tell us where you read or heard it (including the quote, if possible).

Show Comments

https://www.merriam-webster.com/dictionary/fabricate

SINCE 1828

fabricate

DICTIONARY THESAURUS

Every 8 minutes, we respond to a disaster.

fabricate verb

fab·ri·cate | \ ˈfa-bri-ˌkāt \

fabricated; fabricating

Definition of *fabricate*

transitive verb

1 a : INVENT, CREATE

b : to make up for the purpose of deception

// accused of *fabricating* evidence

2 : CONSTRUCT, MANUFACTURE

specifically : to construct from diverse and usually standardized parts

// Their plan is to *fabricate* the house out of synthetic parts

↓ Other Words from *fabricate*

↓ Synonyms

↓ Example Sentences

↓ Learn More about *fabricate*

Other Words from *fabricate*

fabricator \ ˈfa-bri-ˌkā-tər \ *noun*

Synonyms for *fabricate*

Synonyms

fashion, form, frame, make, manufacture, produce

Visit the Thesaurus for More

Examples of *fabricate* in a Sentence

// Only the largest parts were *fabricated* at the factory.

// Their plan is to *fabricate* the house out of synthetic materials.

See More

Recent Examples on the Web

// Park uses square organic rye loaves from Boston's beloved Iggy's artisanal bakery and had custom metal dies *fabricated* to shape square patties that fit the bread perfectly.

— Larry Olmsted, *USA TODAY*, "America's unique burger styles, and where to try them," 4 July 2018

// Her son's adviser had asked him about his status as a track and field athlete, which was *fabricated* to facilitate his admission, according to federal charges unsealed Tuesday.

— Brian Costa, *WSJ*, "At USC, Admissions Cheating Scandal Runs Deeper," 13 Mar. 2019

These example sentences are selected automatically from various online news sources to reflect current usage of the word 'fabricate.' Views expressed in the examples do not represent the opinion of Merriam-Webster or its editors. Send us feedback.

See More

First Known Use of *fabricate*

15th century, in the meaning defined at sense 1a

History and Etymology for *fabricate*

Middle English *fabricaten*, borrowed from Latin *fabricātus*, past participle of *fabricāre*, *fabricari* "to fashion, shape, construct," derivative of *fabrica* "process of making something, craft, art" — more at FABRIC

WORD OF THE DAY

accolade

an award or expression of praise

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April 2019 Words of the Day Quiz

What is a synonym of propitious?

dubious | picayune
profound | heartening

Can you spell these 10 commonly misspelled words?

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Test Your Knowledge - and learn some interesting things along the way.

TAKE THE QUIZ »

TRENDING NOW

1 surveillance
Comey comments on Barr's ...
2 cavalier
Virginia wins men's champio...
3 redact, redacted
Barr discusses release of re...

SEE ALL »

fake adjective

\ ˈfāk \

faker; fakest

Definition of *fake* (Entry 1 of 5)

: not true, real, or genuine : COUNTERFEIT, SHAM

// He was wearing a *fake* mustache.

// She held up the bowl to the window light and smiled her *fakest* smile yet ...
— Lee Durkee

WORD OF THE DAY
accolade
an award or expression of praise
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fake noun (1)

Definition of *fake* (Entry 2 of 5)

: one that is not what it purports to be: such as

a : a worthless imitation passed off as genuine
// The signature was a *fake*.

b : IMPOSTOR, CHARLATAN
// He told everyone that he was a lawyer, but he was just a *fake*.

c : a simulated movement in a sports contest (such as a pretended kick, pass, or jump or a quick movement in one direction before going in another) designed to deceive an opponent

d : a device or apparatus used by a magician to achieve the illusion of magic in a trick

fake verb (1)

faked; faking

Definition of *fake* (Entry 3 of 5)

transitive verb

1 : to alter, manipulate, or treat so as to give a spuriously (see SPURIOUS sense 2) genuine appearance to : DOCTOR
// *faked* the lab results

2 : COUNTERFEIT, SIMULATE, CONCOCT
// *faked* a heart attack

3 : to deceive (an opponent) in a sports contest by means of a fake (see FAKE entry 2 sense c)

4 : IMPROVISE, AD-LIB
// whistle a few bars ... and I'll *fake* the rest
— Robert Sylvester

intransitive verb

1 : to engage in faking something : PRETEND —sometimes used with *it*
// if you don't have the answers, *fake* it

2 : to give a fake to an opponent
// The runner *faked* left and then cut to the right.

TEST YOUR VOCABULARY
April 2019 Words of the Day Quiz
Which is a synonym of propitious?
heartening | prefaced
dubious | picayune
Can you spell these 10 commonly misspelled words?
TAKE THE QUIZ »
Test Your Knowledge - and learn some interesting things along the way.
TAKE THE QUIZ »
TRENDING NOW
1 surveillance
Comey comments on Barr's ...
2 cavalier
Virginia wins men's champio...
3 redact, redacted
Barr discusses release of re...
SEE ALL »
"Professors from renowned universities teach cutting edge content."
coursera Start Learning

fake noun (2)

Definition of *fake* (Entry 4 of 5)

: one loop of a coil (as of ship's rope or a fire hose) coiled free for running

fake verb (2)

faked; faking

Definition of *fake* (Entry 5 of 5)

transitive verb

: to coil in fakes

↓ Other Words from *fake*
↓ Synonyms & Antonyms
↓ Choose the Right Synonym
↓ More Example Sentences
↓ Learn More about *fake*

EXHIBIT G

SOCIAL SECURITY

Refer to: S2RB416/06
S9H: AU7784

April 01, 2019

JACOB ZIMMERMAN
15 CROCUS HL
SAINT PAUL MN 55102

Re: Noah Pozner
SSN: [redacted]

Dear Mr. Zimmerman:

Enclosed is a computer-prepared statement, called a Numident printout, which you requested. This contains the personal identifying information given on Noah Pozner's application for a Social Security number (SS-5). We have deleted the names of the parents, however, as they may still be living.

We do not disclose to the public personal information from our records about living individuals unless disclosure would serve the public interest to a degree that outweighs the individual's right to privacy. The only public interest we can consider is whether the information would improve public oversight and public accountability by giving the public insight into an agency's performance of its duties. I have not found that disclosing this information would provide any such insight. This policy is consistent with the Freedom of Information Act, which exempts from its requirements any disclosure that would be a clearly unwarranted invasion of personal privacy (5 U.S.C. § 552(b) (6)).

If you can provide proof of death for the parents, and if there is enough information available to us to determine that, the proof of death refers to the same individuals shown on this document, we can disclose this information.

Thank you for your payment to cover the cost of processing your request.

For your convenience, we also have enclosed an explanation of the information provided on the Numident printout.

If you would like further assistance with your request, you may contact our FOIA Public Liaison by email at ^FOIA.Public.Liaison@ssa.gov; by phone at 410-965-1727, by choosing Option 2; or facsimile at 410-966-0869. Additionally, you may contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration to inquire about the FOIA mediation services they offer. The contact information for OGIS is as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road – OGIS, College Park, MD 20740-6001; email at ogis@nara.gov; telephone at 202-741-5770; toll-free at 1-877-684-6448; or facsimile at 202-741-5769.

If you disagree with this decision, you may file a written appeal with the Executive Director for the Office of Privacy and Disclosure, Social Security Administration, 617 Altmeyer Building, 6401 Security Boulevard, Baltimore, Maryland 21235. Your appeal must be postmarked or electronically transmitted to ^FOIA.PA.Officers@ssa.gov within 90 days of the date of our response to your initial request. Please mark the envelope or subject line with "Freedom of Information Appeal."

Sincerely,

Monica Chyn
Acting Freedom of Information Officer

Enclosure

The Numident Printout is an official record of the information we have in our records. You presented some of this information when you applied for a Social Security card. Only coded items, which contain information, will appear on the record. If there is no information on our records for a particular item, the item will not be shown.

Some information is used for internal record keeping and has no effect on your records. Following are coded items used for internal use only.

MSG, DTE, NUMI, XC, ID, UN, PG

Explanation for the coded items is as follows:

Coded Item	**Explanation**
SSN	Social Security Number.
ETC	Entry Code-Internal indication of type of record on file.
RFN	Reference Number-Internal File Number.
DOC	District Office Code-Office where application was processed.
IDN	Identification Code-Internal code indicating type of evidence provided.
NAA	Name on Social Security card.
NL2	Other name used.
NL3	Other name used.
DOB	Date of Birth-2 position month, 2-position day, 4-position year.
PDB	Prior Date of Birth-Date of birth previously reported to Social Security Administration (SSA).
PLB	Place of Birth-City and State, or foreign country.
FCI	Foreign Country Place of Birth Indicator-Always an asterisk (*) if present.
SEX	F=Female, M=Male, U=Unknown (not on our records).
ETB	Race/Ethnic Code.
CSP	Citizenship Code.
MNA	Mother's Name at Birth.
FNA	Father's Name at Birth.
CYD	Date record established on SSA's Internal files.

If you have any questions about the Numident printout, contact your local Social Security office.

Form SSA-2554 (9-87)

SOCIAL SECURITY ADMINISTRATION

CERTIFICATION

Pursuant to the provisions of Title 42, United States Code, Section 3505, and the authority vested in me by 45 F. R. 47245-46, I hereby certify that I have legal custody of certain records, documents, and other information established. I certify such fact being true and correct, substantiated by the records maintained by the Social Security Administration, pursuant to Title 42, United States Code, Section 405.

I certify that the annexed computer printout showing the name, Social Security Number XXX-XX-8199 and the dates the information was recorded are true and complete copies of such documents in my custody.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the Social Security Administration to be affixed this 2nd day of April 2019.

Monica De Los Reyes
Director
Division of Earnings and Business Services
Office of Central Operations

	SSN: [redacted] ETC:0 RFN:06346510113 DOC:090 IDN:P
	NAA: NOAH , SAMUEL , POZNER
	DOB:11/20/2006 PLB: DANBURY , CT SEX:M ETB:0 CSP:A
	BCN:10606037904
PARENT	MNA:
	FNA:
INTERNAL	FMC:6 CYD:12/12/2006

ACCOUNT	SSN: [redacted] ETC:T
NAME	NAA: NOAH , S , POZNER
BIRTH	DOB:11/20/2006 SEX:M
INTERNAL	DOD:12/14/2012 SSD:72 POD:P EDR:N CYD:12/19/2012

EXHIBIT H

POZNER, NOAH

TouchWorks

Summary of Settings	**1**
Patient	**2**
Summaries	**3**
Allergies	3
Problems	3
Documents	4
Immunizations	5
Medications	8
Orders	8
Results	9
Messages	10
Vitals	10
Chart Alerts	11
Other	12

Summary of Settings

VitalCenter Online Archival allows for users to export a patient's chart with custom settings. This document was generated using the settings found below.

