UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

14CV2755
CASE #

ANTON PURISIMA,

PLAINTIFF,

VS.

NEW YORK CITY TRANSIT AUTHORITY and or ("MaBSTOA"); CITY OF NEW YORK ("CITY"); NEW YORK CITY ("MTA"); "LATINA" DOG OWNER ("OWNER OF THE DOG"); (THE "INSTIGATORS"); DOES 1 — 1000; AU BON PAIN STORE #000 723 and or ("LAGUARDIA AUBONPAIN 7224"); LAGUARDIA AIRPORT ADMINISTRATION and or ("LAGUARDIA AIRPORT"); CARE POINT HEALTH; HOBOKEN UNIVERSITY MEDICAL CENTER; K MART STORE 7749; MD AMY CAGGIULA; ST. LUKES EMERGENCY DEPT,

DEFENDANTS.

VERIFIED COMPLAINT FOR:

1. PERSONAL INJURY
2. DISCRIMINATION
3. RETALIATION
4. HARASSMENT
5. INTENTIONAL TORT
6. FRAUD; ATTEMPTED MURDER;
7. INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS;
8. CONSPIRACY TO DEFRAUD;
9. NATIONAL ORIGIN DISCRIMINATION; CORRUPT PRACTICES ACTS;
10. CIVIL RIGHTS ACT VIOLATIONS;
11. (PUBLIC "ACCOMMODATIONS") VIOLATIONS;
12. COVER-UP VIOLATIONS; ETC.,

DEMAND FOR JURY TRIAL

FIRST CAUSE OF ACTION — PERSONAL INJURY AGAINST ALL DEFENDANTS

1. DEFENDANT NEW YORK CITY TRANSIT AUTHORITY and or ("MaBSTOA") IS THE AGENCY and or DEPARTMENT OF THE CITY OF NEW YORK. RESPONSIBLE (AS "MANAGER") OF MTA NEW YORK BUS Q32 BUS, WHERE THE ALLEGED ILLEGAL ACTS HAPPENED.

2. DEFENDANT CITY OF NEW YORK ("CITY") - IS RESPONSIBLE (AS "OWNER") OF MTA NEW YORK CITY BUS Q32 WHERE THE ALLEGED ACTS HAPPENED AS WELL AS DEFENDANT CITY OF NEW YORK ("CITY") AS OWNER OF Q32 MTA BUS ALLOWED THESE ILLEGAL ACTS TO HAPPEN INSIDE ITS MTA Q32 BUS WHEREIN THE ALLEGED DOG-BITE TO PLAINTIFF ANTON PURISIMA'S MIDDLE-RIGHT-FINGER WAS CONDUCTED BY ITS PASSENGERS IN CONSPIRACY WITH ITS CODEFENDANTS HEREIN, PURSUANT TO INFORMATION AND BELIEF, THEREFORE

PLAINTIFF ALLEGES HEREIN.

3. DEFENDANT NEW YORK CITY ("MTA"), IS RESPONSIBLE AS ("A "PLACE AND PROVIDER OF PUBLIC ACCOMMODATIONS") AS WELL AS IS RESPONSIBLE AS AN "AGENCY NAME" THAT MANAGES THE PLACE OF THE INCIDENT OF ITS BUS Q32 ROUTE MTA BUS WHERE THE INCIDENT OF "DOG BITE" TO PLAINTIFF'S MIDDLE RIGHT FINGER HAPPENED ON ITS Q32 BUS, IN CONSPIRACY WITH THE ALLEGED ACTS OF ITS CODEFENDANTS HEREIN. DEFENDANT NEW YORK CITY ("MTA") IS THEREFORE RESPONSIBLE THE SAME ACTS AS ITS CODEFENDANT # ONE (1) HEREIN, (AS "CONSPIRATOR AND INSTIGATOR") OF THESE ILLEGAL ACTS ON ITS Q32 BUS.

4. DEFENDANT "LATINA" DOG OWNER ("OWNER OF THE DOG"), IS RESPONSIBLE AS THE ALLEGED OWNER OF THE DOG THAT BIT PLAINTIFF'S MIDDLE-RIGHT-FINGER ON Q32 NEW YORK CITY MTA BUS ON OCTOBER 2013. DEFENDANT "LATINA" DOG OWNER ("OWNER OF THE DOG") AS OWNER OF THE ALLEGED DOG REFUSED TO PROVIDE INFORMATION ABOUT THE ALLEGED DOG THAT IS INFECTED WITH RUBIES PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN. ON OR ABOUT OCTOBER 2013, DEFENDANT ("OWNER OF THE DOG") IN CONSPIRACY OF HER ALLEGED ("PROTECTOR") and ("INSTIGATORS") CONDUCTED THE ACTS OF HER RUBIES INFECTED DOG TO BITE PLAINTIFF'S MIDDLE-RIGHT-FINGER THAT CAUSES "CUT and BLEEDING" OF PLAINTIFF'S MIDDLE RIGHT FINGER. AFTER THESE ACTS OF DOG-BITE THAT CAUSED BLEEDING BLOOD OF PLAINTIFF'S FINGER, DEFENDANTS HEREIN IN CONSPIRACY WITH THE ("RUBIES INFECTED DOG OWNER") REFUSED TO PROVIDE "THE INFORMATION TO PLAINTIFF "ABOUT HER DOG and EXITED THE ALLEGED Q32 MTA NYC BUS, AS INSTRUCTED BY HER (ALLEGED "HANDLERS") THAT WERE INSIDE THE ALLEGED BUS WITH HER, AND EXITED WITH HER AT 61 ST. STREET and ROOSEVELT AVENUE BUS STOP, THESE ACTS OF DEFENDANTS HEREIN, LEAVING PLAINTIFF WITHOUT THE INFORMATION CAUSED MORE PAIN AND SUFFERING IN ADDITION TO THE ALLEGED DOG-BITE. THESE ACTS OF DEFENDANTS HEREIN CONSTITUTED CAUSE OF ACTION ALLEGED ABOVE, THEREFORE, (CAUSED "PRICELESS DAMAGES")

=PAGE TWO

ACP TO PLAINTIFF HEREIN; THE ALLEGED "OWNER OF THE DOG" IS HEREBY SUED INDIVIDUALLY, HEREIN.

5. DEFENDANTS (THE "INSTIGATORS") and DOES 1—1000, WERE AND (ARE "CONSPIRATORS") AS WELL (AS "INSTIGATORS") OF THESE ACTS ALLEGED, THEREFORE, RESPONSIBLE TO ALL THESE ILLEGAL ACTS ALLEGED HEREIN. THESE WERE and ARE UNNAMED DEFENDANTS HEREIN, FOR THESE, PLAINTIFF ANTON PURISIMA WILL AMEND THIS COMPLAINT IF THESE DEFENDANTS ARE KNOWN TO HIM AS THESE INDIVIDUALS WERE and ARE RESPONSIBLE TO ALL CAUSE OF ACTION AND DAMAGES ALLEGED.

6. PLAINTIFF ANTON PURISIMA, IS (A "FILIPINO-AMERICAN") AS WELL AS (A "PASSENGER OF Q32 MTA BUS," OWNED BY AND OPERATED AND MANAGED BY DEFENDANTS ONE (1) — FIVE (5) (PARAGRAPHS)) HEREIN. PLAINTIFF ANTON PURISIMA'S RACE and NATIONAL-ORIGIN AS A FILIPINO-AMERICAN WAS and IS USED AS BASIS BY DEFENDANTS HEREIN INORDER TO DO THESE ILLEGAL ACTS ALLEGED ABOVE.

7. PLAINTIFF NOTIFIED PARTIES DEEMS RESPONSIBLE PRIOR TO FILING THIS ACTION, EXCEPT THOSE ISSUES THAT PROHIBITED HIM TO ACT. OTHERWISE, PLAINTIFF CONDUCTED ALL ACTS NEEDED IN HIS CASE PRIOR TO FILING THIS ACTION. PLAINTIFF ATTACHED HEREWITH TRUE COPIES OF THE FOLLOWING DOCUMENTS MARKED AS "EXHIBITS," INORDER TO INCORPORATE AND TO SUPPORT ALL CAUSE OF ACTION ALLEGED AND TO SUPPORT ALL HIS STATEMENTS, ARGUMENTS, CAUSE OF ACTION, AND DAMAGES ALLEGED IN THIS ACTION.

8. PLAINTIFF INCORPORATES ALL ATTACHMENTS, ALL EXHIBITS ATTACHED IN HIS "PERSONAL INJURY CLAIM FORM," Dated, notarized, and Filed on JANUARY 08, 2014 WITH THE COMPTROLLER'S OFFICE, NYC.; AND TO SUPPORT THIS ACTION HEREIN, HEREBY INCORPORATES THE ABOVE DOCUMENT HEREIN AS WELL AS TO SUPPORT ALL CAUSE OF ACTION and DAMAGES ALLEGED.

9. PLAINTIFF INCORPORATES THE LETTER DATED: FEB. 09, 2014 NOTARIZED ON: FEB. 10, 2014 and FILED ON: FEB. 12, 2014 and MAILED by and through CERTIFIED MAIL # 7013 2250 0001 5562 7541 ON: FEBRUARY 2014 (MAILED)

HEREIN, AND TO SUPPORT THEREOF.

10. PLAINTIFF INCORPORATES THE LETTER DATED: MAR. 10, 2014, notarized on: MAR. 10, 2014 and filed ON: MAR. 10, 2014 WITH NYC COMPTROLLER'S OFFICE as well as MAILED by and through CERTIFIED MAIL # 7012 2920 0001 9727 7929 ON: MAR. 11, 2014, ADDRESSED TO: INVESTIGATION BUREAU, LAW DEPARTMENT, 10Th. FLOOR, 130 LIVINGSTON STREET, BROOKLYN, NEW YORK 11201. AND TO SUPPORT THEREOF.

SECOND CAUSE OF ACTION — TO TWELVETh CAUSES OF ACTIONS AGAINST ALL DEFENDANTS

11. PLAINTIFF INCORPORATES ALL CAUSES OF ACTION ALLEGED ABOVE HEREIN and TO SUPPORT THEREOF.

12. PLAINTIFF INCORPORATES PARAGRAPHS 1—11 ABOVE.

14. ON OR ABOUT OCTOBER 09, 2013, GOING THROUGH EACH INCIDENT and OR ISSUE ALLEGED HEREIN and CONTINUING TO THE PRESENT TIME, DEFENDANTS HEREIN CONSPIRED THEIR ACTS AND BASIS THEIR CONSPIRACY AGAINST PLAINTIFF ANTON PURISIMA'S RACE, NATIONAL-ORIGIN as a FILIPINO-AMERICAN, PLAINTIFF'S MEDICAL DISABILITY AS WELL AS RETALIATION ACTS DUE TO PRIOR FILINGS OF DISCRIMINATION CHARGES BY PLAINTIFF IN RELATED CASE#09-CV-3502 (NGG)(LB) (PURISIMA VS. TIFFANY ENTERTAINMENT et. al.) and OTHER RELATED CASES HEREIN, AS WELL AS THEREIN IN EACH CASE AND OR DISCRIMINATION FILED AGAINST THESE DEFENDANTS AND THEIR CODEFENDANTS HEREIN. PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN AND THESE ACTS BY DEFENDANTS HEREIN IS CONTINUING THEREFORE, THE DAMAGES TO PLAINTIFF HEREIN IS CONTINUING AS WELL.

15. ON OR ABOUT OCTOBER 09, 2013, AND CONTINUING, DEFENDANTS HEREIN IN CONSPIRACY WITH THEIR CODEFENDANTS IN RELATED CASES THEREIN AS WELL AS INSTRUCTED BY (THEIR "INSTIGATORS") and at CODEFENDANTS HEREIN CONSPIRED THEIR ACTS TO INFLICT RETALIATION AGAINST PLAINTIFF ANTON PURISIMA FOR FILING DISCRIMINATION CASES OR CHARGES AGAINST (THESE "DEFENDANTS") IN THESE RELATED CASES ALLEGED. DEFENDANTS ACTS HEREIN WERE AND ARE BASED ON THE RACE and NATIONAL-ORIGIN OF PLAINTIFF AS FILIPINO-AMERICAN.

ADDITIONAL DEFENDANTS

16. DEFENDANT AU BON PAIN STORE #000723 and/or ("LAGUARDIAAUBONPAIN 722A"), IS RESPONSIBLE AS AN EMPLOYER OF ITS INDIVIDUAL EMPLOYEES IN THE ALLEGED STORE. (THE "ACTS") OF THESE ALLEGED AU BON PAIN EMPLOYEES WERE AND ARE IN CONSPIRACY WITH ACTS TO DEFRAUD PLAINTIFF ANTON PURISIMA HEREIN, (BY "KNOWINGLY OVER-CHARGING") PLAINTIFF OF HIS COFFEE, EVERY-TIME PLAINTIFF BUYS HIS ALLEGED COFFEE IN THAT ALLEGED AU BON PAIN STORE AT LA GUARDIA AIRPORT, NEW YORK. PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN, (THESE "ACTS") DID NOT HAPPEN TO OTHER PATRONS / OR OTHER PEOPLE BUT THESE REPEATED OVER-CHARGING-ACTS-TO-PLAINTIFF'S COFFEE, EVERY-TIME HE BUYS HIS COFFEE ("TWO-TIMES"), OR ("THREE-TIMES") OR MORE EXPENSIVE THAN OTHER PATRONS' COFFEE, COMPARED. PURSUANT TO INFORMATION AND BELIEF, THESE ACTS BY DEFENDANTS HEREIN WERE AND ARE DONE, DUE TO PLAINTIFF ANTON PURISIMA'S RACE and NATIONAL ORIGIN AS FILIPINO-AMERICAN, THESE ACTS BY DEFENDANTS HEREIN WERE CONDUCTED BECAUSE OF PLAINTIFF'S RACE AND NATIONAL ORIGIN

AND DUE TO THESE ALLEGED EMPLOYEES OF DEFENDANT AUBON PAIN TOGETHER WITH OTHER EMPLOYEES AT LAGUARDIA AIRPORT WERE AND ARE CORRUPTED BY (THESE "CHINESE INDIVIDUALS") PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN BY (THESE "AGENTS") OF DEFENDANTS IN CASE # 09-CV-3502 (NGG)(LB) (PURISIMA VS. TIFFANY ENTERTAINMENT, et. al.). THESE ACTS CONDUCTED BY THESE PERSONNEL AT LAGUARDIA AIRPORT AGAINST PLAINTIFF ANTON PURISIMA HEREIN WERE THE CONTINUING RETALIATION ACTS CONDUCTED BY DEFENDANTS IN ALLEGED RELATED CASE THROUGH (THEIR "AGENTS") WHO ACTED (AS "INSTIGATORS") OF THESE ACTS AGAINST PLAINTIFF HEREIN, THEREFORE, THESE DEFENDANTS IN PARAGRAPH # 16 and PARAGRAPH # 17 ALLEGED HEREIN WERE and ARE RESPONSIBLE OF ALL THESE ILLEGAL ACTS AND CAUSE OF ACTION ALLEGED.