Enabled Types		Setting	Value
	Allergies	Time Zone	Eastern Standard Time
	Chart Alerts	Chart Annotations	No
	Documents	Details	No
	Immunizations	Versions	Current
	Medications	Comments	No
	Messages	Attachments	Yes
	Orders	Invalidated Data	No
	Other	24-Hour Time	Yes
	Problems	Encounter Date Range	1/1/2010 - 4/4/2019
	Results	Include Secure Data	No
	Vitals		

Patient

Name	NOAH POZNER	**Primary MRN**	533138
Sex	Male	**SSN**	
Address	3 KALE DAVIS RD.	**Date of Birth**	11/20/2006
City, State	SANDY HOOK, CT 06482		
Home Phone	(646) 523 - 6800	**Preferred Language**	ENGLISH
Work Phone		**Ethnicity**	Non - Hispanic or Latino
Cell Phone	(203) 426 - 1121	**Race**	White

Summaries

Allergies

Active

Allergen	Reaction	Status
No Known Drug Allergies		Active
No Known Environmental Allergies		Active
No Known Food Allergies		Active

Other

No other allergies were found in the archive within the specified encounter range.

Denied

No denied allergies were found in the archive within the specified encounter range.

Entered in Error

No entered in error allergies were found in the archive within the specified encounter range.

Inactive

No inactive allergies were found in the archive within the specified encounter range.

Problems

Active

Problem	ICD9	ICD10	Type
Encounter for immunization	V03.89	Z23	Active
Well child visit	V20.2	Z00.129	Active

Other

No other problems were found in the archive within the specified encounter range.

Family History

Problems

Family History

No family history problems were found in the archive within the specified encounter range.

Past Medical History

Problem	ICD9	ICD10	Type
History of Cesarean Delivery - Delivered	669.71		Resolved
History of impetigo	V13.3	Z87.2	Resolved
History of Multiple Gestation - Twins - Delivered	651.01		Resolved
History of Pediculosis capitis	132.0	B85.0	Resolved

Past Surgical History

Problem	ICD9	ICD10	Type
History of Layer Closure Of Wound	V58.41		Resolved

Social History

No social history problems were found in the archive within the specified encounter range.

Suppressed

No suppressed problems were found in the archive within the specified encounter range.

Documents

Other

No other documents were found in the archive within the specified encounter range.

Notes

Type	Date	Owner	Status
Office Visit (Acute)	9/14/2011	BALANON-SORIANO, CORINNA (045840)	Final
Office Visit (HM 4 Year Visit)	1/31/2011	MORTERA, LALAINE (035458)	Final

Documents

Notes

Type	Date	Owner	Status
Office Visit (HM 5 Year Visit)	2/22/2012	BALANON-SORIANO, CORINNA (045840)	Final
Return to Work/School (Acute)	9/14/2011	BALANON-SORIANO, CORINNA (045840)	Final
Telephone Note (Telephone Note)	1/31/2011	Cecilio, Rosa	Final

Scans

Type	Date	Owner	Status
sBilling Forms	1/31/2011	MORTERA, LALAINE (035458)	Final - Receipt
sBilling Forms	2/22/2012	BALANON-SORIANO, CORINNA (045840)	Final - Receipt
sHIPAA	1/31/2011	MORTERA, LALAINE (035458)	Final - Receipt
sHow May We Contact You Form	8/15/2011	AHSAdmin, AHS	Final - Receipt
sImmunizationRecord	10/16/2010	AHSAdmin, AHS	Final - Receipt
sImmunizationRecord	2/17/2012	AHSAdmin, AHS	Final - Receipt
sImmunizationRecord	9/14/2011	AHSAdmin, AHS	Final - Receipt
sImmunizationRecord	1/31/2011	AHSAdmin, AHS	Final - Receipt
sPediatrics NPD Health Summary	2/17/2012	AHSAdmin, AHS	Final - Receipt
sPediatrics NPD Outgoing Communication	1/31/2011	MORTERA, LALAINE (035458)	Final - Receipt
sPediatrics SPD Outgoing Communication	3/8/2012	AHSAdmin, AHS	Final - Receipt

Immunizations

Other

Immunizations

Other

No other immunizations were found in the archive within the specified encounter range.

Canceled

No canceled immunizations were found in the archive within the specified encounter range.

Complete

Immunization	Admin Date	Ordered By	Type
DTaP	5/21/2008	, (CT000463)	IM
DTaP	5/31/2007	, (CT000463)	IM
DTaP-HepB-IPV (Pediarix)	2/22/2007	, (CT000463)	IM
DTaP-HepB-IPV (Pediarix)	4/5/2007	, (CT000463)	IM
Hepatitis A	1/15/2010	, (CT000463)	IM
Hepatitis A	12/14/2008	, (CT000463)	IM
Hepatitis B	10/25/2007	, (CT000463)	IM
HIB	5/31/2007	, (CT000463)	IM
HIB	12/10/2007	, (CT000463)	IM
HIB	4/5/2007	, (CT000463)	IM
HIB	2/22/2007	, (CT000463)	IM
Influenza	12/4/2008	, (CT000463)	IM
Influenza	9/14/2011	BALANON-SORIANO, CORINNA (045840)	IM
Influenza	10/31/2008	, (CT000463)	IM
Influenza	10/25/2007	, (CT000463)	IM
Influenza A (H1N1) Monoval PF Intramuscular Suspension	1/15/2010	, (CT000463)	IM
IPV	5/21/2008	, (CT000463)	IM

Immunizations

Complete

Immunization	Admin Date	Ordered By	Type
Kinrix Intramuscular Suspension	1/31/2011	MORTERA, LALAINE (035458)	IM
MMR	1/31/2011	MORTERA, LALAINE (035458)	IM
MMR	5/21/2008	, (CT000463)	IM
Pneumo (Prevnar)	4/5/2007	, (CT000463)	IM
Pneumo (Prevnar)	5/31/2007	, (CT000463)	IM
Pneumo (Prevnar)	12/10/2007	, (CT000463)	IM
Pneumo (Prevnar)	2/22/2007	, (CT000463)	IM
Prevnar 13 Suspension	1/31/2011	MORTERA, LALAINE (035458)	IM
Rotavirus	5/31/2007	, (CT000463)	IM
Rotavirus	4/5/2007	, (CT000463)	IM
Rotavirus	2/22/2007	, (CT000463)	IM
Varicella	1/31/2011	MORTERA, LALAINE (035458)	IM
Varicella	5/21/2008	, (CT000463)	IM

Entered in Error

No entered in error immunizations were found in the archive within the specified encounter range.

Hold For

No hold for immunizations were found in the archive within the specified encounter range.

Permanent Deferral

No permanent deferral immunizations were found in the archive within the specified encounter range.

Temporary Deferral

No temporary deferral immunizations were found in the archive within the specified encounter range.

Medications

No medications were found in the archive within the specified encounter range.

Orders

Diagnostic

No diagnostic orders were found in the archive within the specified encounter range.

Other

No other orders were found in the archive within the specified encounter range.

Finding

Name	Ordered	Ordered By	Status
Pediatric Vitals	9/14/2011 16:12:52	, (CT000463)	Complete
Pediatric Vitals	2/22/2012 14:36:37	, (CT000463)	Complete
Pediatric Vitals	1/31/2011 14:53:55	, (CT000463)	Complete

Follow-Up

Name	Ordered	Ordered By	Status
Follow-up visit in 1 year	2/22/2012 15:39:33	BALANON-SORIANO, CORINNA (045840)	Complete

Imaging

No imaging orders were found in the archive within the specified encounter range.

Instruction

No instruction orders were found in the archive within the specified encounter range.

Lab

Name	Ordered	Ordered By	Status
POC HEMOGLOBIN 85018	1/31/2011 15:19:50	MORTERA, LALAINE (035458)	Complete

Referral

Orders

Referral

No referral orders were found in the archive within the specified encounter range.

Supplies

No supplies orders were found in the archive within the specified encounter range.

Results

Diagnostic

No results were found in the archive within the specified encounter range.

Other

No results were found in the archive within the specified encounter range.

Imaging

No results were found in the archive within the specified encounter range.

Instruction

Results

No results were found in the archive within the specified encounter range.

Lab

POC HEMOGLOBIN 85018

Date ordered	1/31/2011 15:19:50	Ordered by	MORTERA, LALAINE (035458)
Order status	Complete	Resulted date	1/31/2011 15:38:00
Result Status	Complete		

Test	Result	Flag	Reference
HGB	12.0		

Messages

No messages were found in the archive within the specified encounter range.

Vitals

Other

No other vitals were found in the archive within the specified encounter range.

Active

Date	Finding	Value
2/22/2012 14:41:00	BMI Calculated	17.76 kg/m2
2/22/2012 14:41:00	BSA Calculated	0.83 m2
2/22/2012 14:41:00	Diastolic	50 mm Hg
2/22/2012 14:41:00	Height	44.5 in

Vitals

Active

Date	Finding	Value
2/22/2012 14:41:00	Systolic	90 mm Hg
2/22/2012 14:41:00	Weight	50 lb
9/14/2011 16:13:00	Temperature	98.5 F
9/14/2011 16:13:00	Weight	50 lb
1/31/2011 14:58:00	BMI Calculated	17.96 kg/m2
1/31/2011 14:58:00	BSA Calculated	0.75 m2
1/31/2011 14:58:00	Diastolic	56 mm Hg
1/31/2011 14:58:00	Heart Rate	108 bpm
1/31/2011 14:58:00	Height	41.5 in
1/31/2011 14:58:00	Pulse Quality	Regular
1/31/2011 14:58:00	Respiration	24
1/31/2011 14:58:00	Respiration Quality	Norm
1/31/2011 14:58:00	Systolic	80 mm Hg
1/31/2011 14:58:00	Weight	44 lb

Entered in Error

No entered in error vitals were found in the archive within the specified encounter range.

Chart Alerts

Chart Alerts

No chart alerts were found in the archive within the specified encounter range.

Other

No other were found in the archive within the specified encounter range.

Chief Complaint

lice

History of Present Illness

Was sent home from school today bec of head lice. Lice was first noted last week. Mom treated the child with OTC lice medicine yesterday, per sibling. (+) scalp itching

Review of Systems

Constitutional: no fever.
ENT: no earache, no sore throat, no nasal passage blockage and no nasal discharge.
Respiratory: no cough.
Integumentary: itching, but no rash noted.
Neurological: no headache.