17. DEFENDANT LAGUARDIA AIRPORT ADMINSTRATION ("LAGUARDIA AIRPORT") IS RESPONSIBLE AS ALLEGED ABOVE, THEREFORE, RESPONSIBLE TO ALL THESE ILLEGAL ACTS ALLEGED HEREIN and therefore responsible to all these Damages alleged herein as well. Plaintiff incorporates all exhibits attached herewith and Cause of action alleged herein and to support thereof. DEFENDANT HEREIN ("WAS AND IS USED" BY THEIR CODEFENDANTS) IN ALLEGED RELATED CASE TO RETALIATE AGAINST PLAINTIFF HEREIN TO DENY PLAINTIFF OF (SERVICES OF "PUBLIC ACCOMMODATIONS"), EVEN WHEN THE ALLEGED PLACE (IS A PLACE AS WELL AS PROVIDER OF PUBLIC ACCOMMODATIONS PLAINTIFF HEREIN WAS AND IS DENIED, CORRUPTED, HARASSED,

RETALIATED AGAINST OF THESE PUBLIC ACCOMMODATIONS SERVICES ALLEGED ABOVE, DENIED OF SERVICES DUE TO HIM, REFUSED TO GET DRINKS THAT HE PAID FOR, OVER-CHARGED-KNOWINGLY-BY-EMPLOYEES AT LAGUARDIA AIRPORT, HARASSED REPEATEDLY, EVEN WHEN PLAINTIFF REPORTED THE ALLEGED INCIDENTS TO THE AUTHORITIES and THE ADMINISTRATION AT LAGUARDIA AIRPORT, PLAINTIFF HEREIN WAS AND IS DENIED OF SERVICES AND INVESTIGATION AS WELL AS PLAINTIFF HEREIN WAS AND IS INSULTED VERBALLY BY (THE "EMPLOYEES") AT LAGUARDIA AIRPORT. ON OR ABOUT MARCH 2014, PLAINTIFF WAS PLUGGING HIS ELECTRIC (SMALL-RICE-COOKER) OUT-SIDE-ELECTRIC-OUTLET (SAME PLACE WHERE PLAINTIFF CHARGED HIS CLOCK). PLAINTIFF HEREIN WAS STOPPED BY THE OPERATIONS' MANAGER (AIRPORT MANAGER OF LAGUARDIA) TOGETHER WITH HIS EMPLOYEES EMPLOYEES AND ASSISTANTS. ("I HAVE BEEN DOING THESE COOKING FOR MORE OR LESS ONE (1) YEAR, WHY ONLY STOP ME NOW?"). ADDITIONALLY, I WAS ALLOWED BY THE PORT AUTHORITY POLICE ("ALL OF THEM") because I provided my identification and showed these police the alleged rice cooker. That it was safe to cook-rice-on-the-rice-cooker (By just plugging it in "ANY" the "electrical outlet" - inside or outside the building it SAFE) AS WELL (AS "EVERY RESTAURANT INSIDE THE ALLEGED AIRPORT THAT NEEDS RICE IN THEIR RESTAURANT, USED THE SAME RICE-COOKER, "These Restaurants even used 'BIG-RICE-COOKER.'" Pursuant to information and belief, therefore, Plaintiff alleges herein, these Defendants' ACTS herein were and are corrupted and ("instigated") by the alleged "ACTS of RETALIATION and CONSPIRACY" BY THESE ALLEGED "AGENTS" OF DEFENDANTS IN RELATED CASES PENDING IN U.S.D.C., EASTERN DISTRICT OF NEW YORK (EDNY) CASE# 09-CV-3502 (NGG)(LB) (PURISIMA VS. TIFFANY ENTERTAINMENT, et. al.), SEVERAL CASES CONSOLIDATED INTO ONE ABOVE CASE, AS ORDERED, PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGED HEREIN. ADDITIONALLY, PLAINTIFF HEREIN INFORMED THE ALLEGED HONORABLE COURT THAT PLAINTIFF ANTON PURISIMA HEREIN WAS AND IS FOLLOWED

BY THESE ALLEGED "AGENTS" TO PLAINTIFF'S USUAL PLACES HE HANGS-OUT AND PLACES OF BUSINESSES HE GOES TO, LIKE COPY CENTERS, LIBRARIES, BUS STATIONS, CASINOS, TRAIN STATIONS as well as what Buses and or Trains Plaintiff was and is RIDING as well as places Plaintiff herein was and is RESTING, these (alleged "AGENTS") of DEFENDANTS (FROM "THESE PENDING CASES" ALLEGED) KNOWS WHERE PLAINTIFF HEREIN GOES IN CERTAIN TIME and PLACE of any single DAY. Additionally, Plaintiff herein was watching these Chinese individuals (MAN OR A WOMAN, OR TOGETHER (man & woman) that I do not know these individuals were and are taking pictures of myself I could be walking on the street or sitting at Bus Terminals (Bus Stations), at Train waiting Stations, or at Airport waiting area or food court area or T.V. area (waiting area) these Chinese individuals and or combination (Chinese or non-Chinese individuals) were and are taking picture of myself while I was at these alleged Placed of Businesses. These were and are my own PERSONAL OBSERVATION as I was personally watching them actually Taking pictures of myself REPEATEDLY while I was at these above places as well as pursuant to information and belief therefore, plaintiff alleges herein, THESE ALLEGED INDIVIDUALS ABOVE, TAKING PICTURES OF MYSELF WITHOUT MY PERMISSION, WERE and (ARE "AGENTS") OF THESE ALLEGED DEFENDANTS HEREIN AS WELL AS THEREIN FROM THESE PLAINTIFF'S PENDING CASES.

ON OR ABOUT OCTOBER 12, 2013, DURING PLAINTIFF'S MEDICAL SCHEDULED APPOINTMENT AT ST. LUKES EMERGENCY ROOM (E.R.) HOSPITAL, AS SCHEDULED IN FOR PLAINTIFF'S SECOND (2nd.) RUBIES SHOT, PLAINTIFF WAS FOLLOWED FROM THE BUS — TO THE BUS STOP — and TO THE EMERGENCY ROOM ENTRANCE OF ST. LUKES E.R. HOSPITAL, A CHINESE COUPLE TAKING PICTURES OF PLAINTIFF BEFORE GOING INSIDE E.R. ROOM. PLAINTIFF DOES NOT KNOW THESE INDIVIDUALS AND DID NOT PERMIT THESE PEOPLE TO TAKE HIS PICTURES.

18. PURSUANT TO INFORMATION AND BELIEF DEFENDANTS HEREIN ACTED IN CONSPIRACY TO VIOLATE PLAINTIFF'S RIGHTS AS WELL AS DEFENDANTS' ACTS HEREIN WERE AND ARE INTENDED TO RETALIATE AGAINST PLAINTIFF ANTON PURISIMA FOR FILING DISCRIMINATION CHARGE AND OR FOR FILING HIS PRIOR DISCRIMINATION CASES, Related cases herein. Pursuant to information and belief therefore, Plaintiff alleges herein that Plaintiff's (information and "as believed") these acts by Defendants herein were and are conducted only against Plaintiff herein but these Defendants were and are good to others who were and are their own RACE, Pursuant to information and belief therefore alleged herein by Plaintiff Anton Purisima, UPON PLAINTIFF'S INFORMATION AND BELIEF (ALL "PATRONS") WITH THE SAME RACES WITH THESE EMPLOYEES AT LAGUARDIA AIRPORT, INCLUDING THOSE WHO BASICALLY LIVED THERE and are not even "PATRON" RECEIVE GOOD TREATMENTS and given "free food" and free stuff and were allowed to do illegal things but Plaintiff herein and his race were and are treated bad by Defendants herein.

PUNITIVE AND EXEMPLARY DAMAGES

19-A. DEFENDANTS' ACTS OF ALLEGED HEREIN AND THESE DEFENDANTS ACTED WITH MALICE, FRAUD, OR OPPRESSION ENTITLING PLAINTIFF TO PUNITIVE DAMAGES AND EXEMPLARY DAMAGES.

20-A. DEFENDANTS' ACTED AND OR ("ACTS") OF FRAUD, ATTEMPTED MURDER CORRUPTION, AND OTHER INTENTIONAL TORT ACTS, DISCRIMINATION, RETALIATION,

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17. A THE TRUE NAMES AND CAPACITIES SUED AS DOES ARE UNKNOWN TO PLAINTIFF BUT BELIEVED RESPONSIBLE FOR THE ACTS AND DAMAGES ALLEGED.

18. A PLAINTIFF HAS PERFORMED ALL OBLIGATIONS TO DEFENDANTS EXCEPT THOSE OBLIGATIONS PLAINTIFF WAS PREVENTED OR EXCUSED FROM PERFORMING.

19. PLAINTIFF HAS FILED "PERSONAL INJURY CLAIM FORM," ON JANUARY 08, 2014 AS WELL AS FILED (A "BACK-UP") LETTERS TO SUPPORT THE ALLEGED "P.I. CLAIM FORM" ON FEBRUARY 09, 2014 and ON MARCH 10, 2014 PURSUANT TO SECTION 1212 OF THE PUBLIC AUTHORITIES LAW AND SECTION 50-e OF THE GENERAL MUNICIPAL LAW, THEREFORE, PLAINTIFF INCORPORATES THE ABOVE DOCUMENTS HEREIN AND TO SUPPORT THEREOF.

ACP

20. JURISDICTION OF THIS COURT IS BASED ON VIOLATIONS OF PLAINTIFF'S RIGHTS PROTECTED BY UNITED STATES CONSTITUTION, VIOLATIONS OF PLAINTIFF ANTON PURISIMA'S RIGHTS PRESCRIBED UNDER TITLE II OF THE CIVIL RIGHTS ACT 42 U.S.C. SECTION 2000 a et. seq.; AND OR DEFENDANTS' ACTS HEREIN ARE IN VIOLATION OF THE "PUBLIC ACCOMMODATIONS" TITLE II OF THE CIVIL RIGHTS ACT OF 1964, WHEREIN THE LOCATIONS OF THE INCIDENTS ALLEGED HEREIN, THAT SAID LOCATION OWNED AND ADMINISTERED BY DEFENDANTS HEREIN, WHEREIN SUCH PLACE IS A "PLACE and PROVIDER" OF PUBLIC ACCOMMODATIONS," PRESCRIBED UNDER TITLE II VIOLATIONS OF THE CIVIL RIGHTS ACT OF 1964, THAT THESE ACTS HEREIN BY THESE DEFENDANTS WERE AND ARE INSTIGATED BY THE ACTS OF DEFENDANTS IN RELATED CASES ALLEGED ABOVE, THEREFORE, ALL THESE ACTS BY DEFENDANTS HEREIN CONSTITUTED (AS "RETALIATION ACTS AGAINST PLAINTIFF HEREIN"), PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGED HEREIN. THAT THE ALLEGED

INCIDENT HAPPENED WHILE PLAINTIFF HEREIN WAS AND IS (A "PASSENGER") OF DEFENDANTS' MTA BUS Q32, THEREFORE, UNDER "PUBLIC ACCOMMODATIONS," PRESCRIBED UNDER TITLE II OF THE CIVIL RIGHTS ACT OF 1964. AS RETALIATION UNDER TITLE II; VIOLATION UNDER TITLE VI: THESE ACTS BY DEFENDANTS HEREIN VIOLATED PLAINTIFF's RIGHTS GUARANTEED BY THE U.S. CONSTITUTION, PRESCRIBED UNDER 42 U.S.C. SECTION 2000 a-2 AS WELL AS PLAINTIFF's RIGHTS SECURED BY SECTION 2000 a-1 WERE and ARE VIOLATED BY DEFENDANTS' ACTS HEREIN. PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN THESE ACTS BY DEFENDANTS HEREIN CONSTITUTED, ADMITTED ACTS AS WELL AS (THE "ACTS OF VIOLATIONS") TO EVERY CAUSE OF ACTION ALLEGED ABOVE AND DAMAGES ALLEGED HEREIN. THEREFORE, (EVERY "MEANING AND APPLICABILITY") OF EACH CAUSE OF ACTION ALLEGED ABOVE IS TO INCORPORATE HEREIN, TO INCORPORATE and to support to every cause of ACTION alleged by PLAINTIFF ANTON PURISIMA HEREIN. THEREFORE, PLAINTIFF REQUESTS THIS HONORABLE COURT, "SUA SPONTE," TO CITE THE APPLICABLE CASE LAW HEREIN.

STATEMENT OF FACTS

21. PLAINTIFF INCORPORATES PARAGRAPH 1-20 ABOVE.
22. PLAINTIFF INCORPORATES HIS "PERSONAL IN-JURY CLAIM FORM," FILED: JANUARY 08, 2014, and his TWO (2) LETTERS: DATED: FEB. 09, 2014 and DATED: MAR. 10, 2014, HEREIN AND TO SUPPORT THEREOF.
23. ON OR ABOUT OCTOBER 09, 2013, INSIDE MTA Q32 BUS OF DEFENDANTS HEREIN, DEFENDANTS HEREIN CONSPIRED and RETALIATED AGAINST PLAINTIFF ANTON PURISIMA

FOR FILING DISCRIMINATION CASES, COMPLAINTS AND OR FOR FILING DISCRIMINATION CHARGE AGAINST DEFENDANTS IN HIS PRIOR CASES ALLEGED, DEFENDANTS HEREIN USED THE ACTS ALLEGED ABOVE TO VIOLATE OR VIOLATED PLAINTIFF's RIGHTS ALLEGED. DEFENDANTS' ACTS HEREIN (AS "INSTIGATED") BY THE ACTS OF CONSPIRACY WITH THEIR CODEFENDANTS IN RELATED CASES ALLEGED ABOVE CONSTITUTED PAIN AND SUFFERING, LOST TIME, ATTEMPTED MURDER, FRAUD, DISCRIMINATION, DISCRIMINATION TO NATIONAL ORIGIN, CONSPIRACY TO DEFRAUD, RETALIATION, VIOLATIONS OF TITLE II OF CIVIL RIGHTS ACT OF 1964, VIOLATION OF PLAINTIFF's MEDICAL DISABILITY, PERSONAL INJURY TO PLAINTIFF's PERSON, HARASSMENT, INTENTIONAL TORT, CORRUPT PRACTICES ACT, INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS, CIVIL RIGHTS ACT VIOLATIONS, PUBLIC ACCOMMODATIONS VIOLATION, COVER-UP VIOLATIONS, 440 CIVIL RIGHTS VIOLATIONS, THESE ACTS BY DEFENDANTS WERE and ARE CONSOLIDATED INTO ALLEGED DOG-BITE WITH RABIES INFECTED DOG IN CONSPIRACY BY DEFENDANTS HEREIN TO TRAINED AND ALLOWED THE RABIES INFECTED DOG TO BITE PLAINTIFF's MIDDLE RIGHT FINGER, INSIDE NYC, MTA Q 32 BUS, BY (THESE "SKILLFUL ACTS") OF DEFENDANTS HEREIN, PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN. DUE TO THESE ACTS BY DEFENDANTS HEREIN AGAINST PLAINTIFF ANTON PURISIMA, CAUSED DAMAGES TO PLAINTIFF's RIGHTS THAT IS "PRICELESS," CANNOT BE REPAIRED BY MONEY THEREFORE PRICELESS.

PRAYER

24. THUS, PLAINTIFF PRAYS FOR:

1. PLAINTIFF'S DAMAGES IN APPROXIMATE AMOUNT OF: TWO THOUSAND DECILLION DOLLARS ($2,000,000,000,000,000,000,000,000,000,000,000,000.00 XX);
2. PUNITIVE AND EXEMPLARY DAMAGES;
3. INJUNCTIVE RELIEF — TBA;
4. COSTS OF SUIT INCLUDING ATTORNEYS FEES;
5. SUCH OTHER RELIEF AS THE COURT DEEMS PROPER.

ACP DATED: APRIL 10, 2014.
NEW YORK, NEW YORK.

RESPECTFULLY SUBMITTED,

ANTON PURISIMA,
PLAINTIFF PRO SE
390 9TH AVENUE,
NEW YORK, NEW YORK 1000.
E-MAIL:

ACP

DONATION

25. PLAINTIFF HEREBY DONATING FORTY-FIVE-PERCENT (45%) OF THE PROCEEDS OF HIS CASE HEREIN TO HIS COUNTRY, THE UNITED STATES OF AMERICA (U.S.A.), AS A GUARANTEE TO PROTECT THE FUNDAMENTAL RIGHTS OF ALL AMERICANS, AND INORDER TO STRENGHTEN AND EQUIP THE U.S. ARMED FORCES AS WELL AS FOR RESEARCH EXPENSES FOR U.S. MILITARY.

DATED: APRIL 10, 2014
NEW YORK, NEW YORK.

RESPECTFULLY SUBMITTED,

ANTON PURISIMA,
PLAINTIFF, PRO SE
DONOR

ATTACHED EXHIBITS TO INCORPORATE IN THIS ACTION

26. PLAINTIFF INCORPORATES THE ATTACHED EXHIBITS AND TO SUPPORT EVERY CAUSE OF ACTION ALLEGED HEREIN AND TO SUPPORT EVERY PAGE IN THIS ACTION, IN PLAINTIFF'S CASE.

A. PICTURE OF THE WOUND OF THE ALLEGED DOG-BITE OF PLAINTIFF'S MIDDLE-RIGHT-FINGER. This Picture was taken by Cell-phone on OCTOBER 09, 2013, after the alleged Dog-Bite and was sent by E-MAIL TO PLAINTIFF'S E-MAIL @ acpurisima@HOTMAIL.COM. With Document information of the alleged

DOG BITE INCIDENT ON OCTOBER 09, 2013.
MARKED AS EXHIBIT "ONE" other clearer picture attached to "Personal Injury Claim form" filed on Jan. 08, 2013.

B. formerly lost letter, (I found it).
Letter dated: February 19, 2014 "notice to appear for oral examination," from new York City Transit Authority, LAW Department.
MARKED AS EXHIBIT "TWO."

C. Letter dated: March 10, 2014, " from Plaintiff Anton Pricima.
MARKED AS EXHIBIT "THREE"

D. Personal Injury claim form, filed on January 08, 2014, completed with attachments when filed as well as mailed but the "Law Department of NYC, MTA returned the alleged Document without the attachments. Plaintiff herein is hereby filing this "Incomplete - Returned 'PERSONAL INJURY CLAIM FORM,'" as exhibit in this action.
MARKED AS EXHIBIT "FOUR"

E. Letter, dated: February 09, 2014 from Plaintiff Anton Pricima. "response to Jan. 17, 2014 letter.
MARKED AS EXHIBIT "FIVE."

F. EMERGENCY ROOM, medical record of Plaintiff (ROOSEVELT) ST. LUKE'S E.R. (Instructions after the E.R. Visit at St. Luke's) on OCTOBER 09, 2013 (DOG-BITE, INCIDENT). The alleged attachments Documents to "personal Injury claim form," is hereby marked at EXHIBIT "SIX" HEREIN, FILED ON JAN. 08, 2014.

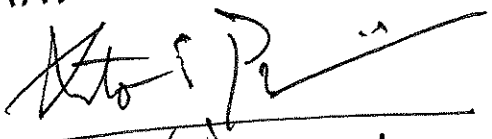
AP

VERIFICATION

THE MATTERS STATED IN VERIFIED COMPLAINT ARE TRUE EXCEPT THOSE MATTERS WHICH ARE STATED ON INFORMATION AND BELIEF AND AS TO THOSE MATTERS, I BELIEVED THEM TO BE TRUE.

I DECLARE UNDER PENALTY OF PER-JURY UNDER THE LAWS OF THE STATE OF NEW YORK THAT THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF, AND THAT THIS DECLARATION WAS EXECUTED ON MARCH 26, 2014, IN THE CITY OF NEW YORK, NEW YORK.

DATED: APRIL 10, 2014
NEW YORK, NEW YORK.

BY: 

ANTON DURISIMA,
PLAINTIFF, PRO SE

ACP

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ADDITIONAL PARTIES

27. DEFENDANT CARE POINT HEALTH, IS (THE "OWNER" and 'ADMINISTRATOR") THAT MANAGES DEFENDANT HOBOKEN UNIVERSITY MEDICAL CENTER (HOBOKEN UMC). PURSUANT TO INFORMATION AND BELIEF, THEREFORE, PLAINTIFF ALLEGES HEREIN THAT DEFENDANT ("CARE POINT HEALTH") WAS AND IS A PARTY IN (ALL "THESE ACTS") BY DEFENDANTS HEREIN, PARTICIPATED THEREFORE IN EVERY CONSPIRACY TO THE ALLEGED "DOG-BITE-TO-PLAINTIFF's-MIDDLE-RIGHT-FINGER-BY-RABIES-INFESTED-DOG," OWNED BY DEFENDANTS HEREIN BECAUSE (EACH "ACT" IS THE ACTS OF ALL DEFENDANTS HEREIN DUE TO (THESE "CONSPIRACY ACTS") BY DEFENDANTS IN THIS ACTION, THEREFORE, DEFENDANT CARE POINT HEALTH IS RESPONSIBLE TO ALL THESE CAUSE OF ACTION, AND DAMAGES ALLEGED.

28. DEFENDANT HOBOKEN UNIVERSITY MEDICAL CENTER, IS AN EMERGENCY ROOM ACTED AS (A "PLACE AND PROVIDER") OF PUBLIC ACCOMMODATIONS AS MEDICAL FACILITY THAT PLAINTIFF HEREIN SEEKED HELP FOR HIS PAINS IN HIS RIGHT ARM AND HIS BODY AS WELL AS HIS SWOLLEN RIGHT-ELBOW AND SO MUCH PAIN AS WELL, DUE TO DOG-BITE ON OR ABOUT OCTOBER 09, 2013 "BY THE RABIES INFESTED DOG." DEFENDANT HOBOKEN UNIVERSITY MEDICAL CENTER AS WELL DID NOT ADDRESS THE MAIN ISSUES OR CONCERNS OF PLAINTIFF IN GOING TO DEFENDANTS' EMERGENCY ROOM (E.R.) OCT. 14, 2013 THAT PLAINTIFF HEREIN WAS GIVEN TWO (2) SHOTS (TWO IN-JECTIONS) DURING HIS SCHEDULED APPOINTMENT ON OCTOBER 12, 2013 AT ST. LUKES EMERGENCY ROOM (HIS SECOND SHOT FOR RABIES TREATMENT). DEFENDANT ("HOBOKEN, UMC") HEREIN ACTED (AS "CORRUPTOR") and as well (AAS "INSTIGATOR") OF THESE ILLEGAL ACTS CONDUCTED BY ITS EMPLOYEES THEREIN AGAINST PLAINTIFF ANTON PURISIMA, PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN THESE ACTS BY DEFENDANTS HEREIN WERE AND (ARE "INSTIGATED") BY (THE "AGENTS") OF DEFENDANTS IN (RELATED "CASES") HEREIN, THEREFORE THESE DEFENDANTS FROM THESE ALLEGED RELATED

CASES INTO THIS ACTION. THEREFORE, DEFENDANT HOBOKEN UNIVERSITY MEDICAL CENTER (HOBOKEN "UMC") IS RESPONSIBLE IN THE ACTS OF CONSPIRACY, CORRUPTION ATTEMPTED MURDER, (AND "OTHER ILLEGAL ACTS ALLEGED"), TOGETHER WITH ITS CODEFENDANTS HEREIN. THEREFORE, RESPONSIBLE TO ALL THESE CAUSE OF ACTION AND DAMAGES ALLEGED IN THIS CASE.

29. DEFENDANT KMART STORE 7749, IS A COMPANY STORE WHO SELLS KNOWINGLY DEFECTIVE PUSH-CART TO PLAINTIFF ANTON PURISIMA IN CONSPIRACY AS INSTIGATED BY THE ACTS OF "AGENTS" OF DEFENDANTS IN RELATED CASE #09-CV-3502 (NGG)(LB) (PURISIMA VS. TIFFANY ENTERTAINMENT, et. al.) PENDING BEFORE THE U.S. DISTRICT COURT IN BROOKLYN, NEW YORK, PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN. (THESE "SELLING INCIDENTS") TO PLAINTIFF HEREIN IN CONSPIRACY BY (THE "ACTS") OF DEFENDANTS HEREIN IN THE FORM OF OR THROUGH ACTS OF RETALIATION and DISCRIMINATION AGAINST PLAINTIFF HEREIN BY AND THROUGH (THE "EMPLOYEES OF DEFENDANT KMART STORE 7749") AS INSTIGATED BY THE ALLEGED "AGENTS" OF DEFENDANTS IN THE ALLEGED RELATED CASE TO CONDUCT THESE ACTS OF RETALIATION, HARASSMENT, DISCRIMINATION, DISCRIMINATION TO NATIONAL ORIGIN OF PLAINTIFF AS FILIFINO-AMERICAN, PUBLIC ACCOMMODATIONS VIOLATION OF PLAINTIFF'S RIGHTS TO DEFENDANTS' PLACE and (at "a PROVIDER") OF PUBLIC ACCOMMODATIONS OBLIGATIONS TO PLAINTIFF BY DEFENDANTS HEREIN WERE AND ARE VIOLATED THROUGH CONSPIRACY AND RETALIATION ACTS INSTIGATED BY DEFENDANTS HEREIN AND THEIR CODEFENDANTS IN THE ALLEGED RELATED CASE ABOVE AGAINST PLAINTIFF ANTON PURISIMA HEREIN, PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN. FOR THESE REASON, DEFENDANT KMART STORE IS RESPONSIBLE TO ALL THESE ACTS ALLEGED, ALL CAUSE OF ACTION ALLEGED HEREIN, THEREFORE, RESPONSIBLE TO ALL DAMAGES ALLEGED BY PLAINTIFF IN THIS ACTION. ADDITIONALLY, (THESE "ACTS") OF DEFENDANTS HEREIN WERE AND ARE PART (OF "GLOBAL CONSPIRACY") TO SELL KNOWINGLY DEFECTIVE PRODUCTS TO ALL AMERICANS and to EVERY COUNTRY AROUND THE WORLD THAT SUPPORTED AMERICAN ENTEREST OR SUPPORTED THE U.S.A., INORDER TO