Active Problems

- Impetigo 684

Past Medical History

- History of Cesarean Delivery - Delivered 669.71
- History of Layer Closure Of Wound V58.41
- History of Multiple Gestation - Twins - Delivered 651.01

Allergies

- No Known Drug Allergies
- No Known Environmental Allergies
- No Known Food Allergies

Vitals

	14Sep2011 04:13PM
Weight	50 lb
Temperature	98.5 F, Axillary

Physical Exam

Constitutional: alert, interactive, in no acute distress, well nourished and well developed.
Head and Face: (+) one nit on the hair shaft detected ; no live lice seen, but normal in appearance.
Eyes: the sclera and conjunctiva were normal.
ENT: the ears and nose were normal in appearance.
Neck: normal in appearance, supple and no mass was observed.
Skin: normal skin color and pigmentation, no significant rash and no skin lesions.
Psychiatric: active and alert and interactive.

Assessment

- Pediculosis Capitis 132.0
- Vaccines Prophylactic Need Against Influenza V04.81

Plan

- Influenza; as directed; Dose: 0.25ml; Route: Intramuscular; Site: Left Upper Arm; Done: 14Sep2011 04:58PM; Status: Complete

May re-treat with OTC lice shampoo in 1 week. Discussed head lice.

Attending Note

May return to school 9/15/2011. Restrictions: No live lice seen.

Signatures

Electronically signed by : CORINNA BALANON-SORIANO, M.D.; Sep 14 2011 6:13PM (Author)

History of Present Illness

concerns about a rash on the back.
NOAH POZNER presents today for routine health maintenance with his father. No illness since last visit.
Dental hygiene: Good.
Diet: The child's current diet needs improvement: is insufficient in vegetables.
Elimination: No elimination issues are reported. He does not get constipitated and does not get diarrhea.
Sleep: Sleeps for 9 hours at night. He sleeps with sibling(s). He does not snore. He does not have nightmares.
School: in preschool 5 days/week. School performance has been excellent.
Sports: He participates in karate.
Development: alternates feet when descending stairs; hops; jumps forward, can climb a ladder; build a tower of 10 or more cubes, can cut and paste, copy a cross and a circle, dresses and undresses without supervision, plays make-believe, gender identification, can draw a person with three parts, identifies 3 or 4 colors, counts to 5, rides a bike and ready for school.
Tuberculosis Risk: No tuberculosis risk factors.
Safety/Anticipatory Guidance: healthy diet, limit juice, sunscreen/tick checks, drowning risks / water safety, playground and stranger safety, lock medicines, helmet use, car seat/seat belt use, limit TV/video game time, school readiness.
Caregiver Concerns: None.
May fully participate in school/pe program.

Past Medical History

- History of Cesarean Delivery - Delivered 669.71
- History of Multiple Gestation - Twins - Delivered 651.01

Allergies

- No Known Drug Allergies
- No Known Environmental Allergies
- No Known Food Allergies

Immunizations

DTP/DTaP — Series1: 22Feb2007; Series2: 05Apr2007; Series3: 31May2007; Series4: 21May2008
Hepatitis A --- Series1: 14Dec2008; Series2: 15Jan2010
Hepatitis B — Series1: 22Feb2007; Series2: 05Apr2007; Series3: 25Oct2007
HIB --- Series1: 22Feb2007; Series2: 05Apr2007; Series3: 31May2007; Series4: 10Dec2007
Influenza --- Series1: 25Oct2007; Series2: 31Oct2008; Series3: 04Dec2008
MMR --- Series1: 21May2008
Pneumococcal --- Series1: 22Feb2007; Series2: 05Apr2007; Series3: 31May2007; Series4: 10Dec2007
Polio --- Series1: 22Feb2007; Series2: 05Apr2007; Series3: 21May2008
Rotavirus --- Series1: 22Feb2007; Series2: 05Apr2007; Series3: 31May2007
Varicella --- Series1: 21May2008
Influenza A (H1N1) Monoval PF Suspension --- Series1: 15Jan2010

Vitals

Primary Care [Data Includes: Current Encounter]

Height: 3 ft 5.5 in
Weight: 44 lb
Systolic: 80, LUE, Sitting
Diastolic: 56, LUE, Sitting
Heart Rate: 108, L Radial
Pulse Quality: Regular, L Radial
Respiration: 24
Respiration Quality: Norm
BMI: 17.96 kg/m2
BSA: 0.75 m2

Results

All Results [Data Includes: Current Encounter]

POC HEMOGLOBIN 85018
HGB 12.0

Physical Exam

Constitutional
General appearance: Normal.
Eyes
Conjunctiva and lids: Normal.
Pupils and irises: Normal.
Ears, Nose, Mouth, and Throat
External inspection of ears and nose: Normal.
Otoscopic examination: Normal.
Lips, teeth, and gums: Normal.
Oropharynx: Normal.
Neck
Neck: Normal.
Thyroid: Normal.
Pulmonary
Respiratory effort: Normal.
Auscultation of lungs: Normal.
Cardiovascular
Auscultation of heart: Normal.
Abdomen
Abdomen: Normal.
Liver and spleen: Normal.
Examination for hernias and masses: Normal.
Genitourinary
Scrotal contents: Normal.
Penis: Normal.
Genital development Tanner stage: 1
Pubic hair Tanner stage: 1
Lymphatic
Palpation of lymph nodes in neck: Normal.
Palpation of lymph nodes in groin: Normal.
Musculoskeletal Evaluation for scoliosis: Negative.
Gait and station: Normal.
Inspection/palpation of joints, extremities, and muscles: Normal.
Range of motion: Normal.
Muscle strength/tone: Normal.
Skin
Skin: Normal.
Examination of the skin for lesions: Abnormal. Bacterial infection, buttocks.
Palpation of skin: Normal.
Neurologic
Reflexes: Normal.
Psychiatric
judgment and insight: Normal.
Orientation to person, place, and time: Normal.
Mood and affect: Normal.

Procedure

Hearing Acuity Test
Indication: routine screening.
Audiometry:. Normal bilaterally.

Visual Acuity Test
Results: By Titmus test, vision was 20/25 in the right eye, 20/25 in the left eye.

Assessment

- Health Maintenance V20.2
- Impetigo 684

Plan

- POC HEMOGLOBIN 85018 Status: Complete Done: 31Jan2011 03:38PM
- Kinrix Suspension; INJECT 0.5 ML Intramuscular; Dose: .5ml; Route: Intramuscular; Site: Left Upper Arm; Status: Complete; Done: 31Jan2011 03:28PM
- MMR; INJECT 0.5 ML Subcutaneous; Dose: .5ml; Route: Intramuscular; Site: Right Upper Arm; Status: Complete; Done: 31Jan2011 03:29PM
- Prevnar 13 Suspension; INJECT 0.5 ML Intramuscular; Dose: 0.5ml; Route: Intramuscular; Site: Left Upper Arm; Status: Complete; Done: 31Jan2011 03:29PM
- Varicella; INJECT 0.5 ML Subcutaneous; Dose: .5ML; Route: Intramuscular; Site: Right Upper Arm; Status: Complete; Done: 31Jan2011 03:31PM

Discussion/Summary

Impression:
No growth, development, elimination, feeding, skin and sleep concerns. No medical problems. Anticipatory guidance addressed as per the history of present illness section.

Signatures

Electronically signed by : LALAINE MORTERA, M.D.; Jan 31 2011 3:39PM (Author)

History of Present Illness

NOAH POZNER presents today for routine health maintenance with his father. No illness since last visit.
Dental hygiene: Good.
Diet: The child's current diet is diverse and healthy. Daily fluid intake averages 0-8 oz of milk, no juice, 16+ oz of water and no soda.
Elimination: No elimination issues are reported. He has accidents at night, but has no daytime accidents. 1 stools per day. He does not get constipitated and does not get diarrhea.
Sleep: Sleeps for 7 hours at night. He sleeps with sibling(s), shares with 2 sibs. He does not snore.. He does not have nightmares.
School: He is in kindergarten. School performance has been good.
Sports: He does not participate in organized sports
Development: skips, walks on tiptoes, or broad jumps, defines at least one word (ball, shoe, chair, table, dog), dresses and undresses without supervision, draws a person with a head, a body, arms, and legs, copies a triangle from an illustration, identifies 4 or 5 colors, counts to 5, plays make-believe and rides a bike.
No behavior issues identified.
Tuberculosis Risk: No tuberculosis risk factors.
Safety/Anticipatory Guidance: healthy diet, limit juice, helmet use, car seat/seat belt use, limit TV/video game time.
Caregiver Concerns: None.
May fully participate in school/pe program.

Active Problems

Problems

- Vaccines Prophylactic Need Against Influenza V04.81

Past Medical History

Problems

- History of Cesarean Delivery - Delivered 669.71
- History of Impetigo 684
- History of Layer Closure Of Wound V58.41
- History of Multiple Gestation - Twins - Delivered 651.01
- History of Pediculosis Capitis 132.0
- Vaccines Prophylactic Need Against Influenza V04.81

Allergies

Medication

- No Known Drug Allergies

Non-Medication

- No Known Environmental Allergies
- No Known Food Allergies

Immunizations

DTP/DTaP --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 31May2007 (6M); Series4: 21May2008 (18M); Series5: 31Jan2011 (4Y)
Hepatitis A --- Series1: 14Dec2008 (25M); Series2: 15Jan2010 (3Y)
Hepatitis B --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 25Oct2007 (11M)
HIB --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 31May2007 (6M); Series4: 10Dec2007 (12M)
Influenza --- Series1: 25Oct2007 (11M); Series2: 31Oct2008 (23M); Series3: 04Dec2008 (24M); Series4: 14Sep2011 (4Y)
MMR --- Series1: 21May2008 (18M); Series2: 31Jan2011 (4Y)
Pneumococcal --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 31May2007 (6M); Series4: 10Dec2007 (12M)
Polio --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 21May2008 (18M); Series4: 31Jan2011 (4Y)
Rotavirus --- Series1: 22Feb2007 (3M); Series2: 05Apr2007 (4M); Series3: 31May2007 (6M)
Varicella --- Series1: 21May2008 (18M); Series2: 31Jan2011 (4Y)
Influenza A (H1N1) Monoval PF Intramuscular Suspension --- Series1: 15Jan2010 (3Y)
Prevnar 13 Intramuscular Suspension --- Series1: 31Jan2011 (4Y)

Vitals

Primary Care [Data Includes: Current Encounter]
22Feb2012 02:41PM
BMI Calculated: 17.76
BSA Calculated: 0.83
Height: 3 ft 8.5 in
Weight: 50 lb
Systolic: 90
Diastolic: 50

Physical Exam

Constitutional
General appearance: Normal.
Head and Face
Head and face: Normal.
Eyes
Conjunctiva and lids: Normal.
Pupils and irises: Normal.
Ears, Nose, Mouth, and Throat
External inspection of ears and nose: Normal.
Otoscopic examination: Normal.
Lips, teeth, and gums: Normal.
Oropharynx: Normal.
Neck
Neck: Normal.
Thyroid: Normal.
Pulmonary
Respiratory effort: Normal.
Auscultation of lungs: Normal.
Cardiovascular Peripheral vascular exam: Normal.
Auscultation of heart: Normal.
Chest
Chest: Normal.
Abdomen
Abdomen: Normal.
Liver and spleen: Normal.
Examination for hernias and masses: Normal.
Genitourinary
Scrotal contents: Normal.
Penis: Normal.
Genital development Tanner stage: 1
Pubic hair Tanner stage: 1
Lymphatic
Palpation of lymph nodes in neck: Normal.
Palpation of lymph nodes in groin: Normal.
Musculoskeletal Evaluation for scoliosis: Negative.
Gait and station: Normal.
Inspection/palpation of joints, extremities, and muscles: Normal.
Skin
Skin: Normal.
Palpation of skin: Normal.
Psychiatric
Mood and affect: Normal.