DAMAGE THESE COUNTRIES AND ITS PEOPLE, PURSUANT TO INFORMATION AND BELIEF THEREFORE ALLEGED HEREIN. THIS (ALLEGED "DEFECTIVE PUSH-CART") PRODUCT SOLD TO PLAINTIFF HEREIN (AND "REFUSED TO CHANGE OR REFUND") CONSTITUTED (AS "ACTS") OF FRAUD, CORRUPTION, CONSPIRACY AS WELL AS DEFENDANTS (HEREIN "USED THE RACE, and NATIONAL-ORIGIN" OF PLAINTIFF) HEREIN AS THEIR BASIS TO CONDUCT THESE ACTS OF DISCRIMINATION AGAINST PLAINTIFF ANTON PURISIMA IN DEFENDANTS' PLACE OF BUSINESS AS (A "PLACE AND PROVIDER") OF PUBLIC ACCOMMODATIONS UNDER TITLE II OF THE CIVIL RIGHTS ACT OF 1964 (THE "ACT"), WERE AND ARE VIOLATED BY THESE ALLEGED ACTS BY DEFENDANTS HEREIN. THIS ALLEGED INCIDENT WAS INITIALLY FILED AT "SMALL CLAIMS COURT," DURING PROCEEDING COURTDATE PLAINTIFF HEREIN ASKED AN ADJOURNMENT INORDER TO TRANSFER PLAINTIFF'S CLAIM TO THIS COURT AS (THE "ALLEGED INCIDENTS" AS WELL AS ACTS OF DEFENDANTS IN THESE INCIDENTS HEREIN WERE AND (ARE "INTERCONNECTED"), INSTIGATED BY THE "AGENTS" OF DEFENDANTS IN RELATED CASE #09-CV-3502 (NGG) (LB) (PURISIMA VS. TIFFANY INTERTAINMENT, et. al.), PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGED HEREIN. THE ACTS OF THESE DEFENDANTS' IN ADDITION TO THE ABOVE AND AS PART OF (THEIR "ACTS OF RETALIATION AND CONSPIRACY TO DAMAGE PLAINTIFF ANTON PURISIMA HEREIN"), DUE TO THESE INCIDENTS THAT KEPT HAPPENING. THESE CONTINUING ACTS OF RETALIATION CONDUCTED BY DEFENDANTS HEREIN AGAINST PLAINTIFF ANTON PURISIMA AS ALLEGED ABOVE AND PURSUANT TO INFORMATION AND BELIEF THEREFORE, PLAINTIFF ALLEGES HEREIN.

DUE TO TIME LIMITATIONS AS WELL AS (THE "STATUTES OF LIMITATIONS") OF THESE INCIDENTS ALLEGED, PLAINTIFF HEREIN IS COMPELLED TO STOP IN THIS ISSUE ("INORDER") TO FILE THIS COMPLAINT, BUT PLAINTIFF HEREIN WILL FILE AN "AMENDED COMPLAINT" HEREIN BY THE TIME HE GATHERED ALL FACTS AND EVIDENCE IN THIS ACTION.

EXHIBIT "FOUR"
for: "P.E. Claim form"
&

EXHIBIT "ONE"
for: COMPLAINT

* Email Communication
w/ Two (2) Pictures
(One is Picture of the Dog - bite - wound, and sheet information about the incident on 10/09/2013).

ACP

Please note: Plaintiff herein incorporates this exhibit to every page of this Complaint.

ACP

Search email | New | Reply | Delete | Archive | Junk | Sweep | Move to | Categories

Folders

Inbox 9106

Junk 64

Drafts 52

Sent

Deleted

New folder

Dog bite report pegny

ruff edward julian

ruff edward julian (ruff_julian@yahoo.com) Ad

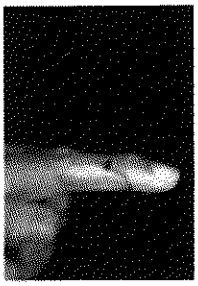
To: acpurisima@hotmail.com

Ruff Julian

Sign up

Already on Facebook?

2 attachments (total 2021.3 Outlook.com Active View



Download Download

View slide show (2) Download all as zip

Sent from Yahoo! Mail on Android

Content from

EXHIBIT "OMG"

EXHIBIT "TWO"

* Letter from: New York City Transit Authority Law Department dated: Feb. 19, 2014

* To incorporate herein.

New York City Transit Authority
Law Department
130 Livingston Street
Brooklyn, New York 11201

NOTICE TO APPEAR FOR ORAL EXAMINATION

February 19, 2014

PURISIMA, ANTON
390 9TH AVENUE
NEW YORK NY 10001

Claim No.: BU 20131009 0035 001

By virtue of the power conferred on the New York City Transit Authority by Sec. 1200 et seq, as amended, of the Public Authorities Law, you are hereby required to appear and be sworn at the Office of the Authority, Room 11127, 130 Livingston Street, Brooklyn New York on March 14 , 2014 at 11 : 00 A M and testify as to all facts relative to the above claim presented by you to the Authority

Martin B. Schnabel
Vice President and General Counsel
By: Wallace D. Gossett
Executive Assistant General Counsel

In order to obtain a prompt disposition of your claim, please bring with you a copy of your doctor's certificate including the date of your last treatment and amount of his bill; X-rays, and X-ray reports; authorization for hospital records; a statement from employer as to salary, and as to lost time and earnings, if any. Also, you must bring proper photo ID and any and all other proof regarding your claim for special damages.

IF AN INTERPRETER IS NECESSARY, THIS OFFICE MUST BE NOTIFIED AT LEAST THREE DAYS PRIOR TO HEARING DATE SCHEDULED ABOVE. Please be advised that failure of your client to appear for this appointment will result in your office being billed for any no-show fees incurred. Any such fee(s) will be deducted from any future settlements paid to dispose of this matter.

Application for adjournment should be made at least one day prior to the date set for the examination. No adjournment may be had except on written stipulation and in the form given below:

For information pertaining to adjournment or interpreter,
Call 718-694-4646

- -

Claim No.: BU 20131009 0035 001 Form of Adjournment
PURISIMA, ANTON

Prepare in duplicate.
Copy will be returned to you.

It is hereby stipulated that the examination of claimant be adjourned from

The Day of , at O'clock M to the

Day of , at O'clock M

With the distinct understanding that such adjournment is without prejudice to the right of the New York City Transit Authority to settle or adjust the claim within the same period of the time after such examination is held as the Authority had at the date fixed originally for such examination, and that no suit may be brought until after the expiration of such period of time.

Dated:

_____
Attorney for Claimant

New York City Transit Authority

By: _____

Exhibit "Two"

EXHIBIT "THREE"

This March 10, 2014, letter

* Plaintiff incorporates herein

ANTON PURISIMA
390 9Th. AVENUE,
NEW YORK, NEW YORK 10001.

MARCH 10, 2014

INVESTIGATION BUREAU;
LAW DEPARTMENT, 10 Th. FLOOR,
130 LIVINGSTON STREET,
BROOKLYN, NEW YORK 11201

RE: ANTON PURISIMA
BU-2013-10-09-0035-001
[APPEARANCES; DAMAGES; THOUROUGH INVESTIGATION
MEDICAL RECORDS; REQUEST FOR POSTPONEMENT;
CONSPIRACY; COVER-UP OF INCIDENT; ETC.]

Dear INVESTIGATION BUREAU and TO WHOM IT MAY CONCERN:
THIS LETTER IS RESPONSE TO NOTICE OF APPEARANCE (& LOST THE ALLEGED LETTER), and if there is appearances Requested in this case, Please take notice of the following:

1. Please take notice, that if there is APPEARANCE NEEDED IN THIS CASE, IT IS TOO SOON TO APPEAR AS THE DOCUMENTS IN THIS CASE ARE NOT COMPLETE AT THIS TIME and some Agencies are still conducting their investigation and or issue regarding the alleged incident therefore, it is too soon;

2. THE Alleged DAMAGES as well is still not computed yet therefore NOT COMPLETE. Please take notice, my Rights (are "PRICELESS") CANNOT BE REPAIRED By MONEY, therefore, PRICELESS;

3. YOUR AGENCY MUST THOUROUGHLY INVESTIGATE

ex. "Three"

THE ALLEGED INCIDENT, and SUBPOENA THE SURVEILLANCE CAMERA AT ROOSEVELT AVENUE CORNER 61ST. STREET STATION (BUS STOP) IN ORDER TO IDENTIFY THE OWNER OF THE ALLEGED DOG THAT YOU ALLOWED INSIDE YOUR MTA Q32 BUS, THAT BIT MY MIDDLE RIGHT FINGER INSIDE YOUR MTA NEW YORK BUS. YOUR OFFICE MUST CONDUCT THIS INVESTIGATION IMMEDIATELY as there are EVIDENCE IN THIS CASE. Additionally, the owner of the alleged DOG Refused to provide the information about the alleged DOG as well as she was protected by another Latino-looking-MALE (HE WAS HOLDING ME, and GOING-in-between her and me) as well as both of these individuals EXITED THE MTA Q32 BUS AT ROOSEVELT AVENUE and 61ST. STREET BUS STOP. INFRONT OF RESTAURANT (METRO KITCHEN), THERE IS SURVEILLANCE CAMERA AT THAT PLACE POINTING TOWARDS (THE "BUS STOP"), Please SUBPOENA THESE SURVEILLANCE CAMERA RECORDS, as there are evidence in this incident as well as my evidence;

4. my medical Records regarding this incident are still incomplete therefore, it is too soon to produce to your office;

5. Please take notice, I am requesting Postponement (to "any") Appearances at this time due to incomplete records as well as still in investigation Process, and YOUR OFFICE must also conduct and Complete the investigation of the alleged incident;

6. It is therefore necessary that your office must thoroughly investigate this DOG Bite INCIDENT as well as these individuals involved therein;

7. Please stop these time consuming correspondence that compelled me to Response;

8. I am therefore waiting for immediate result of your delayed investigation of the above incident.

9. If for any reason you have questions or any concerns to any of the above, please respond through and by E-MAIL AT: ACPURISIMA@HOTMAIL.COM

Very truly yours,

ANTON PURISIMA,
CLAIMANT
390 9TH AVE., NEW YORK, NY 10001.
E-MAIL: ACPURISIMA@HOTMAIL.COM

State of New York
County of New York

Sworn to before me this
10th day of March 2014

MARGARET A. SCHWARTZ
Notary Public, State of New York
Reg. No. 01SC6152068
Qualified in New York County
Commission Expires Aug. 23, 2014

=PAGE THREE OF 3=

EXHIBIT "FOUR"

* P.I. Claim form
filed: Jan. 8, 2014

Plaintiff incorporates herein and to support thereof.

* Returned, but incomplete, NO EXHIBITS (missing) when returned.

BU/3/0109-35

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

New York City Comptroller
Scott M. Stringer

Form Version: NYC-COMPT-BLA-PI1-M

Personal Injury Claim Form

Claim must be filed *in person or by registered or certified mail within 90 days of the occurrence* at the NYC Comptroller's Office, 1 Centre Street, Room 1225, New York, New York 10007. It must be *notarized*. If claim is not resolved within *1 year and 90 days* of the occurrence, you may take legal action to preserve your rights.

TYPE OR PRINT

2014 JAN 13 AM 12:06
CLAIMS SERVICES
RECEIVED FOR PROCESSING

I am filing: [X] On behalf of myself.
[ ] On behalf of someone else. If on someone else's behalf, please provide the following information.

Last Name:	PURISIMA
First Name:	ANTON
Relationship to the claimant:	CLAIMANT

[ ] Attorney is filing.

Attorney Information (If claimant is represented by attorney)

Firm or Last Name:	
Firm or First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	
Tax ID:	
Phone #:	
Email Address:	

2014 JAN 18 PM 4:29

Claimant Information

*Last Name:	PURISIMA
*First Name:	ANTON
Address:	390 9TH. AVENUE
Address 2:	
City:	NEW YORK,
State:	NEW YORK
Zip Code:	10001
Country:	NEW YORK, U.S.A.
Date of Birth.	12/15/1951 Format: MM/DD/YYYY
Soc. Sec. #	570-75-6624
HICN. (Medicare #)	N/A
Date of Death.	NOT APPLICABLE Format: MM/DD/YYYY
Phone:	NONE
Email Address:	ACPURISIMA@HOTMAIL.COM
Occupation:	

City Employee? [ ] Yes [X] No [ ] NA

Gender [X] Male [ ] Female [ ] Other

ATTACHED HEREWITH Exhibits "ONE", "TWO", "THREE", and "FOUR".

ACP

NOTE: There are additional Exhibit that will be provided as soon as possible in addition to the Attached herewit

ACP

EX. "4"

RECEIVED BY CERTIFIED MAIL

* Denotes required field(s).

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

MTA NYC TRANSIT
LAW DEPARTMENT

2014 JAN 13 PM 12:06

RECEIVED
CLAIMS PROCESSING

The time and place where the claim arose

*Date of Incident: 10/09/2013 Format: MM/DD/YYYY

Time of Incident: @ 16:05 Format: HH:MM AM/PM

*Location of Incident: Q32 N/E, BUS # 6903 MTA, NEW YORK CITY TRANSIT, STOPPED @ 61 AT./ROOSVELT (INSIDE MTA BUS # 6903) QUEENS, NEW YORK

Address:
Address 2:
City:
State:
Borough:

***Manner in which claim arose:**

Attach extra sheet(s) if more room is needed.

PLEASE SEE ATTACHED EXHIBITS TO INCORPORATE HEREIN AND TO SUPPORT EVERY STATEMENT MADE BY THE CLAIMANT ANTON PURISIMA.
I WAS ON MTA Q32 BUS # 6903 GOING NORTHEAST FROM MANHATTAN TO QUEENS, NEW YORK ON OCTOBER 09 2013 ON OR ABOUT BEFORE THAT TIME, THE PUPPY DOG ON THE BUS OWNED BY LATINA PASSENGER ON THE BUS WHICH THE HEAD OF THE DOG WAS STICKING-OUT FROM HER BAG THAT SHE WAS CARRYING ON HER LAP BITE MY MIDDLE FINGER OF MY RIGHT HAND WHILE I WAS WALKING ON THE AISLE TO GET-OFF THE NEXT STOP (BUS STOP). MY FINGER WAS BLEEDING FROM THE DOG. THE BUS OPERATOR WAS INFORMED AND CALLED THE POLICE. PARAMEDICS CAME AND THE MTA SUPERVISOR & PROBABLY THE MTA POLICE CAME ALSO. THE DOG-BITE-WOUND WAS SEEN TO THE PARAMEDICS OPERATOR, MTA SUPERVI
I SIGNED THE RELEASE THAT I WILL GO TO HOSPITAL
PLS. SEE: ATTACHED PAGE MARKED AS PAGE TWO-A

The items of damage or injuries claimed are (include dollar amounts):

Attach extra sheet(s) if more room is needed.

UNKNOWN AT THIS BUT WILL PROVIDE IN THE FUTURE, AS SOON AS POSSIBLE
SEE ATTACHED EXHIBITS AS REFERED HEREIN.

RECEIVED BY CERTIFIED MAIL

** Denotes required field(s).*

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Medical Information

1st Treatment Date:	~~0009~~ 10/09/2013 Format: MM/DD/YYYY
Hospital/Name:	ST. LUKES
Address:	1111 AMSTERDAM AVE.
Address 2:	NY, NY 10025.
City:	
State:	(SEE ATTACHED EXHIBITS
Zip Code:	AS REFERENCE)
Date Treated in Emergency Room:	10/09/2013 Format: MM/DD/YYYY

ACP

Was claimant taken to hospital by an ambulance? ○ Yes ⊗ No ○ NA

Employment Information (If claiming lost wages)

Employer's Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	
Work Days Lost:	
Amount Earned Weekly:	

Treating Physician Information

Last Name:	CHRISTOPHER REVERTE, MD
First Name:	
Address:	
Address 2:	
City:	
State:	
Zip Code:	

10/09/2013, 21:4

** Denotes required field(s).*

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

Witness 1 Information

Last Name:	See attached Exhibits to incorporated in this page and for support thereof.
First Name:	
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 2 Information

Last Name:	
First Name:	Same
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 3 Information

Last Name:	
First Name:	Same
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 4 Information

Last Name:	
First Name:	Same
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 5 Information

Last Name:	
First Name:	Same
Address	
Address 2:	
City:	
State:	
Zip Code:	

Witness 6 Information

Last Name:	
First Name:	
Address	Same
Address 2:	
City:	
State:	
Zip Code:	

ACP

** Denotes required field(s).*

New York City Comptroller
Scott M. Stringer

Office of the New York City Comptroller
1 Centre Street
New York, NY 10007

RECEIVED BY
CERTIFIED MA

Complete if claim involves a NYC vehicle

Owner of vehicle claimant was traveling in

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code:

Non-City vehicle driver

Last Name:
First Name:
Address
Address 2:
City:
State:
Zip Code:

2014 JAN 13 AM 12:01
CLAIMS PROCESSING
RECEIVED

Insurance Information

Insurance Company Name:
Address
Address 2:
City:
State:
Zip Code:
Policy #:
Phone #:

Non-City vehicle information

Make, Model, Year of Vehicle:
Plate #:
VIN #:

City vehicle information

Plate #: MTA Q32 BUS #69
(see attached exhibits)

City Driver Last Name:
City Driver First Name:

Description of claimant:

○ Driver ○ Passenger
○ Pedestrian ○ Bicyclist
○ Motorcyclist ☒ Other PASSENGER OF MTA Q32 BUS #6903

***Total Amount Claimed:** "PRICELESS" DAMAGES *Format: Do not include "$" or ",".*

JANUARY 08, 2013
Date

Signature of Claimant ANTON PURISIMA
CLAIMANT

State of New York
County of NY

I, ANTON PURISIMA, being duly sworn depose and say that I have read the foregoing NOTICE OF CLAIM and know the contents thereof: that same is true to the best of my own knowledge, except as to the matter here stated to be alleged upon information and belief, and as to those matters. I believe them to be true.

Signature of Claimant

Sworn before me this day JAN 08 2014

Signature of notary

* *Denotes required field(s).*

EXHIBIT "FIVE"

* Feb. 09, 2014, Plaintiff's letter
* to incorporate herein as well as
to support thereof.

KG

ANTON PURISIMA
390 9Th. AVENUE,
NEW YORK, NEW YORK 10001

7013 2250 0001 5562 7541

FEBRUARY 09, 2014

INVESTIGATION BUREAU
NEW YORK CITY TRANSIT AUTHORITY
130 LIVINGSTON STREET, 10Th. FLOOR
BROOKLYN, NEW YORK 11201

2014 FEB 12 AM 10:16
CENTRAL TRACKING FACILITY
BUR. INFORMATION SYSTEMS
RECEIVED
CITY OF NEW YORK

RE: ANTON PURISIMA
BU-2013-10-09-0035-001
[RESPONSIBLE PARTIES; DEFENDANTS; ("CAPTION") ON THE "NOTICE OF CLAIM"]

Dear INVESTIGATION BUREAU and TO WHOM IT MAY CONCERN
please take notice that this is a response to JANUARY 17, 2014 letter (Certified mail# 7011 1150 0002 4073 1791), received on FEBRUARY 05, 2014.

ATTACHED HEREWITH A COPY OF "RETURN RECEIPT" OF THE ABOVE CERTIFIED MAIL WITH DATE AND SIGNATURE, FOR YOU TO REVIEW.

PURSUANT TO SECTION 1212 OF THE PUBLIC AUTHORITIES LAW and SECTION 50-e OF THE GENERAL MUNICIPAL LAW AS ALLEGED IN YOUR LETTER AS WELL AS THE ALLEGED ("CAPTION") ON THE NOTICE OF CLAIM IS THE FOLLOWING THAT MUST BE INCORPORATED IN THE "NOTICE OF CLAIM" DATED: JANUARY 08, 2014, AS IN ADDITION TO ALREADY ALLEGED THEREI

ANTON PURISIMA,
CLAIMANT/PLAINTIFF,
VS.
NEW YORK CITY TRANSIT AUTHORITY and OR ("MaBSTOA")
CITY OF NEW YORK ("CITY"); NEW YORK CITY ("MTA");

ex. fine

"LATINA" DOG OWNER ("OWNER OF THE DOG");
("THE INSTIGATORS"); DOES 1—100,
DEFENDANTS/RESPONSIBLE PARTIES.

CLAIMANT ANTON PURISIMA INCORPORATES THE ABOVE CAPTION TO (HIS "NOTICE OF CLAIM") DATED: JANUARY 08, 2014, at alleged and pursuant to SECTION 1212 and SECTION 50-e of THE NYC STATUTES.

ATTACHED ARE THE FOLLOWING:

1. COPY OF "RETURN RECEIPT" OF CERTIFIED MAIL # 7011 1150 0002 4073 1791, WITH DATE and SIGNATURE;

2. COPY OF "JANUARY 17, 2014 LETTER," WITH "NOTE," @ UPPER RIGHT CORNER.

IN VIEW OF THE FOREGOING, AND IF FOR ANY REASON / QUESTIONS OR CONCERNS, PLEASE EMAIL @ ACPURISIMA@HOTMAIL.COM

Very truly yours,

ANTON PURISIMA,
CLAIMANT
390 9TH. AVENUE,
NEW YORK, NEW YORK 10001.
E-MAIL: ACPURISIMA@HOTMAIL.COM

State of New York
County of New York

Sworn to before me this
10th day of FEB. 2014

JASMINE J. VADEN
Notary Public, State of New York
Reg. No. 01VA6132291
Qualified in New York County
Commission Expires Aug. 18, 2017

=PAGE TWO of TWO=

New York City
Transit
Authority

130 Livingston Street
Law Department, 10th Floor
Brooklyn, New York 11201

Received: Feb. 05, 2014
By: ANTON PURISIMA
Anton Purisima
Claimant

January 17, 2014

RE: ANTON PURISIMA
BU-2013-10-09-0035-001

ANTON PURISIMA
390 9TH AVENUE
NEW YORK, NY 10001

Dear Sir/Madam:

Pursuant to section 1212 of the Public Authorities Law and Section 50-e of the General Municipal Law the attached Notice of Claim is being returned for the reason(s) stated below:

- o New York City Transit Authority or MaBSTOA is not stated in the caption on the Notice Of Claim.

A Notice of Claim filed against the New York City Transit Authority MUST BE SERVED WITHIN 90 DAYS AFTER THE INCIDENT, be notarized and in writing.

Failure to file a claim in accordance with applicable statutes will result in its automatic disallowance. You may file again within 10 days after receiving this correspondence if you have complied with the 90 day service requirement.

Very truly yours,

E. Maria Landa

Investigation Bureau, (718) 694-3997

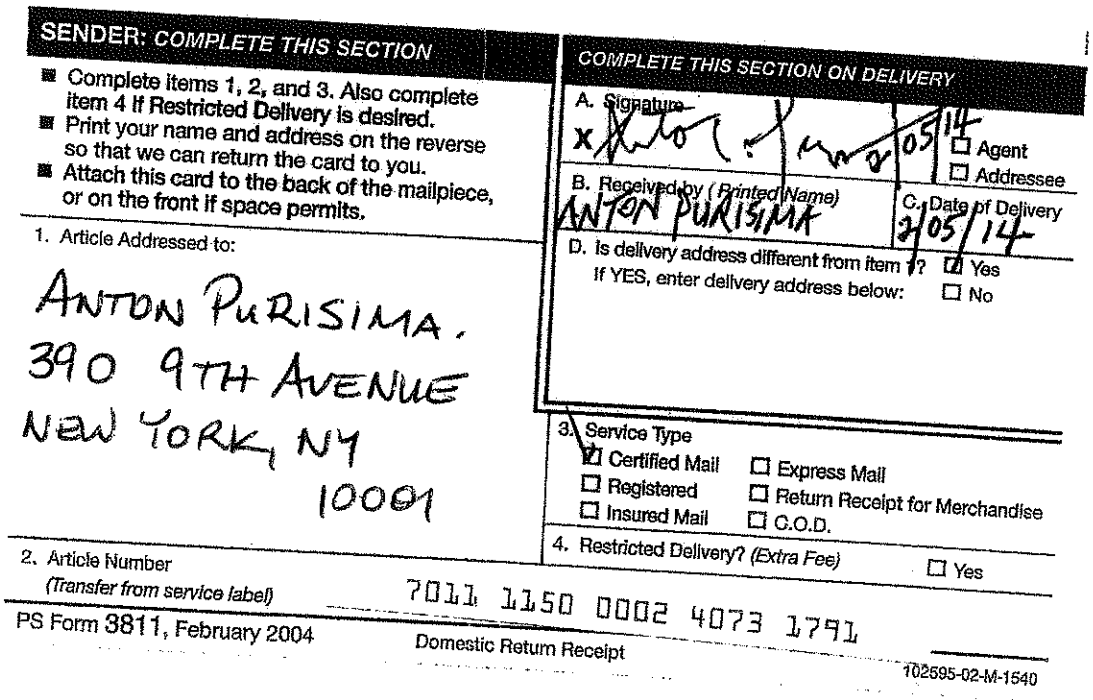
UNITED STATES POSTAL SERVICE

First-Class Mail
Postage & Fees Paid
USPS
Permit No. G-10

• Sender: Please print your name, address, and ZIP+4 in this box •

NEW YORK CITY TRANSIT
AUTHORITY
LAW DEPT. CLAIMS PROCESSING
130 LIVINGSTON STREET - RM 10037E
BROOKLYN, N.Y. 11201-5190

BU 2013-10-09-0035-001 (RER)



SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3. Also complete item 4 if Restricted Delivery is desired.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

ANTON PURISIMA.
390 9TH AVENUE
NEW YORK, NY
10001

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X [signature] 05/14 ☐ Agent ☐ Addressee

B. Received by (Printed Name) ANTON PURISIMA C. Date of Delivery 2/05/14

D. Is delivery address different from item 1? ☑ Yes
If YES, enter delivery address below: ☐ No

3. Service Type
☑ Certified Mail ☐ Express Mail
☐ Registered ☐ Return Receipt for Merchandise
☐ Insured Mail ☐ C.O.D.

4. Restricted Delivery? (Extra Fee) ☐ Yes

2. Article Number (Transfer from service label) 7011 1150 0002 4073 1791

PS Form 3811, February 2004 Domestic Return Receipt 102595-02-M-1540

EXHIBIT "SIX"

* Philadelphia Fire Dept. - EMS
10/17/2013

* Plaintiff incorporates herein and to support thereof.

ALP

PAYMENT MAILED: 12/10/2013

Anton Purisma
390 9th Ave
Ny City NY 10001

Philadelphia Fire Department- EMS
Phone: 888-987-1135

Emergency Medical Services Bill

Statement Date: 11/16/2013

Date of Service: 10/17/2013
Account Number: 17437124
Incident No. 132900145

This invoice is the result of a response for ambulance services on 10/17/2013. If you have insurance, please complete and sign the back of this form, and return to us. Please make sure your name is exactly as it appears on your insurance card. To pay online or update your insurance information, go to www.intermedix.com/billpay. We will file a claim on your behalf. If you do not have insurance, this payment is your responsibility. Please see options below to submit payment. For information or assistance on this account, please call 888-987-1135.