Procedure

Hearing Acuity Test
Indication: routine screening.
Audiometry: Normal hearing in both ears.
Hearing in the right ear: passed at 20 decibels.

Hearing in the left ear: passed at 20 decibels.

Visual Acuity Test
Indication: routine screening.
Results: By Titmus test, vision was 20/30 in the right eye, 20/30 in the left eyenormal in both eyes.

Assessment

Assessed

- Health Maintenance V20.2

Plan

Health Maintenance (V20.2)

- Follow-up visit in 1 year Outpatient Follow-up Done: 22Feb2012

Discussion/Summary

Impression:
No growth, development, elimination, feeding, skin and sleep concerns. No medical problems. Anticipatory guidance addressed as per the history of present illness section. No vaccines needed. He is not on any medications. Information discussed with father.

Signatures

Electronically signed by : Diane Schweter, L.P.N.; Feb 22 2012 2:36PM
Electronically signed by : CORINNA BALANON-SORIANO, M.D.; Feb 22 2012 3:41PM (Author)

Return to Work/School

May return to school 9/15/2011. Restrictions: No live lice seen.

Signatures

Electronically signed by : CORINNA BALANON-SORIANO, M.D.; Sep 14 2011 6:13PM (Author)

Pozner, Noah 11.20.06

DANBURY OFFICE OF PHYSICIAN SERVICES PAYMENT POLICIES

DOPS kindly reminds you of the following payment policies. Please Inquire if you have any questions. Thank you.

- **Medicare**
  Accurate and complete Medicare information must be provided at the time of registration. As a Medicare patient, we remind you that there is an annual deductible and a patient responsibility of 20% for the balance of Medicare's allowed amount. Medicare may require you to sign an Advanced Beneficiary Notice (ABN) as Medicare refuses to pay for some services.
  -By signing below,I request that payment of authorized Medicare benefits be made either to me or on my behalf to DOPS for any services furnished me by a physician employed by DOPS. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid services and its agents any information needed to determine these benefits or the benefits payable for related services.

- **Participating Insurance Plans**
  Accurate and complete information regarding your insurance must be provided at the time of registration. Insurance card must be presented at time of service to verify information and determine co-payment. Your annual deductible(if applicable) and any non-covered services we provide are your responsibility and MUST be paid within 30 days of receiving a statement from our Business Office.
  Insurance Patients: Failure to provide accurate and complete information at the time of registration may result in having a self-pay balance. If you are insured, but your Insurance Plan does not cover certain services that you wish to receive and/or your provider feels are important to your care, you may be asked to sign a Waiver of Insurance (Acceptance of Payment Responsibility for Non-covered Services) and you are then falling under the guidelines of a "self-pay patient".

- **Self-Pay Payment**
  If you are non-insured, you are considered a "self-pay patient" and are 100% responsible for the services provided to you and/or your family. Payment, in full, is expected at time of service for all office charges.

- **Referrals**
  It is the patient's responsibility to obtain the proper "referrals" from your Primary Care Physician for continued treatment when needed. This will be based on each individual Insurance Plan. Failure to provide proper referrals may cause the patient to be financially responsible for the bill.

- **Co-pays; Deductibles**
  Co-payments (patient responsibility of Insurance Plan) must be paid at the time of each office visit. It is your responsibility to understand your deductible or percentage of payment from your plan. Under no circumstances will this payment be waived.

- **Prompt-Pay**
  It is the policy of DOPS to provide a standardized financial discounting methodology to an uninsured individual (self-pay) should they request a prompt payment discount.

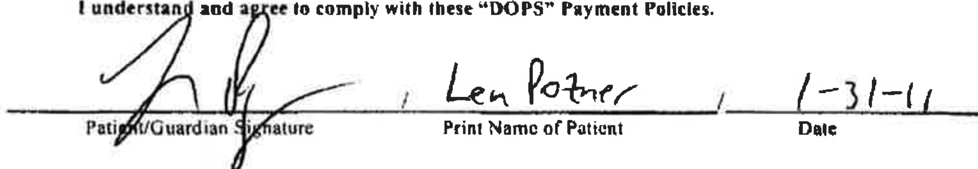
- **Financial Hardship**
  You may qualify for "Financial Hardship" based on your financial status. Qualification will be determined by standardized methodology and approved by DOPS Administration.

- **Budget Plan**
  In order to accommodate those individuals with fixed incomes that cannot afford a one time fee, it is the policy of DOPS to offer budget standardized payment plans to those individuals as they may not be able to pay balances in full in one payment.

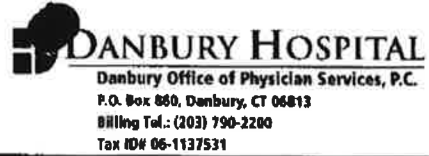
- **No-Show Policy**
  Patients not complying with scheduled appointments, who fail to *properly notify* the physician office within 48 hours of the appointment, or fail to show at all, are subject to a self-pay penalty of $40 per missed visit. In the event that the patient misses three unexcused appointments within one year, the physician has the right to terminate your patient status.

- **Returned –Check Policy**
  It is DOPS Policy to charge a returned checks service fee of $20.00. The patient will be afforded the opportunity to contact the DOPS Representative regarding alternative payment arrangements. More than two returned checks may affect patient status.

I understand and agree to comply with these "DOPS" Payment Policies.



Patient/Guardian Signature	Len Pozner Print Name of Patient	1-31-11 Date



05/13/09 533138 MORTERA, LALAINE

PATIENT INFORMATION

Field	Value
Name	POZNER, NOAH
AKA/Maiden Name	
Patient SS No.	
Date of Birth	11/20/06
Gender	M
Marital Status	SINGLE
Street/P.O. Box	3 KALE DAVIS RD.
City, State, Zip	SANDY HOOK, CT 06482
Patient Tel. #	203-426-1121
Cell #	
Email Address	

PATIENT EMPLOYER INFORMATION

Field	Value
Employer's Name	
Status	
Street/P.O. Box	
City, State, Zip	
Employer Tel. #	
Ext.	

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Field	Value
Name	POZNER, VERONICA
Relationship	MOTHER
P.O. Box/Apt. Address	3 KALE DAVIS RD.
City, State, Zip	SANDY HOOK, CT 06482
Tel. #	203-426-1121
Work #	

EMERGENCY CONTACT INFORMATION

Field	Value
Emergency Contact Name	POZNER, LEONARD
Relationship	FATHER
Emergency Contact Tel. # (other than home phone)	646-533-1140

FAMILY MEMBERS (TO INCLUDE PATIENT)

#	Role	Name	DOB	Sex
1	Mother/Guardian	Veronique Pozner	4-24-67	F
2	Employer	Mason Care	Phone:	
3	Social Security Number	[redacted]		
4	Father/Guardian	Leonard Pozner	10-1-67	M
5	Employer	Newtown Consulting	Phone: 203,426-1121	
6	Social Security Number	107-56-6911		
1	Child	Sophia Pozner	1-25-05	F
2	Child	Noah "	11-20-06	M
3	Child	Arielle "	11 20-06	F
4	Child		DOB	Sex
5	Child		DOB	Sex
	Child		DOB	Sex
	Child		DOB	Sex

PATIENT INSURANCE INFORMATION

Field	Priority 1	Priority 2	Priority 3
Insurance/FSC	CIGNA HEALTHCARE 49 CHO	CIGNA HEALTHCARE 49 AIM	
Street/P.O. Box	P.O. BOX 5200	P.O. BOX 5200	
City, State, Zip	SCRANTON, PA 18505-5200	SCRANTON, PA 18505-5200	
Policy ID No.	U3656526904	U3656526904	
Group / Plan	3328399 / OA PLUS	3328399 / OA PLUS	/
Effective	05/01/09	05/01/09	
Expires			
PCP			
Insurance Tel. #	800-633-1110	800-633-1110	
PCP Co-pay/Co-Pay	$25.00 / 40.00	$25.00 / 40.00	/
Relationship to Subscriber	DEP CHIL	DEP CHIL	
Subscriber's Name	POZNER, VERONIQUE	POZNER, VERONIQUE	
Gender	F	F	
Subscriber's Address	3 KALE DAVIS RD	3 KALE DAVIS RD	
Subscriber's Social Security #			
Subscriber's Date of Birth	04/24/67	04/24/67	
Subscriber's Tel. #			
Subscriber's Employer	MASONICARE	MASONICARE	
Employment Status	EMPLOYED FULL TIME	EMPLOYED FULL TIME	

I understand and agree to comply with the Danbury Office of Physician Service's, P.C. (D.O.P.S.) Payment Polices. I hereby authorize them to treat me and release any medical or other information necessary to process this claim. I understand that I am responsible for any charges not covered by my insurance plan.

Patient /Legal Representative Signature / Date

Parent /Legal Representative Signature if Patient is a Minor / 5-1-09 Date

DOPS-02 Rev. 4/08

(SEE REVERSE SIDE)

WESTERN CONNECTICUT MEDICAL GROUP

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

WESTERN CONNECTICUT MEDICAL GROUP, PEDIATRICS – Southbury Office
Western Connecticut Medical Group

Acceptance of Payment Responsibility
For Non covered Services

The American Academy of Pediatrics strongly advises Pediatricians to perform a Pure Tone Hearing Test on a child to detect a possible hearing loss. There may be long term problems by not having a timely diagnosis.

I understand that my private insurance may not cover the service requested for the following reason:

_X_ Services provided are not covered by my insurance plan

Procedures	Cost
CPT 92551 Pure Tone Hearing Test	$31.00

☑ **YES** I want my child to receive this service. I understand that, for the reason checked above, the service may not be covered by my insurance plan. I request that I receive the service and agree to pay for all services rendered should my insurance plan refuse to pay.

☐ **NO** I do not want my child to receive this service.