Statement of Account

Emergency Medical Services	**$970.00**
Amount Due:	**$970.00**

****DETACH LOWER PORTIONS AND RETURN STUB WITH YOUR PAYMENT, THANK YOU****

Philadelphia Fire Department
1105 SCHROCK RD SUITE 610
Columbus OH 43229

IF PAYING BY CREDIT CARD, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX

CARD NUMBER	EXP. DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

INCIDENT NO	STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO
132900145	11/16/2013	$970.00	17437124

Make checks payable to: Philadelphia Fire Department- EMS

To pay online, go to www.intermedix.com/billpay

07/12/10 09:30 3 0000033 20131117 IKK54101 ZIR-LTD 1 oz DOM IKK5410000 159903 LD

ANTON PURISMA
390 9TH AVE
NEW YORK NY 10001-9901

Philadelphia Fire Department- EMS
Lockbox 9437
PO Box 8500
Philadelphia PA 19178-9437

6

EXHIBIT "SEVEN"

* This receipt shows that I paid for the coffee but I was not allowed to get my coffee by the employees at Defendant's Au Bon pain Two employees and one supervisor (Fatima). I called the Port Authority police.

The usual coffee that I got was not hot (warm) and dirty (as something was floating on my coffee). "I put my finger in my cup of coffee, in front of supervisor and employee and threw the coffee in their trash. And I got (filled my cup with another brand (morning blend) next to French Roast (my usual coffee). They told me then, I have to pay for it, again. "I threw the second-cup in their trash in front of them," and I told them "I did not get any coffee," by showing my cup (up-side-down) in front of these Au bon pain employees. Then, I watched them replacing their French Roast (display container), by taking it inside," while I waited for the police to arrive. (one African-American female & one white male POLICE came) & reported the incident and told them, "I called the police in order to get on the safe-side, I do not want that "they might say, I took something W/O paying."

AU BON PAIN's Receipt
3-3-2014, 5:03 A.M
@ La Guardia Airport

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

PAID BUT I WAS NOT ALLOWED TO GET A COFFEE, THE COFFEE WAS WORN & THREW, & DIRTY-

Au Bon Pain
STORE #000723
Laguardia Airport
Flushing, NY 11371
Office Catering Specialists 800-765-4227

(& THREW IN TRASH INFRONT OF 3 EMPLOYEES (1 LATINA SUP.)

QUESTIONS - CONCERNS?
Call us at 1 800 TALK ABP
Visit us at our website:
http://WWW.AUBONPAIN.COM

Ticket #2069905
2014-03-03 5:09 AM
000723 10 113 206905

ABP Coffee Refill	1.29
FOR HERE	1.29
Tax	.11
Amount Due	$1.40
CASH	$2.00
Change	$.60

Some like it cold.
Some like it hot.
But everyone likes the price.
$1.99 Espresso drinks. Only at ABP.

Thank you for visiting Au Bon Pain !

I CALLED P.A. POLICE @ 6:16 A.M. TALKED TO MALE WHITE OFFICER & W/ FAMALE (AF. AM. OFFICER) →

7

EXHIBIT "EIGHT"

* NYC, Commission on Human Rights
dated: march 3, 2014

* π_1 filed complaint against Defendant AU BON PAIN on march 03, 2014

* Plaintiff incorporates this document herein and to Documents and HRC support thereof.

The City of New York

COMMISSION ON HUMAN RIGHTS
40 RECTOR STREET, NEW YORK, NY 10006
Dial 311 www.nyc.gov/cchr

PATRICIA L. GATLING
Commissioner and Chair

March 3, 2014

To Whom It May Concern:

This letter is to confirm that Anton Purisima visited our offices today.

Regards,

Laura Flyer
Staff Attorney
Law Enforcement Bureau

EXHIBIT "NINE"

* TD Bank's "Statement of Account" for: TT Anton Puriima herein that shows (the "overcharged charges posted by Defendant Am Bor Pain in Plaintiff's account as alleged by the Bank to Plaintiff herein.

* Plaintiff incorporates this Document in this action as well as to support thereof.

ACP

TD Bank
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7 STATEMENT OF ACCOUNT

ANTON C PURISIMA
300 BLOOMFIELD ST
HOBOKEN NJ 07030

Page: 1 of 3
Statement Period: Dec 18 2012-Jan 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

TD Simple Checking
ANTON C PURISIMA

Account # 426-8713067

YOUR WALLET WOULD SMILE, IF IT COULD.
INTRODUCING OUR NEW TD VISA SIGNATURE REWARDS CREDIT CARDS. CHOOSE TO EARN REWARD POINTS OR CASH BACK - PLUS GET DOZENS OF VISA SIGNATURE PERKS AND DISCOUNTS. APPLY TODAY AT YOUR LOCAL TD BANK. CALL 1-888-561-0608 OR VISIT WWW.TDBANK.COM/SMILE.

ACCOUNT SUMMARY

Beginning Balance
Deposits
Electronic Payments
Other Withdrawals
Service Charges
Ending Balance

Average Collected Balance
Annual Percentage Yield Earned 0.00%
Days in Period 31

	Total for This Period	Total Prior Year
Total Overdraft Fees	$0.00	$20.00
Total Returned Item Fees (NSF)	$0.00	$0.00

DAILY ACCOUNT ACTIVITY

Deposits

POSTING DATE	DESCRIPTION	AMOUNT
	DEPOSIT	
	DEPOSIT	
	Subtotal:	

Electronic Payments

POSTING DATE	DESCRIPTION	AMOUNT
12/26	DEBIT CARD PURCHASE, *****45037774417, AUT 122612 VISA DDA PUR GREYHOUND KIOSK 0549 NEW YORK * NY	38.00
12/27	DEBIT CARD PURCHASE, *****45037774417, AUT 122712 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/7	DEBIT CARD PURCHASE, *****45037774417, AUT 010713 VISA DDA PUR PACIFIC SUPERMARKET EL ELMHURST * NY	2.22
1/14	DEBIT CARD PURCHASE, *****45037774417, AUT 011413 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/14	DEBIT POS, *****45037774417, AUT 011413 DDA PURCHASE USPS 3596280028 NEW YORK * NY	0.45
1/14	DEBIT POS, *****45037774417, AUT 011413 DDA PURCHASE USPS 3596280028 NEW YORK * NY	0.45
1/15	DEBIT POS, *****45037774417, AUT 011513 DDA PURCHASE USPS 3596570057 NEW YORK * NY	3.15

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7 STATEMENT OF ACCOUNT

ANTON C PURISIMA
300 BLOOMFIELD ST
HOBOKEN NJ 07030

Page: 1 of 4
Statement Period: Mar 18 2013-Apr 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

TD Simple Checking
ANTON C PURISIMA

Account # 426-8713067

ACCOUNT SUMMARY

Beginning Balance		Average Collected Balance	
Deposits		Annual Percentage Yield Earned	0.00%
		Days in Period	31
Electronic Payments			
Other Withdrawals			
Service Charges			
Ending Balance			

DAILY ACCOUNT ACTIVITY

Deposits

POSTING DATE	DESCRIPTION	AMOUNT
3/26	DEPOSIT	
3/28	DEPOSIT	
4/8	DEPOSIT	
	Subtotal:	

Electronic Payments

POSTING DATE	DESCRIPTION	AMOUNT
3/18	DEBIT CARD PURCHASE, *****45037774417, AUT 031813 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
3/20	DEBIT CARD PURCHASE, *****45037774417, AUT 032013 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
3/21	DEBIT POS, *****45037774417, AUT 032113 DDA PURCHASE MTA VENDING MACHINES 718 330 1234 * NY	2.75
3/25	DEBIT CARD PURCHASE, *****45037774417, AUT 032513 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
3/28	DEBIT POS, *****45037774417, AUT 032813 DDA PURCHASE MTA VENDING MACHINES 718 330 1234 * NY	2.25
3/29	DEBIT CARD PURCHASE, *****45037774417, AUT 032913 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.44
3/29	DEBIT CARD PURCHASE, *****45037774417, AUT 032913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.28
3/29	DEBIT POS, *****45037774417, AUT 032913 DDA PURCHASE CVS 02457 NEW YORK * NY	1.13
4/1	DEBIT POS, *****45037774417, AUT 040113 DDA PURCHASE BIG APPLE MEAT MARKET NEW YORK * NY	13.63

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7 STATEMENT OF ACCOUNT

ANTON C PURISIMA
300 BLOOMFIELD ST
HOBOKEN NJ 07030

Page: 1 of 4
Statement Period: Jan 18 2013-Feb 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

TD Simple Checking
ANTON C PURISIMA

Account # 426-8713067

ACCOUNT SUMMARY

Beginning Balance		Average Collected Balance	
Deposits		Annual Percentage Yield Earned	0.00%
		Days in Period	31
Electronic Payments			
Service Charges			
Ending Balance			

DAILY ACCOUNT ACTIVITY

Deposits

POSTING DATE	DESCRIPTION	AMOUNT
1/23	DEPOSIT	
2/11	DEPOSIT	
	Subtotal:	

Electronic Payments

POSTING DATE	DESCRIPTION	AMOUNT
1/22	DEBIT CARD PURCHASE, *****45037774417, AUT 012213 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/22	DEBIT CARD PURCHASE, *****45037774417, AUT 012213 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/22	DEBIT CARD PURCHASE, *****45037774417, AUT 012213 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/23	DEBIT CARD PURCHASE, *****45037774417, AUT 012313 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/23	DEBIT CARD PURCHASE, *****45037774417, AUT 012313 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/24	DEBIT CARD PURCHASE, *****45037774417, AUT 012413 VISA DDA PUR HOT AND CRUSTY NEW YORK * NY	3.45
1/24	DEBIT CARD PURCHASE, *****45037774417, AUT 012413 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/25	DEBIT CARD PURCHASE, *****45037774417, AUT 012513 VISA DDA PUR STAPLES 00115741 NEW YORK * NY	8.48
1/25	DEBIT CARD PURCHASE, *****45037774417, AUT 012513 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/28	DEBIT CARD PURCHASE, *****45037774417, AUT 012813 VISA DDA PUR PATHTVM 33RD STREET 800 234 7284 * NY	17.00
1/28	DEBIT CARD PURCHASE, *****45037774417, AUT 012813 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	6.51
1/28	DEBIT CARD PURCHASE, *****45037774417, AUT 012813 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	5.61

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STATEMENT OF ACCOUNT

ANTON C PURISIMA

Page: 3 of 4
Statement Period: Jan 18 2013-Feb 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

DAILY ACCOUNT ACTIVITY

Electronic Payments (continued)

POSTING DATE	DESCRIPTION	AMOUNT
1/28	DEBIT CARD PURCHASE, *****45037774417, AUT 012813 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	3.89
1/28	DEBIT CARD PURCHASE, *****45037774417, AUT 012813 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/28	DEBIT POS, *****45037774417, AUT 012813 DDA PURCHASE CVS 02457 NEW YORK * NY	1.63
1/29	DEBIT CARD PURCHASE, *****45037774417, AUT 012913 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	4.92
1/29	DEBIT CARD PURCHASE, *****45037774417, AUT 012913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	3.79
1/29	DEBIT CARD PURCHASE, *****45037774417, AUT 012913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/29	DEBIT CARD PURCHASE, *****45037774417, AUT 012913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
1/29	DEBIT POS, *****45037774417, AUT 012913 DDA PURCHASE USPS 3596280028 NEW YORK * NY	1.12
2/1	DEBIT CARD PURCHASE, *****45037774417, AUT 020113 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.28
2/4	DEBIT CARD PURCHASE, *****45037774417, AUT 020413 VISA DDA PUR NEW YORK * NY	2.06
2/12	DEBIT POS, *****45037774417, AUT 021213 DDA PURCHASE USPS 3596570057 NEW YORK * NY	0.58
2/13	DEBIT CARD PURCHASE, *****45037774417, AUT 021313 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	5.46
2/14	DEBIT CARD PURCHASE, *****45037774417, AUT 021413 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	1.40
2/15	DEBIT CARD PURCHASE, *****45037774417, AUT 021513 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	1.40
	Subtotal:	

Service Charges

POSTING DATE	DESCRIPTION	AMOUNT
2/15	MAINTENANCE FEE	3.99
	Subtotal:	3.99

DAILY BALANCE SUMMARY

DATE	BALANCE	DATE	BALANCE
1/17		1/29	
1/22		2/1	
1/23		2/4	
1/24		2/11	
1/25		2/12	
1/28		2/13	

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STATEMENT OF ACCOUNT

ANTON C PURISIMA

Page: 3 of 4
Statement Period: Feb 18 2013-Mar 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

DAILY ACCOUNT ACTIVITY

Electronic Payments (continued)