Patient Name: Noah Pozner D.O.B. 11-20-06

Patient/Guardian Signature: [signature]

Date: 2-22-12

DANBURY OFFICE OF PHYSICIAN SERVICES ("DOPS")

AUTHORIZATIONS FOR BASIC EXAMINATION AND TREATMENT, CONDITIONS OF EXAMINATION AND TREATMENT, AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient Pozner, Noah

MRN 11.20.06

Authorization to Examine, Provide Treatment, and Perform Diagnostic Procedures Other Than Procedures Requiring Informed Consent. To the extent that specific authorization is required by law, I authorize the performing of all examinations, treatments, and care provided to me under the general or specific instructions or direction of my physician or DOPS Staff. I also understand that by the fact of my seeking diagnosis and/or treatment, routine examination, treatment, and care generally may be provided to me without specific authorization.

Informed Consent. I understand that if I require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency my own physician will discuss the risks, benefits, and alternatives, and answer my questions. I am entitled to consent or refuse to consent.

Use of Protected Health Information for Treatment Payment, or Health Care Operations, or for Other Lawful Purposes. DOPS will keep your health care information confidential. The authorizations that you provide to us, including the DOPS Record Release, do not in any manner limit appropriate disclosures that do not require specific or additional authorization. For example, DOPS is permitted to disclose information without your specific authorization (i) for purposes of billing, treatment or health care operations, or (ii) where it must be disclosed in accordance with the provisions of applicable law, or (iii) because you previously agreed to the disclosure.

Authorization to Pay Benefits From Third Party Payment Sources / Financial Obligations. I authorize third party payors, including insurers and managed care companies (including governmental payers), to make payment directly to DOPS for medical expenses and any/all (Group or Direct) medical benefits otherwise payable to me. I understand that I am financially responsible for payment for services not covered by this authorization, and that I will pay all costs of collection of any delinquent balance including reasonable attorney's fees, which may be added to my account. I understand that my refusal to grant authorization to my third party payors will in no way jeopardize my right to obtain present or future treatment except where disclosure is necessary for treatment, but understand that under such circumstances I will be responsible for paying my bill in full.

Acknowledgement of Receipt of Notice of Privacy Practices. I acknowledge that I have received a copy of DOPS' Notice of Privacy Practices (HIPAA).

Pozner, Noah 11.20.06

MEDICARE PATIENTS ONLY
Medicare One-time Payment Authorization Applicable to Current or Future Treatment.

Name of Beneficiary: ______________________ HICN:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to D.O.P.S. for any services furnished me by the D.O.P.S. physician. I authorize any holder of Medical Information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Students and Resident Physicians. I understand that medical, nursing and other health care students as well as resident physicians provide or observe services provided to patients, and may be present during examinations and treatment and special procedures as part of their training and learning experiences.

★ ★ ★

I HAVE READ AND UNDERSTAND THE AUTHORIZATIONS, AGREEMENTS AND NOTICES SET FORTH IN THIS FORM, AND I AGREE TO SUCH AUTHORIZATIONS, AGREEMENTS, AND NOTICES

1-31-11
Date

Signature

Witness/ guardian

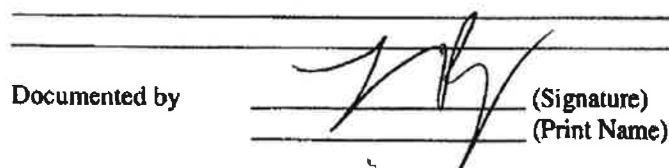
Father
Relationship

If this form has not been signed by the patient, please specify the signer's relationship to the patient, and, if necessary, explain why the patient did not sign: ______________________

COMPLETE THE FOLLOWING DOCUMENTATION OF GOOD FAITH EFFORTS IF IT IS NOT POSSIBLE TO OBTAIN A SIGNATURE:

The following good faith efforts were made to obtain a signature:

A signature could not be obtained for the following reasons:



Documented by ______________ (Signature)
______________ (Print Name)

Danbury Office of Physician Services, P.C.

NEWTOWN PEDIATRICS

HOW MAY THIS OFFICE CONTACT YOU?

THIS DOPS OFFICE will make all efforts to accommodate all reasonable requests depending on the communications you have selected below.

*If you opt not to use this form, DOPS may continue to use or disclose health information to remind you about appointments as stated in our **Notice of Privacy Practices**.*

Print Patient Full Name: Danielle Varner ✓ D.O.B.: 1-18-1994

Print Patient Full Name: Michael Varner ✓ D.O.B.: 4-27-1995

Print Patient Full Name: Sophia Pozner ✓ D.O.B.: 01-25-2005

Print Patient Full Name: Noah Pozner ✓ D.O.B.: 11-20-2006

Print Patient Full Name: Arielle Pozner ✓ D.O.B.: 11-20-2006

Please select all that apply.

*An appointment reminder may be left on my voice mail or answering machine: Yes X No ____

*In the event I do not answer the telephone, I authorize this office to disclose my personal health information such as test or laboratory results or medications on the following voice mail or answering machine:

- ☐ **Home phone:** ____
- ☐ **Work Phone:** ____
- ☒ **Cell phone:** (646) 523-6800
- ☐ **DO NOT DISCLOSE ANY PERSONAL INFORMATION ON THE VOICE MAIL/MACHINE**

May your provider or clinical staffs leave a message with your spouse? Yes X No ____

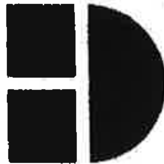
You may disclose the health information to the following people: Lenny Pozner (Father)

Note: If DOPS cannot accommodate your above request, the Office Manager or DOPS Privacy Officer will contact you discuss alternative options.

Signed: [signature] Date: 8/15/2011

Print signature name: Veronique P. Pozner

If not signed by the patient, please indicate your relationship to the patient: Mother



Danbury Visiting Nurse Association
www.danburyvna.org

Record of Influenza Vaccine Administration

Please keep a copy and bring one to your doctor.

DOB: 11.20.06

Name: NOAH SAMUEL POZNER

Influenza vaccine was given on: 10/16/10

☐ **Your child will need a second dose of seasonal flu on or after 28 days from the date listed above. Please check with your doctor or check our website for a flu clinic that is convenient.**

☐ **Your child may need a second dose. Please check with your doctor.**

☑ **Your child does not need any more seasonal flu shots this year.**

Signature

Visit www.SayBoototheFlu.com

Take the Pledge for your Flu Shot & enter the Sweepstakes to win some great prizes including –

GRAND PRIZE Family Trip for Four to Universal Theme Park's Wizarding World of Harry Potter in Orlando, FL !!

Vaccine Administration Record for Children and Teens

Patient name: Pozner, Noah
Birthdate: 11·20·06
Chart number:

Vaccine	Type of Vaccine[1] (generic abbreviation)	Date given (mo/day/yr)	Source (F,S,P)[2]	Site[3]	Vaccine Lot #	Vaccine Mfr.	Vaccine Information Statement Date on VIS[4]	Vaccine Information Statement Date given[4]	Signature/ initials of vaccinator
Hepatitis B[5] (e.g., HepB, Hib-HepB, DTaP-HepB-IPV) Give IM.	Pediarix ✓	2/22/07							
	pediarix ✓	4/5/07							
	✓	10/25/07							
Diphtheria, Tetanus, Pertussis[5] (e.g., DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, DTaP-Hib-IPV, Tdap, DTaP-IPV, Td) Give IM.	Pediarix ✓	2/22/07							
	pediarix ✓	4/5/07							
	✓	5/31/07							
	✓	5/21/08							
***Haemophilus influenzae* type b**[5] (e.g., Hib, Hib-HepB, DTaP-Hib-IPV, DTaP-Hib) Give IM.	✓	2/22/07							
	✓	4/5/07							
	✓	5/31/07							
	✓	12/10/07							
Polio[5] (e.g., IPV, DTaP-HepB-IPV, DTaP-Hib-IPV, DTaP-IPV) Give IPV SC or IM. Give all others IM.	Pediarix ✓	2/22/07							
	Pediarix ✓	4/5/07							
	✓	5/21/08							
Pneumococcal (e.g., PCV, conjugate; PPV, polysaccharide) Give PCV IM. Give PPV SC or IM.	✓	2/22/07							
	✓	4/5/07							
	✓	5/31/07							
	✓	12/10/07							
Rotavirus (Rota) Give oral (po).	✓	2/22/07							
	✓	4/5/07							
	✓	5/31/07							
Measles, Mumps, Rubella[5] (e.g., MMR, MMRV) Give SC.	✓	5/21/08							
Varicella[5] (e.g., Var, MMRV) Give SC.	✓	5/21/08							
Hepatitis A (HepA) Give IM.	✓	12/4/08							
	Hep A ✓	11/15/10	P	LA	AHAVB359A	GSK	3/?/06		[signature]
Meningococcal (e.g., MCV4; MPSV4) Give MCV4 IM and MPSV4 SC.									
Human papillomavirus (e.g., HPV) Give IM.									
Influenza[5] (e.g., TIV, inactivated; LAIV, live attenuated) Give TIV IM. Give LAIV IN.	✓	10/25/07							
	✓	10/31/08							
	✓	12/4/08							
Other	H1N1 (2) 1-15-10 ✓	1/15/10	S	nasal	500830P	Med.	10-2-09		[signature]

1. Record the generic abbreviation for the type of vaccine given (e.g., DTaP-Hib, PCV), not the trade name.
2. Record the source of the vaccine given as either F (Federally-supported), S (State-supported), or P (supported by Private insurance or other Private funds).
3. Record the site where vaccine was administered as either RA (Right Arm), LA (Left Arm), RT (Right Thigh), LT (Left Thigh), IN (Intranasal), or po (by mouth).
4. Record the publication date of each VIS as well as the date it is given to the patient.
5. For combination vaccines, fill in a row for each antigen in the combination.

*Remom H1N1 #1 - around Halloween

Technical content reviewed by the Centers for Disease Control and Prevention, February 2008.

www.immunize.org/catg.d/p2022.pdf • Item #P2022 (2/08)

Distributed by the Immunization Action Coalition • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org

NEWTOWN PEDIATRICS
172 Mt. Pleasant Rd.
Newtown, CT 06470
203-426-2400

PPd

Hgb 10·1 1/22/07

Newtown Pediatrics
172 Mt. Pleasant Road Newtown, CT 06470

Vaccine Consent Form

Name: POZNER, NOAH

Birthdate: 11-20-06

I have read (VIS), or have explained to me, information about diseases and the vaccines listed below. I have had a chance to ask questions and I understand the benefits and risks of the vaccines cited, and ask that the vaccines listed below be given to me or to the person named above (for whom I am authorized to make this request).