POSTING DATE	DESCRIPTION	AMOUNT
2/25	DEBIT CARD PURCHASE, *****45037774417, AUT 022513 VISA DDA PUR PENN STAT AUBONPAIN 21 NEW YORK * NY	1.40
2/25	DEBIT POS, *****45037774417, AUT 022513 DDA PURCHASE USPS 3508780354 BROOKLYN * NY	0.58
2/28	DEBIT CARD PURCHASE, *****45037774417, AUT 022813 VISA DDA PUR GREYHOUND KIOSK 0549 NEW YORK * NY	38.00
2/28	DEBIT CARD PURCHASE, *****45037774417, AUT 022813 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
2/28	DEBIT POS, *****45037774417, AUT 022813 DDA PURCHASE USPS 3303000401 ATLANTIC CITY * NJ	0.92
2/28	DEBIT POS, *****45037774417, AUT 022813 DDA PURCHASE USPS 3303000401 ATLANTIC CITY * NJ	0.58
3/1	DEBIT CARD PURCHASE, *****45037774417, AUT 030113 VISA DDA PUR THE UPS STORE 6066 ATLANTIC CITY * NJ	0.97
3/4	DEBIT POS, *****45037774417, AUT 030413 DDA PURCHASE MTA VENDING MACHINES 718 330 1234 * NY	2.25
3/5	DEBIT POS, *****45037774417, AUT 030513 DDA PURCHASE CVS 07019 NEW YORK * NY	1.13
3/6	DEBIT POS, *****45037774417, AUT 030613 DDA PURCHASE USPS 3596570057 NEW YORK * NY	0.78
3/7	DEBIT CARD PURCHASE, *****45037774417, AUT 030713 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	3.06
3/7	DEBIT CARD PURCHASE, *****45037774417, AUT 030713 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.28
3/8	DEBIT CARD PURCHASE, *****45037774417, AUT 030813 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	0.99
3/11	DEBIT CARD PURCHASE, *****45037774417, AUT 031113 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.44
3/12	DEBIT CARD PURCHASE, *****45037774417, AUT 031213 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	3.89
3/12	DEBIT POS,	
3/12	DEBIT POS,	
3/12	DEBIT CARD PURCHASE, *****45037774417, AUT 031213 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
3/12	DEBIT POS, *****45037774417, AUT 031213 DDA PURCHASE USPS 3508780354 BROOKLYN * NY	0.80
3/13	DEBIT CARD PURCHASE, *****45037774417, AUT 031313 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38

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7 STATEMENT OF ACCOUNT

ANTON C PURISIMA
300 BLOOMFIELD ST
HOBOKEN NJ 07030

Page: 1 of 4
Statement Period: Feb 18 2013-Mar 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

CONVENIENCE IS A CLICK AWAY.
GET MORE SECURITY, MORE ACCESS TO YOUR STATEMENTS AND LESS CLUTTER WHEN YOU CLICK TO "GO PAPERLESS." NOW YOU CAN VIEW ALL OF YOUR STATEMENTS ISSUED ON OR AFTER APRIL 2010 FROM YOUR ONLINE BANKING ACCOUNT. REVIEW AND SAVE THESE STATEMENTS ANYTIME, AND, GET E-MAIL ALERTS WHEN YOUR NEW STATEMENT IS POSTED. TO LEARN MORE, VISIT WWW.TDBANK.COM/GO-ONLINE

TD Simple Checking
ANTON C PURISIMA

Account # 426-8713067

ACCOUNT SUMMARY

Beginning Balance		Average Collected Balance	
Deposits		Annual Percentage Yield Earned	0.00%
		Days in Period	28
Electronic Payments			
Other Withdrawals			
Service Charges			
Ending Balance			

DAILY ACCOUNT ACTIVITY

Deposits

POSTING DATE	DESCRIPTION	AMOUNT
2/25	DEPOSIT	
2/26	DEPOSIT	
3/11	DEPOSIT	
	Subtotal:	

Electronic Payments

POSTING DATE	DESCRIPTION	AMOUNT
2/19	DEBIT CARD PURCHASE, *****45037774417, AUT 021913 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.78
2/19	DEBIT CARD PURCHASE, *****45037774417, AUT 021913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	1.40
2/19	DEBIT CARD PURCHASE, *****45037774417, AUT 021913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	1.40
2/19	DEBIT CARD PURCHASE, *****45037774417, AUT 021913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	1.40
2/19	DEBIT POS, *****45037774417, AUT 021913 DDA PURCHASE USPS 3596280028 NEW YORK * NY	0.69
2/25		
2/25	DEBIT POS,	
2/25	DEBIT POS, ****	
2/25	DEBIT POS, ****	

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STATEMENT OF ACCOUNT

ANTON C PURISIMA

Page: 3 of 4
Statement Period: Mar 18 2013-Apr 17 2013
Cust Ref #: 1268713067-622-7-###
Primary Account #: 426-8713067

DAILY ACCOUNT ACTIVITY

Electronic Payments (continued)

POSTING DATE	DESCRIPTION	AMOUNT
4/1	DEBIT POS,	
4/1	DEBIT POS, *****45037774417, AUT 040113 DDA PURCHASE MI TIERRA 81 02 NO JACKSON HEIGH * NY	2.33
4/1	DEBIT CARD PURCHASE, *****45037774417, AUT 040113 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.28
4/1	DEBIT CARD PURCHASE, *****45037774417, AUT 040113 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	1.45
4/1	DEBIT POS, *****45037774417, AUT 040113 DDA PURCHASE CVS 02457 NEW YORK * NY	1.13
4/2	DEBIT POS, *****45037774417, AUT 040213 DDA PURCHASE BIG APPLE MEAT MARKET NEW YORK * NY	6.07
4/2	DEBIT CARD PURCHASE, *****45037774417, AUT 040213 VISA DDA PUR CVS PHARMACY 2457 Q03 NEW YORK * NY	4.12
4/3	DEBIT CARD PURCHASE, *****45037774417, AUT 040313 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
4/4	DEBIT CARD PURCHASE, *****45037774417, AUT 040413 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
	DEBIT POS.	
4/8	DEBIT CARD PURCHASE, *****45037774417, AUT 040813 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.07
4/8	DEBIT POS, *****45037774417, AUT 040813 DDA PURCHASE CVS 02457 NEW YORK * NY	1.13
4/10	DEBIT POS, *****45037774417, AUT 041013 DDA PURCHASE MTA VENDING MACHINES BROOKLYN * NY	2.50
4/10	DEBIT CARD PURCHASE, *****45037774417, AUT 041013 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
4/10	DEBIT CARD PURCHASE, *****45037774417, AUT 041013 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	2.16
4/11	DEBIT CARD PURCHASE, *****45037774417, AUT 041113 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
	Subtotal:	

Other Withdrawals

POSTING DATE	DESCRIPTION	AMOUNT
3/21	DEBIT	
	Subtotal:	

Service Charges

POSTING DATE	DESCRIPTION	AMOUNT
4/17	MAINTENANCE FEE	3.99
	Subtotal:	3.99

Call 1-800-937-2000 for 24-hour Bank-by-Phone services or connect to www.tdbank.com

TD Bank
America's Most Convenient Bank®

STATEMENT OF ACCOUNT

ANTON C PURISIMA

Page: 3 of 3
Statement Period: Jun 18 2013-Jul 17 2013
Cust Ref #: 4268713067-622-7-###
Primary Account #: 426-8713067

DAILY BALANCE SUMMARY

DATE	BALANCE	DATE	BALANCE
6/17		7/12	
6/19		7/15	
7/10		7/17	

TD Bank

America's Most Convenient Bank®

7 STATEMENT OF ACCOUNT

ANTON C PURISIMA
300 BLOOMFIELD ST
HOBOKEN NJ 07030

Page: 1 of 3
Statement Period: Jun 18 2013-Jul 17 2013
Cust Ref #: 1268713067-622-7-###
Primary Account #: 426-8713067

TD Simple Checking
ANTON C PURISIMA

Account # 426-8713067

BETTER BILL PAY IS HERE!
PAYING BILLS IS NOW EASIER AND MORE CONVENIENT WITH OUR NEW BILL PAY FEATURES. AND, IT'S STILL FREE! ENJOY MORE CONTROL AND FLEXIBILITY OVER PAYMENT DATES. MAKE NEXT-DAY PAYMENTS UP UNTIL 9:59PM (ET) AND GET E-BILLS POSTED RIGHT IN YOUR BILL PAY ACCOUNT. LOG IN OR SIGN UP TODAY AT WWW.TDBANK.COM/BILLPAY.

ACCOUNT SUMMARY

Beginning Balance	2.24	Average Collected Balance	3.51
Deposits	20.00	Annual Percentage Yield Earned	0.00%
		Days in Period	30
Electronic Payments	14.72		
Service Charges	5.99		
Ending Balance	1.53		

DAILY ACCOUNT ACTIVITY

Deposits

POSTING DATE	DESCRIPTION	AMOUNT
7/10	DEPOSIT	
	Subtotal:	

Electronic Payments

POSTING DATE	DESCRIPTION	AMOUNT
6/19	DEBIT CARD PURCHASE, *****45059885364, AUT 061913 VISA DDA PUR LAGUARDIAAUBONPAIN722A NEW YORK * NY	2.38
	DEBIT POS,	
	DEBIT POS,	
7/12	DEBIT POS, *****45059885364, AUT 071213 DDA PURCHASE USPS 3508780354 BROOKLYN * NY	0.20
7/15	DEBIT CARD PURCHASE, *****45059885364, AUT 071513 VISA DDA PUR KFC 636 BROOKLYN * NY	3.58
7/15	DEBIT CARD PURCHASE, *****45059885364, AUT 071513 VISA DDA PUR JACKS 99 32ND STREET NEW YORK * NY	3.56
	Subtotal:	

Service Charges

POSTING DATE	DESCRIPTION	AMOUNT
7/17	MAINTENANCE FEE	5.99
	Subtotal:	5.99

Call 1-800-937-2000 for 24-hour Bank-by-Phone services or connect to www.tdbank.com

EXHIBIT "TEN"

* The same day treatment to plaintiff's Dog-Bite wound, after he was bitten by that dog-infested with rabies, pursuant to information and belief, therefore, alleged herein by plaintiff.

ACP

ST. LUKES, E.R.

10/09/2013, 21:40

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025

212-523-3335

Take-Home Instructions for the Patient

Patient's Name: Purisima, Anton **Date: 10/09/13 22:08:54**
Medical Record Number: 200004713603 **Date of Service: 10/09/2013 21:36**
Diagnosis:
Emergency Attending Physician: MD CHRISTOPHER REVERTE
Emergency Resident Physician:
Emergency Physician's Assistant:
Emergency Primary Nurse: SIOBHAN DUFFY GIRA, RN
Primary Care Provider: * YOUR PRIVATE PHYSICIAN/CLINIC - PMD

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. For patients receiving imaging studies, (e.g. x-rays), please be advised that all study interpretations are preliminary and are followed by a review and final report. If there is a significant change in interpretation you will be notified.

Referral/Appointment:
Refer Patient To:: * Fast Track (no appointment necessary)
PMD/Clinic not in list: PMD
Phone Number: DO NOT CALL
Follow-up in: 3 days

Call to arrange an appointment ***immediately***, to ensure you get an appointment for follow-up care within the indicated time frame. If for any reason the doctor you have been referred to cannot see you for a follow-up appointment, you can obtain additional referrals at 1-877-463-6362.

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

****

If you smoke, you are encouraged to quit in order to live longer, feel better, and heal faster. Quitting will lower your chance of heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. Please contact the following numbers for additional information:

At St. Luke's: (212) 523-4410 At Roosevelt: (212) 523-6056

****

FINANCIAL ASSISTANCE

If you are uninsured and unable to pay your hospital bill, you may qualify for Financial

St. Lukes Emergency Department
1111 Amsterdam Avenue NY, NY 10025
212-523-3335

****
Return to ER for completion of rabies vaccine in 3 days, 7 days and 14 days from now;
****

NEURO ANTIVERT:
You have been given a prescription for a medication called meclizine (Antivert).

· This medication is used to treat dizziness and vertigo.
· Take this medication as directed.
· DO NOT drink alcoholic beverages while taking this medicine.
· If you become dizzy, sit or lie down at the first signs. You should be careful going up and down stairs.
· DO NOT take it if you are pregnant or planning to get pregnant.
· Keep this medication out of the reach of children. Always keep this medication in child-proof containers. DO NOT give your medication to anyone else.
You have been given a medication, or a prescription for a medication, that causes drowsiness or lightheadedness. DO NOT drive a car, operate machinery, or perform jobs that require you to be alert until you know how you are going to react to this medicine.

THESE INSTRUCTIONS ARE NOT COMPREHENSIVE (complete): Ask your pharmacist for additional information and precautions for this medication.

St. Lukes Emergency Department
1111 Amsterdam Avenue NY, NY 10025
212-523-3335

PAIN NSAID:
You have been given a medication that is considered a non-steroidal anti-inflammatory drug, or NSAID.

· Some common NSAIDS include: Ibuprofen (Advil, Motrin), Naproxen (Naprosyn, Aleve), Celecoxib (Celebrex), and Rofecoxib (Vioxx). There are many others!
· This medication is often used to relieve pain, reduce fever, and reduce inflammation.
· These are common medications; some are over-the-counter and others require a prescription from your doctor.
· DO NOT take this medication if you have stomach ulcers or are sensitive / allergic to it.
· DO NOT take this medication if you are taking other over-the-counter non-steroidal anti-inflammatory drugs. Never take more of the medication than prescribed. Overdosing of medication may cause damage to your kidneys.
· If you have side-effects that you think are caused by this medicine, tell your doctor. If you develop stomach pain, vomit blood, or have bowel movements that become black and tarry, discontinue the medication and notify your physician immediately.
· This medication may upset your stomach. Always take medication with milk or meals.
Keep this medication out of the reach of children. Always keep this medication in child-proof containers. DO NOT give your medication to anyone else.

THESE INSTRUCTIONS ARE NOT COMPREHENSIVE (complete): Ask your pharmacist for additional information and precautions for this medication.

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025

212-523-3335

ANTIBIOTIC PCN AUGMENTIN:
You have been given a an antibiotic in the penicillin class. It treats many kinds of infections including those of the skin, respiratory tract, sinuses, ear, dental and urinary tract.