DTaP	☐ 1 2 3 4 5	MMR	☐ 1 2
Hepatitis A	☐ 1 2	Pediarix	☐ 1 2 3
Hepatitis B	☐ 1 2 3	Pentacel	☐ 1 2 3
HIB	☐ 1 2 3 4	Pneumococcal	☐ 1 2 3 4
HPV	☐ 1 2 3	PCV 13	☐ 1 2 3 4
Inactivated Flu	☑	Rotarix	☐ 1 2
Intranasal Flu	☐	Rotateq	☐ 1 2 3
IPV	☐ 1 2 3 4	Td	☐
Kinrix	☐	Tdap	☐
Meningococcal	☐	Varicella	☐ 1 2

Parent or Guardian Signature: ____________ Date: 9-14-11

Newtown Pediatrics
172 Mt. Pleasant Road Newtown, CT 06470

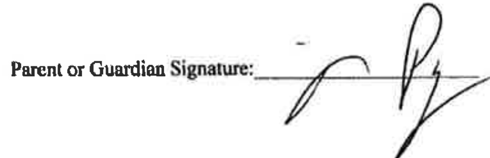
Vaccine Consent Form

Name: POZNER, NOAH

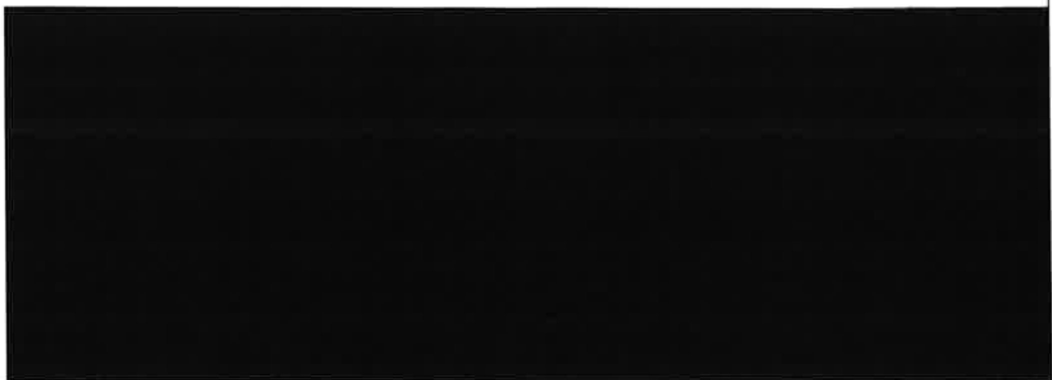
Birthdate: 11-20-06

I have read (VIS), or have explained to me, information about diseases and the vaccines listed below. I have had a chance to ask questions and I understand the benefits and risks of the vaccines cited, and ask that the vaccines listed below be given to me or to the person named above (for whom I am authorized to make this request).

DTaP	☐ 1 2 3 4 5	MMR	☒ 1 ②
Hepatitis A	☐ 1 2	Pediarix	☐ 1 2 3
Hepatitis B	☐ 1 2 3	Pentacel	☐ 1 2 3
HIB	☐ 1 2 3 4	Pneumococcal	☐ 1 2 3 4
HPV	☐ 1 2 3	PCV 13	☒ ① 2 3 4
Inactivated Flu	☐	Rotarix	☐ 1 2
Intranasal Flu	☐	Rotateq	☐ 1 2 3
IPV	☐ 1 2 3 4	Td	☐
Kinrix	☒	Tdap	☐
Meningococcal	☐	Varicella	☒ 1 ②

Parent or Guardian Signature: 

Date: 1-31-11



Newtown Pediatrics
17A Mt. Pleasant Road
Newtown, CT 06470
tel # (203)426-2400
fax # (203)270-0141

Name of Patient Pozner, Noah

Date of Birth 11 · 20 · 06

DATE/ SURGERIES

DATE/ HOSPITALIZATIONS/ ER VISITS/INJURIES

12/09 · [illegible] ER Croup Rx [illegible]

DATE / CONSULTATIONS

State of Connecticut

Early Childhood Health Assessment Record

To Parent or Guardian:

In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Pozner Noah Samuel *Please print*

Name of Child (Last, First, Middle)	Social Security Number	Birth Date	Sex
Pozner Noah Samuel		11-20-06	M

Address (Street): 3 Kale Davis Rd

(Town and ZIP code): Sandy Hook, CT 06482

Race/Ethnicity:
- ☐ American Indian
- ☐ Asian
- ☐ Black, not of Hispanic origin
- ☑ White, not of Hispanic origin
- ☐ Hispanic/Latino
- ☐ Other

Parent/Guardian (Last, First, Middle)	Home Phone Number	Work/Cell Phone Number
Pozner, Leonard	203-426-1121	646-533-1140

Early Childhood Program	Program Phone Number
Childrens Adventure Center	203-426-3018

Primary Health Care Provider	Preferred Hospital	Health Insurance Company/Number* or Medicaid/Number*
Americhoice	Danbury Hosp.	ID: 003 645 [illegible] Group 03100

* If applicable

If your child does not have health insurance, call 1-877-CT-HUSKY

Part I — To be completed by parent

***Important*: Complete Part I before your child is examined.**
Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" answers in the space provided below.)

	Yes	No	
1.	☐	☑	Do you have any concerns about your child's general health, development or behavior?
2.	☐	☑	Has your child been diagnosed with any chronic disease ☐ asthma ☐ diabetes ☐ seizure disorder ☐ other ______
3.	☐	☑	Does your child have any allergies (food, insects, medication, latex, etc.)? Please specify: ______
4.	☐	☑	Does your child take any medications (daily or occasionally)?
5.	☐	☑	Does your child have any problems with vision, hearing or speech (glasses, contacts, ear tubes, hearing aids)?
6.	☐	☑	Has your child had any hospitalization, operation, major illness or injury, or significant accident?
7.	☐	☑	In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
8.	☐	☑	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination?
9.	☑	☐	Has your child had a dental examination in the last 12 months?
10.	☐	☑	Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator?

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

I give permission for release of information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian: [signature] Date: 2-1-11

ED191 REV. 6/2004 C.G.S. Section 10-16q, 10-206, 19a-79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

To be maintained in the child's Health Record

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

POZNER, NOAH	11-20-06	1-31-11
Child's Name	Birth Date (mm/dd/yy)	Date of History/Physical Exam (mm/dd/yy)

LENGTH/HEIGHT	WEIGHT	WT FOR HT/BMI	HEAD CIRCUMFERENCE[1]	BLOOD PRESSURE[3]
41.5 IN/CM %ILE	44 LB/KG %ILE	—— %ILE	—— IN/CM —— %ILE	80/56

Screening/Test Results

Screening Test	Result	Date	Abnormal/Comments
Vision[2] Test type:	20/25 20/25		
Hearing[3] Test type:	PASS		
Lead[4] Risk: Yes/No (No circled)			
TB[4] Risk: Yes/No (No circled)			
Urinalysis (UA)[4]	N/A		
Anemia[5] (HGB/HCT) Risk: Yes/No (No circled)	12.0		
Developmental Assessment[6] Test type:	WELL CHILD		

Has this child received dental care in the last 12 months?[7] ☐ Yes ☐ No ☐ N/A

* **Chronic Disease Assessment:** Yes No — Date of onset

- ☐ ☒ Asthma: ☐ mild ☐ moderate ☐ severe ☐ exercise induced ☐ unclassified ____
- ☐ ☒ Diabetes: ☐ Type I ☐ Type II ____
- ☐ ☒ Anaphylaxis: ☐ med. ☐ food ☐ insect ☐ latex ____
- ☐ ☒ Seizures: Type ____ ____
- ☐ ☒ Other: Please specify ____ ____

Minimum requirements: [1]Up to 2 years; [2]annual at 3 years; [3]annual at 4 years; [4]as needed; [5]9–12 months; [6]each visit through 5 years; [7]annual at 2–3 years.
Federal requirements (eg. Head Start, WIC) may vary.
*Prior to Public School Entry: Same as above and Hgb/hct.

Immunization Record

Vaccine (Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP						
DTP/Hib						
DTaP						
DT/Td						
OPV						
IPV						
MMR						
Measles						
Mumps						
Rubella						
HIB						
Hep B						
Varicella						
PCV					Pneumococcal conjugate vaccine	

(handwritten across table: See attached)

Other Vaccines (Specify)

Disease Hx of above ____ (Specify) ____ (Date mm/yy) ____ (Confirmed by)

Exemption

Religious ____ Medical: Permanent ____ Temporary ____ Date ____

Recertify Date ____ Recertify Date ____ Recertify Date ____

This child has the following problems which may adversely affect his or her educational experience:

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional/Social ☐ Behavior

☐ The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* ____

☐ Yes ☒ No This child has a medical or emotional illness/disorder that now poses a risk to other children or affects the child's ability to participate safely in the program.

☒ Yes ☐ No Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

☒ The child may fully participate in the program.

☒ The child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐ I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider (MD/DO NP PA)	Name (Please type or print.)	Phone number
[signature]	LALAINE HOOTERA, MD	203-426-2400

Address:

☐ Yes ☐ No Is this the child's Medical Home? | Next Appointment (mm/yy): | Next Immunization Appointment (mm/yy):

NEWTOWN PEDIATRICS
172 Mt. Pleasant Rd.
Newtown, CT 06470

3/7/12 - LM that H-A is ready.

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle): Pozner, Noah Samuel
Birth Date (mm/dd/yyyy): 11-20-06
☑ Male ☐ Female

Address (Street, Town and ZIP code): 3 Kale Davis Rd, Sandy Hook CT 06482

Parent/Guardian Name (Last, First, Middle): Pozner Leonard
Home Phone: 203-426-1121
Cell Phone: 646-533-1140

Early Childhood Program (Name and Phone Number): Childrens Adventure Center

Race/Ethnicity:
☐ American Indian/Alaskan Native ☐ Hispanic/Latino
☐ Black, not of Hispanic origin ☐ Asian/Pacific Islander
☑ White, not of Hispanic origin ☐ Other

Primary Health Care Provider: HUSKY

Name of Dentist: Brookfield Family Dental Ad

Health Insurance Company/Number* or Medicaid/Number* [redacted]

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? (Y) N

If your child does not have health insurance, call 1-877-CT-HUSKY

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Item	Answer	Item	Answer	Item	Answer
Any health concerns	N	Frequent ear infections	N	Asthma treatment	N
Allergies to food, bee stings, insects	N	Any speech issues	N	Seizure	N
Allergies to medication	N	Any problems with teeth	N	Diabetes	N
Any other allergies	N	Has your child had a dental examination in the last 6 months	Y	Any heart problems	N
Any daily/ongoing medications	N			Emergency room visits	N
Any problems with vision	N	Very high or low activity level	N	Any major illness or injury	N
Uses contacts or glasses	N	Weight concerns	N	Any operations/surgeries	N
Any hearing concerns	N	Problems breathing or coughing	N	Lead concerns/poisoning	N
Developmental — Any concern about your child's:				Sleeping concerns	N
1. Physical development	N	5. Ability to communicate needs	N	High blood pressure	N
2. Movement from one place to another	N	6. Interaction with others	N	Eating concerns	N
3. Social development	N	7. Behavior	N	Toileting concerns	N
4. Emotional development	N	8. Ability to understand	N	Birth to 3 services	N
		9. Ability to use their hands	N	Preschool Special Education	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

All medications taken in child care programs require a separate Medication Authorization Form signed by an authorized prescriber and parent/guardian.

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian [signature] Date 2-22-12

ED 191 REV. 8/2011 C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2)

Part II — Medical Evaluation

ED 191 REV. 8/2011

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name Pozner, Noah Birth Date 11-20-06 (mm/dd/yyyy) Date of Exam 2-22-12 (mm/dd/yyyy)

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT 3'8 1/2 in/cm ___% *Weight 50 lbs. ___ oz / ___% BMI ___ / ___% *HC ___ in/cm ___% (Birth – 24 months) *Blood Pressure 90 / 50 (Annually at 3 – 5 years)

Screenings

***Vision Screening**

☐ EPSDT Subjective Screen Completed (Birth to 3 yrs)
☐ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/30	20/30

☐ Unable to assess
☐ Referral made to: ______

***Hearing Screening**

☐ EPSDT Subjective Screen Completed (Birth to 4 yrs)
☐ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type: Right ☑ Pass ☐ Fail; Left ☑ Pass ☐ Fail

☐ Unable to assess
☐ Referral made to: ______

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL) ☑ No ☐ Yes

***Result/Level:** *Date

Other:

***TB:** High-risk group? ☑ No ☐ Yes
Test done: ☐ No ☐ Yes Date: ______
Results: ______
Treatment: ______

***Dental Concerns** ☑ No ☐ Yes
☐ Referral made to: ______
Has this child received dental care in the last 6 months? ☐ No ☐ Yes

***Developmental Assessment:** (Birth – 5 years) ☐ No ☐ Yes **Type:**
Results:

*IMMUNIZATIONS

☑ Up to Date or ☐ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ☑ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
If yes, please provide a copy of an Asthma Action Plan
☐ Rescue medication required in child care setting: ☐ No ☐ Yes

Allergies ☑ No ☐ Yes: ______
Epi Pen required: ☐ No ☐ Yes
History/risk of Anaphylaxis: ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☑ No ☐ Yes: ☐ Type I ☐ Type II **Other Chronic Disease:** ______
Seizures ☑ No ☐ Yes: Type: ______

☐ This child has the following problems which may adversely affect his or her educational experience:
☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical ☐ Emotional/Social ☐ Behavior
☐ This child has a developmental delay/disability that may require intervention at the program.
☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* ______

☐ No ☐ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
☐ No ☑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
☐ No ☑ Yes This child may fully participate in the program.
☑ No ☐ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify restrictions)

☐ No ☑ Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Giovanni D. Soriano, M.D. 3-5-12

Signature of health care provider MD / DO / APRN / PA — Date Signed — Printed/Stamped Provider Name and Phone Number

WCMG – PEDIATRICS
22 Old Waterbury Rd.
Suite 204
Southbury, CT 06488
(203) 262-4250

Child's Name: Noah Pozner **Birth Date:** 11/20/06 REV. 8/2011

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year)

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

See Attached

Disease history for varicella (chickenpox) ______ (Date) ______ (Confirmed by)

Exemption: Religious ____ Medical: Permanent ____ †Temporary ____ Date ____

†Recertify Date ________ †Recertify Date ________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

CS	3-5-12	WCMG - PEDIATRICS 22 Old Waterbury Rd. Suite 204 Southbury, CT 06488
Initial/Signature of health care provider (MD) / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number

Message
left message school form done via Rosa

Results/Data

Plan
1 POC HEMOGLOBIN 85018 Status: Complete Done: 31Jan2011 03:38PM
2 Kinrix Suspension; INJECT 0.5 ML Intramuscular; Dose: .5ml; Route: Intramuscular; Site: Left Upper Arm; Status: Complete; Done: 31Jan2011 03:28PM
3 MMR; INJECT 0.5 ML Subcutaneous; Dose: .5ml; Route: Intramuscular; Site: Right Upper Arm; Status: Complete; Done: 31Jan2011 03:29PM
4 Prevnar 13 Suspension; INJECT 0.5 ML Intramuscular; Dose: 0.5ml; Route: Intramuscular; Site: Left Upper Arm; Status: Complete; Done: 31Jan2011 03:29PM
5 Varicella; INJECT 0.5 ML Subcutaneous; Dose: .5ML; Route: Intramuscular; Site: Right Upper Arm; Status: Complete; Done: 31Jan2011 03:31PM

Signatures
Electronically signed by : LALAINE MORTERA, M.D.; Feb 3 2011 10:37AM (Author)

Western Connecticut Health Network

DANBURY HOSPITAL
NEW MILFORD HOSPITAL

CERTIFICATION OF RECORDS

The Undersigned hereby declares:

1. That said is the person in charge of or an authorized assistant to the person in charge of the Health Information Services Department at Danbury Hospital / New Milford Hospital (circle appropriate hospital).

2. That the attached record is a true and complete copy of the record of

Noah Pozner in said hospital.
(Name of Patient) Newtown Pediatric Records.

3. That: (a) said record was made in the regular course of the business of said hospital; (b it was the regular course of business to make such record at the time of the transactions, occurrences and/or events recorded therein or within a reasonable time thereafter; and (c) said record was kept in the course of regularly conducted business activity.

I am familiar with the mode of preparation of, and have the authority to certify, the facility records. I declare under penalty of perjury that the foregoing is true and accurate.

[signature]
Health Information Services Department

4/3/19
Date

EXHIBIT I

REPORT OF INVESTIGATION

ME-102 (revised 10/08)

M.E. CASE NO. 12-17604

State of Connecticut
OFFICE OF THE CHIEF MEDICAL EXAMINER
11 Shuttle Road, Farmington, Connecticut 06032
(860) 679-3980

DECEASED	Name (First, Middle or Maiden, Last): Noah Pozner	Age: 6	Race: White	Sex: ☒male ☐female
	Last Residence (No.,Street): 37 Alpine Cir	Town: Sandy Hook	State: CT	Zip Code: 06482
INJURY (if any)	Place of Injury: N/A			Date of Injury:
DEATH	Place of Death (No., Street): 12 Dickinson Drive	Town: Sandy Hook		State: CT
	Reported By (Name): Sgt. James Thomas	Affiliation: CT State Police Central District Major Crime		
	OCME Investigator Notified Date Time	OCME Notified Date Time		
	Arrival at Scene Date 12/14/12 Time 1605	Departure from Scene Date 12/14/12 Time 2330	Death Determined By: Paramedic	Date 12/14/12 Time 1100
	Deceased Identified By (Name): CT State Police	Address (Street, Town, State):		
INFORMANT	Other Informants (Names):			

CIRCUMSTANCES OF DEATH (Include when deceased last seen alive and pertinent medical and occupational history)

On 12/14/12 at 1115 hours Sgt. James Thomas of Connecticut Central District Major Crimes informed me that there were at least twenty fatalities at the Sandy Hook Elementary School as a result of a shooting. The extent of the shooting was not known until Dr. Carver assessed the scene and it was reported that there were two child victims at Danbury Hospital and twenty-five at the scene. Once at the scene we generated case numbers for each victim, tagged each victim with a case number, and once positive identifications were made the victims information was appropriately added. All victims were pronounced at the scene on 12/14/12 at 1100 hours by EMS. The following facts and circumstances were provided by police personnel and from personal observation.

EXTERNAL EXAMINATION	Deceased Examined At: Sandy Hook Elementry School	On (Date): 12/14/12

Briefly describe position of body, estimated height & weight, eye color, hair characteristics, scars, tattoos, blemishes, & signs of injury or disease. Note signs of death, including rigor mortis and lividity. In homicides or suspicious deaths, record appearance of clothing.

The body is that of a white male approx. 6 years. Decedent is supine on the floor in classroom eight.

Head hair is dark brown He is clad in a red and black hooded sweat shirt with Batman on the front, black sneakers with red and gray, white socks and underwear. There are two EKG tabs on the upper chest and two on the lower torso.

There are injuries noted to the right lower mouth and chin area.

COUNTY OF HARTFORD
STATE OF CONNECTICUT ss: at Farmington
TRUE COPY OF THE ORIGINAL RECORD 12-17604
DATE 4/9/19
NOTARY PUBLIC
COMMISSION EXPIRES 11-30-22

CERTIFICATION	I certify that I made an external examination of the deceased on the date shown.		
	Date: 12/15/12	Name of Investigator: Louis. Rinaldi ****Typographical Errors Corrected on 12/5/13	Signed: [signature]

STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: 12-17604-Pozner, Noah

Date of Death: **12/14/2012**
County of Death: **FAIRFIELD**

Time of Death: **11:00 AM**
City of Death: **SANDY HOOK**

This is to certify that **H. Wayne Carver, II, M.D., Chief Medical Examiner**, performed a postmortem examination on the body of **Noah Samuel Pozner** at the Office of the Chief Medical Examiner on **12/15/2012** at **8:27 AM.**

EXTERNAL EXAMINATION:

The body is that of a well-developed, well-nourished, preadolescent male. The body is 47 inches tall and weighs 61 pounds.

The body is received clothed in a red Batman sweatshirt, black pants, white underpants, white socks and black athletic style shoes.

Just lateral to the wound tract, in the clothing, a small caliber bullet jacket is recovered. It is inscribed "852".

Internal examination is not performed in keeping with the wishes of the family as expressed to the undersigned through a representative of the funeral home. In addition, all clothing is packaged and placed in the body bag and all disposable personal protective equipment, which is contaminated with blood, similarly packaged and placed in the body bag.

The head is covered with approximate 1 ½" to 2" long straight brown hair. The eyes are light brown. The pupils are mid position and equal. The corneas are clear. The conjunctivae are present. The native teeth are present. Injuries to the face will be described below.

The chest is symmetrical.

The abdomen is flat. The genitalia are those of a preadolescent circumcised male.

The upper extremities show injuries to be described below.

STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: 12-17604-Pozner, Noah

EVIDENCE OF INJURY:

1. There is a gunshot wound to the right shoulder blade 11" from the top of the head and 4" to the right of the posterior midline. It consists of a round hole ¼" in diameter surrounded by a slightly skewed margin of abrasion, which is wider laterally than medially. The gunshot wound passes from right to left and slightly forward. It passes through both chest cavities. Needle aspiration demonstrates hemothorax in both chest cavities, as does X-ray. The wound tract exits through a wound of exit 11" from the top of the head and in the posterior axillary line, ½" from the apex of the axilla and re-enters the arm through a wound of entrance ½" x ¼" with irregular rectangular abrasion and exits the arm through a short wound of exit on the lateral aspect of the ram 12" from the top of the head surrounded by a 1" irregular margin of abrasion. Just lateral to this, in the clothing, a deformed small caliber bullet is recovered.

2. There is a gunshot wound to the extensor aspect of the left thumb consisting of a ¼" round hole surrounded by a roughly round margin of abrasion surrounded by soot deposits, a total of 3" in diameter and powder stipple abrasions a total of 2" in diameter. It passes through the thenar eminence for a distance of ¾" and leaves the thumb through a ½" irregular stellate laceration.

3. There is a gunshot wound across the lower lip and anterior face. There is irregular marginal abrasion on the left corner of the mouth. There is almost complete destruction of the lower lip and a jagged exit 2" in diameter in the anterior portion of the right horizontal ramus of the jaw. X-ray examination reveals no retained projectiles in this wound.

LABORATORY PROCEDURES: Specimens submitted for toxicologic analysis: Cardiac Blood and Vitreous.

ANATOMIC DIAGNOSIS:

GUNSHOT WOUND OF CHEST
    BILATERAL HEMOTHORAX
    RE-ENTRANCE INTO LEFT ARM

GUNSHOT WOUND OF HAND
    INJURY TO SOFT TISSUE
    SOOT DEPOSITS AND POWDER STIPPLING ADJACENT TO WOUND OF ENTRANCE

POSTMORTEM COMPLETED AT: 8:53

STATE OF CONNECTICUT
Office of the Chief Medical Examiner
11 Shuttle Road, Farmington, CT 06032

M.E. CASE NUMBER: 12-17604-Pozner, Noah

CAUSE OF DEATH:

MULTIPLE GUNSHOT WOUNDS

MANNER OF DEATH:

HOMICIDE

This is a true statement of the postmortem findings upon the body of **Noah Samuel Pozner**.

H. Wayne Carver, II, M.D.
Chief Medical Examiner
29 January 2013

COUNTY OF HARTFORD
STATE OF CONNECTICUT ss: at Farmington
TRUE COPY OF THE ORIGINAL RECORD 12-17604
DATE 4/9/19
NOTARY PUBLIC
COMMISSION EXPIRES 11-30-20

Office of the Chief Medical Examiner
State of Connecticut

11 Shuttle Road Farmington, CT 06032
(860) 679-3980

TOXICOLOGY REPORT

DATE OF REPORT: 2/28/2013

LAB NUMBER:	DECEASED:	ME CASE NUMBER:
L12-1851	Noah Samuel Pozner	12-17604

SPECIMENS SUBMITTED BY: Dr. H. Wayne Carver

Sample Type	Amount	Received	Received By	Sample Type	Amount	Received	Received By
Blood, Cardiac	50 mL	12/18/2012	V. Dawson	Vitreous	1 mL	12/18/2012	V. Dawson
DNA Label		12/18/2012	V. Dawson	DNA Label		12/18/2012	V. Dawson

ANALYTICAL FINDINGS

No toxicology analyses were requested.

COUNTY OF HARTFORD
STATE OF CONNECTICUT ss: at Farmington
TRUE COPY OF THE ORIGINAL RECORD 12-17604
DATE 4/9/19
NOTARY PUBLIC
COMMISSION EXPIRES 11-30-22

Unless OCME is notified in writing, specimens and/or evidence retained in this case will be destroyed one year after the date of this report.

EXHIBIT J

VS-4ME 4/04 boxes 12 & 22 corrected as per Father 6-14-13 Leonard Pozner

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF DEATH RW
OFFICE OF THE CHIEF MEDICAL EXAMINER

STATE FILE NUMBER: 2012-07-078033

I HEREBY CERTIFY THAT THIS IS A TRUE COPY OF THE ORIGINAL RECEIVED FOR RECORD;
ATTEST: Debbie A. Aurelia, REGISTRAR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last): Noah Samuel Pozner
2. SEX: [X] MALE [ ] FEMALE
3. ACTUAL OR PRESUMED DATE OF DEATH (MM/DD/YYYY) (Spell Month): December 14, 2012
4. ACTUAL OR PRESUMED TIME OF DEATH: 11:00 AM
5. Age at last birthday: 6
6. Under 1 Year (Mo, Days) / Under 1 Day (Hours, Min):
7. Date of Birth (MM/DD/YYYY): November 20, 2006
8. BIRTHPLACE (City, State or Foreign Country): Danbury, Connecticut
9. RESIDENCE-STATE: Connecticut
10. RESIDENCE-COUNTY: Fairfield
11. RESIDENCE - CITY OR TOWN: Sandy Hook
12. RESIDENCE - STREET AND NUMBER: ~~37 Alpine Circle~~ 3 Kale Davis Road
13. APT NO: -----
14. ZIP CODE: 06482
15. EVER IN US ARMED FORCES? [ ] Yes [X] No
16. MARITAL STATUS AT TIME OF DEATH: [ ] Married [ ] Married but Separated [ ] Widowed [ ] Divorced [X] Never Married [ ] Unknown
17. SURVIVING SPOUSE'S NAME (If wife, give maiden name): -----
18. FATHER'S NAME (First, Middle, Last): Lenny Pozner
19. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last): Veronique Patricia Haller
20. INFORMANT'S NAME: Veronique Pozner
21. INFORMANT'S RELATIONSHIP TO DECEDENT: Mother
22. MAILING ADDRESS (Street and Number, City, State, Zip Code): ~~37 Alpine Circle~~, 3 Kale Davis Road, Sandy Hook, Connecticut 06482
23. IF DEATH OCCURRED IN A HOSPITAL: [ ] Inpatient [ ] ER/Outpatient [ ] Dead on Arrival
24. IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL: [ ] Hospice Facility [ ] Nursing Home [ ] Decedent's Home [X] Other (specify) Public School
25. FACILITY NAME (If not institution, give street & number): 12 Dickinson Drive
26. CITY OR TOWN OF DEATH & ZIP CODE: SANDY HOOK 06482
27. COUNTY OF DEATH: FAIRFIELD
28. METHOD OF DISPOSITION: [X] Burial [ ] Cremation [ ] Donation [ ] Entombment [ ] Removal from state [ ] Other (specify)
29. DISPOSITION (Name of cemetery, crematory, other place): B'nai Israel Cemetery
30. LOCATION: Monroe, Connecticut
31. DATE: 12/17/2012
32. WAS BODY EMBALMED? [ ] Yes [X] No If Yes, Name of Embalmer
33. FUNERAL FACILITY - Name and Address (street, town, state, zip): Abraham L. Green and Son Funeral Home, 88 Beach Rd. Fairfield, Connecticut 06824
34. SIGNATURE OF FUNERAL DIRECTOR OR EMBALMER: Samuel A. Green
35. LICENSE NUMBER of SIGNEE IN BOX 34: 2130
36. M.E. CASE NUMBER: 12-17604
37. DATE PRONOUNCED DEAD (MM/DD/YYYY): 12/14/2012
38. TIME PRONOUNCED: 11:00 AM
39. WAS AN AUTOPSY PERFORMED? [ ] Yes [X] No

CAUSE OF DEATH

40. PART I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

IMMEDIATE CAUSE (Final disease or condition resulting in death) ——> (a) Multiple Gunshot Wounds

Due to (or as a consequence of):

Sequentially list conditions if any, leading to the cause listed on line (a). Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST (b)

Due to (or as a consequence of):

(c)

Due to (or as a consequence of):

(d)

APPROXIMATE INTERVAL ONSET TO DEATH

41. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I.
42. IF FEMALE: [ ] Not pregnant within past year [ ] Not pregnant, but pregnant 43 days to 1 year before death [ ] Pregnant at the time of death [ ] Unknown if pregnant within past year [ ] Not pregnant, but pregnant within 42 days of death
43. DID TOBACCO USE CONTRIBUTE TO DEATH? [ ] Yes [ ] Probably [ ] No [X] Unknown
44. MANNER OF DEATH (Natural, Homicide, Accident, Suicide, Undetermined, Pending): Homicide
45. DATE OF INJURY (Spell Month): December 14, 2012
46. TIME OF INJURY: AM
47. PLACE OF INJURY: School, Primary or Secondary
48. INJURY AT WORK? [ ] Yes [ ] No
49. LOCATION OF INJURY (Street, Apt. #, City or Town, State, Zip Code): 12 Dickinson Dr., Sandy Hook, CT
50. DESCRIBE HOW INJURY OCCURRED: Shooting
51. IF TRANSPORTATION INJURY, SPECIFY: [ ] Driver/Operator [ ] Passenger [ ] Pedestrian [ ] Other specify
52. CERTIFIER: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
H. Wayne Carver, II, M.D.
Certifier Name (type or print) — Certifier signature — Chief Medical Examiner (Title of Certifier) — Dec 15, 2012 (Date Certified)
53. MAILING-CERTIFIER: Office of the Chief Medical Examiner, 11 Shuttle Road, Farmington, CT 06032-1939 (Street) (CITY OR TOWN) (STATE) (ZIP CODE)

THIS CERTIFICATE WAS RECEIVED FOR RECORD ON: December 26, 2012 BY: Debbie A. Aurelia, REGISTRAR

Administrative Purposes

54. DECEDENT'S EDUCATION - Check the box that best describes the highest degree or level of school completed at the time of death: [X] 8th grade or less [ ] 9-12th grade, no diploma [ ] High School Graduate/GED [ ] Some college credit, but no degree [ ] Associate degree [ ] Bachelor degree [ ] Master's degree [ ] Doctorate or Professional degree [ ] Unknown [ ] Not available
55. DECEDENT OF HISPANIC ORIGIN? [X] No, Not Spanish/Hispanic/Latino [ ] Yes, Mexican, Mexican American, Chicano [ ] Yes, Puerto Rican [ ] Yes, Cuban [ ] Yes other Spanish/Hispanic/Latino (specify)
56. DECEDENT'S RACE: [X] White [ ] Black or African American [ ] Asian Indian [ ] American Indian or Alaska Native (Name of the enrolled or principle tribe) [ ] Chinese [ ] Filipino [ ] Japanese [ ] Korean [ ] Vietnamese [ ] Other Asian (specify) [ ] Native Hawaiian [ ] Guamanian or Chamorro [ ] Samoan [ ] Other Pacific Islander (specify) [ ] Other (specify)
57. DECEDENT'S USUAL OCCUPATION: Student
58. KIND OF BUSINESS/INDUSTRY: Elementary School
SOCIAL SECURITY NUMBER: -

THE SEAL OF THE STATE OF CONNECTICUT IS AFFIXED TO CERTIFY THAT THE ABOVE IS A TRUE COPY OF A RECORD FILED WITH THE STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH PURSUANT TO THE PROVISIONS OF THE GENERAL STATUTES OF CONNECTICUT.

Elizabeth Frugale

ELIZABETH FRUGALE
REGISTRAR OF VITAL RECORDS

NOV 14 2018

DATE OF ISSUE