· DO NOT take this medication if you have an allergy to penicillins or clavulanate or have experienced an unusual allergic reaction to cefaclor, other cephalosporin antibiotics, penicillin, penicillamine, other foods, dyes or preservatives.
· Keep this medication out of the reach of children. Always keep this medication in child-proof containers. DO NOT give your medication to anyone else.
If you develop the following side-effects, you should report them to your doctor as soon as possible and immediately STOP taking the medication:

· Difficulty breathing, wheezing, dizziness, fever or chills, hoarseness or throat swelling, reduced amount of urine, seizures, severe watery or bloody diarrhea, skin rash or itching.
· Stomach pain or cramps, swollen joints, unusual bleeding or bruising, weakness.
IT IS VERY IMPORTANT that you finish all the medication in this prescription, since the medicine is used to treat an ongoing infection in your body.

THESE INSTRUCTIONS ARE NOT COMPREHENSIVE (complete): Ask your pharmacist for additional information and precautions for this medication.

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025
212-523-3335

ANIMAL BITE, RABIES-PRONE:
You have been bitten by, or exposed to, an animal that carries a risk of spreading rabies.

Rabies is a deadly viral infection that causes fever, confusion, and death. Fortunately, it is very rare in the United States. Wild Animals accounted for 93% of reported cases of rabies in 2001. Raccoons continued to be the most frequently reported rabid wildlife species (37.2% of all animal cases during 2001), followed by skunks (30.7%), bats (17.2%), foxes (5.9%), and other wild animals, including rodents and lagomorphs (rabbits and hares) (0.7%). While uncommon, it can also be transmitted by dogs and cats.

Symptoms of rabies include pain or numbness at the bite site, headache, fever, nausea and vomiting, anxiety, agitation, confusion, and problems swallowing.

There is no effective treatment once rabies develops. People who are bitten by animals that can transmit rabies need to be vaccinated, according to the guidelines published by the Centers for Disease Control (CDC). This includes shots the day you sought treatment, as well as returning for vaccinations on days 3, 7, and 14 (which is 3 additional shots). Because untreated rabies is 100% fatal, it is extremely important that you return for the remaining shots. YOU MUST COMPLETE ALL OF THE SHOTS IN ORDER TO BE PROTECTED FROM DEVELOPING RABIES!

The shots that you received today are the first in a series of shots. You must complete the series in order to prevent the development of rabies. It is your responsibility to return for the scheduled series of shots in 3, 7, and 14 days from today. If you have a medical condition associated with a weakened immune system like HIV, you will require a 5th rabies shot 28 days from today in addition.

Keep your wound clean and dry. Wash it twice a day with soap and water. Apply an antibiotic cream (Neosporin or Polysporin) to the wound after you wash it. Cover it with a clean, dry bandage after each washing.

You have been started on antibiotics. Take them as directed. Even if your bite wound does not appear to be infected or clears before the antibiotics are gone, continue the prescription for the entire course. Watch your wound very closely for signs of worsening infection.

Wild animals should be captured and turned over to local health department authorities. DO NOT attempt to capture the animal yourself! Call your local Animal Control authorities. A test can be performed on the animal to determine if it is infected with the rabies virus.

Since the incubation period (time until symptoms develop) for rabies is long, if the animal is a dog or cat, it can be observed for abnormal behavior. If the animal is dead, they will have the animal's brain tested for the rabies virus.

Follow-up is EXTREMELY IMPORTANT for repeat vaccination 3, 7, and 14,days from today. Today is day 0, so day 3 is actually 4 days from today. For example if today is Monday day 3 is Thursday

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Unusual redness or swelling.

· Red streaks starting up the arm or leg.
· Foul drainage or odor from the wound.
· Pain with movement of the extremity and / or swollen lymph glands (nodules found along the neck, groin and armpits).
· Fever, chills, increasing pain and / or swelling.

St. Lukes Emergency Department
1111 Amsterdam Avenue NY, NY 10025
212-523-3335

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YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Unusual redness or swelling.

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025
212-523-3335

HYPERTENSION:
You have been diagnosed with elevated blood pressure (>140/90).

The medical term for high blood pressure is hypertension. Many people feel anxious or uncomfortable about being at the hospital. If you feel anxious today, this could make your blood pressure appear high, even if your blood pressure is usually normal. Check your blood pressure several more times when you are not feeling stress. Keep a record of these readings and give this information to your regular doctor. He or she will decide whether you have hypertension that requires medical treatment.

You should call your physician this week to schedule an appointment to recheck your blood pressure. If you do not have a primary care physician please call 1-800-420-4004 Monday through Friday 9:00AM to 5:00PM for a referral.

If your blood pressure becomes extremely high all of a sudden, you will probably notice symptoms. In fact, very high blood pressure is a medical emergency. Most people with hypertension have blood pressure that is only a little too high. Mild high blood pressure does not cause specific symptoms. Instead, the effects of hypertension develop slowly over time. Untreated hypertension can affect the heart, brain, kidneys, eyes, and blood vessels. Unfortunately, by the time side-effects become noticeable, the body has already been damaged. This is why hypertension is called "the silent killer"!

It is important to follow up with your regular doctor. Check your blood pressure several times in the next 1-2 weeks and tell your doctor about the results. It may be helpful to keep a log or a journal where you can write down your blood pressures, noting the time of day and the activity you were doing when the reading was taken.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Headache.
- Chest pain.
- Shortness of breath or problems breathing.
- Weakness, especially on only one side of the body.
- Any other worsening symptoms or concerns.

EmSTAT Report of Home Medications, Medications Given and Medications Prescribed

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department 212-523-3335

Name: **Purisima, Anton** Sex: M
MR #: 200004713603 Account #: 000485977243
DOB: 15-Dec-1951 Age: 61 Weight:
Chief Complaint: **Dog Bite**
Prim Diagnosis:
ED Physician: **REVERTE, CHRISTOPHER - Emergency Medicine**
PCP: *** YOUR PRIVATE PHYSICIAN/CLINIC**

Our records indicate that at the time of discharge you are taking these medications. Please share this list with the physician providing your follow-up care

Allergies:

NKDA

Home Medications

Recorded by CHRISTOPHER REVERTE, MD - 10/09/2013 21:40

Medication/Route/Dose/Frequency	Last Dose	Disposition	PCP Contacted
Meclizine oral		Continue/Stop	No
Comment:			
Ibuprofen oral		Continue/Stop	No
Comment:			
Tylenol oral		Continue/Stop	No
Comment:			

Medications Given in ED

No Medications Given

Medications Prescribed by ED Physician

Medication Name/Dose/Route	Time Prescribed	Prescribed By
Augmentin 875 mg-125 mg Tab Sig: one tablet PO bid Dispense: Fourteen (14)	10/09/2013 21:57	CHRISTOPHER REVERTE, MD
Meclizine 25 mg Chewable Tab Sig: 1 po TID prn, vertigo (spinning sensation Dispense: *15*	10/09/2013 21:57	CHRISTOPHER REVERTE, MD
Ibuprofen 400 mg Tab Sig: 1 q 6 hr prn Dispense: 30	10/09/2013 21:57	CHRISTOPHER REVERTE, MD

Verified By: _____ PCP / EDMD (circle one) Date/Time: _____

Assistance. Please call 212-523-3900 and speak with a Financial Counselor for more information. Information about the Financial Assistance Program is also available on our website: www.wehealny.com <http://www.wehealny.com>

EXHIBIT "ELEVEN"

* Walgreens "your personal prescription information;"
for: Anton Puzina, Plaintiff's medications:
(or "other pain medications")
1. AMOX-CLAV 875 MG TABLETS
Quantity: 14
Refill on Going → 2. IBUPROFEN 400 MG TABLETS or other replacements
Quantity: 30
Refill on going → 3. MECLIZINE 25 MG RX TABLET
Quantity: 15
* Prescribed By: DR. C. REVERTE
* Started on OCT. 09, 2013 - AMOX-CLAV 875 MG

ACP

old and

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

YOUR PERSONAL PRESCRIPTION INFORMATION

POWERED BY Walgreens pharmacy network

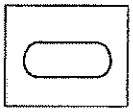
Your Duane Reade Pharmacy Location
2864 Broadway
New York, NY 10025
(212)316-5113

PATIENT ANTON PURISIMA
BIRTH DATE 12/15/51
MEDICATION AMOX-CLAV 875MG TABLETS
QUANTITY 14
DIRECTIONS TAKE 1 TABLET BY MOUTH TWICE DAILY

DOCTOR DR C. REVERTE

PATIENT ALLERGIES

DRUG DESCRIPTION



WHITE
FRONT: GG N7

INGREDIENT NAME: AMOXICILLIN (a-MOX-i-SIL-in) and CLAVULANATE (KLAV-ue-la-nate)

COMMON USES: This medicine is a penicillin antibiotic used to treat infections caused by certain bacteria.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking a tetracycline antibiotic (eg, doxycycline). ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking anticoagulants (eg, warfarin), chloramphenicol, hormonal birth control (eg, birth control pills), macrolide antibiotics (eg, erythromycin), methotrexate, probenecid, or sulfonamides (eg, sulfamethoxazole). DO NOT START OR STOP any medicine without doctor or pharmacist approval. Inform your doctor of any other medical conditions, including kidney problems, gonorrhea, allergies, pregnancy, or breast-feeding. Tell your doctor if you have a history of asthma, hay fever, hives, or liver problems or yellowing of the eyes or skin. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have infectious mononucleosis (mono). USE OF THIS MEDICINE IS NOT RECOMMENDED if you have a history of liver problems or yellowing of the eyes or skin caused by this medicine. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for taking this medicine provided by your doctor. Take this medicine by mouth at the start of a meal to decrease the chance of stomach upset. STORE THIS MEDICINE at or below 77 degrees F (25 degrees C). Store away from heat, moisture, and light. Do not store in the bathroom. KEEP THIS MEDICINE out of the reach of children and away from pets. BE SURE TO USE THIS MEDICINE FOR THE FULL COURSE OF TREATMENT. If you do not, the medicine may not clear up your infection completely. The bacteria could also become less sensitive to this or other medicines. This could make the infection harder to treat in the future. Do not miss any doses. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you have had an allergic reaction to it, to any ingredient in this product, or to another penicillin antibiotic (eg, ampicillin). BEFORE TAKING THIS MEDICINE, check with your doctor if you have had an allergic reaction to a cephalosporin antibiotic (eg, cephalexin) or another beta-lactam antibiotic (eg, imipenem). If you have a question about whether you are allergic to this medicine, or if a medicine is a penicillin, cephalosporin, or beta-lactam antibiotic, contact your doctor or pharmacist. LABORATORY AND/OR MEDICAL TESTS may be performed to monitor your progress or to check for side effects. Keep all doctor and laboratory appointments, while you are taking this medicine. THIS MEDICINE MAY CAUSE DIZZINESS. Do not drive, operate machinery, or do anything else that could be dangerous until you know how you react to this medicine. Using this medicine alone, along with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. MILD DIARRHEA IS COMMON WITH ANTIBIOTIC USE. However, a more serious form of diarrhea (pseudomembranous colitis) may rarely occur. This may develop while you use the antibiotic or within several months after you stop using it. Contact your doctor right away if stomach pain or cramps, severe diarrhea, or bloody stools occur. Do not treat diarrhea without first checking with your doctor. BROWN, YELLOW, OR GRAY TOOTH DISCOLORATION has occurred rarely in some patients taking this medicine. It occurred most often in children. The discoloration was reduced or removed by brushing or dental cleaning in most cases. Contact your doctor if you experience this effect. DO NOT RECEIVE A LIVE VACCINE (eg, typhoid) while you are taking this medicine. Talk with your doctor before you receive any vaccine. THIS MEDICINE ONLY WORKS against bacteria; it does not treat viral infections (eg, the common cold). Long-term or repeated use of this medicine may cause a second infection. Tell your doctor if signs of a second infection occur. Your medicine may need to be changed to treat this. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. FOR WOMEN: HORMONAL BIRTH CONTROL (eg, birth control pills) may not work as well while you are using this medicine. To prevent pregnancy, use an extra form of birth control (eg, condoms). IF YOU BECOME PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. THIS MEDICINE IS EXCRETED IN BREAST MILK. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby. DIABETES PATIENTS: This medicine may cause false test results with some urine glucose tests. Check with your doctor before you adjust the dose of your diabetes medicine or change your diet.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine include diarrhea, nausea, or vomiting. If they continue or are bothersome, check with your doctor. CONTACT YOUR DOCTOR IMMEDIATELY if you experience behavior changes; bloody stools; confusion; dark urine; fever, chills, or persistent sore throat; red, swollen, blistered, or peeling skin; seizures; severe or persistent diarrhea; severe stomach pain or cramps; unusual bruising or bleeding; unusual tiredness or weakness; vaginal discharge or irritation; white patches in the mouth or on the tongue; or yellowing of the skin or eyes. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash; hives; itching; difficulty breathing; tightness in the chest; or swelling of the mouth, face, lips, or tongue. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: IF OVERDOSE IS SUSPECTED, contact your local poison control center or emergency room immediately. Symptoms may include decreased urination; severe nausea, vomiting, or diarrhea; stomach pain; or unusual drowsiness.

ADDITIONAL INFORMATION: If your symptoms do not improve or if they become worse, contact your doctor. DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. CHECK WITH YOUR PHARMACIST about how to dispose of unused medicine.

Call your doctor for medical advice about side effects.
You may report side effects to FDA at 1-800-FDA-1088.

Do not flush unused medications or pour down a sink or drain.

WIC# 957300

11

KEEP OUT OF REACH OF CHILDREN: STORE IN SAFETY CONTAINER OR SECURE AREA.

YOUR PERSONAL PRESCRIPTION INFORMATION

POWERED BY Walgreens pharmacy network

Your Duane Reade Pharmacy Location
2864 Broadway
New York, NY 10025
(212)316-5113

PATIENT ANTON PURISIMA
BIRTH DATE 12/15/51
MEDICATION IBUPROFEN 400MG TABLETS
QUANTITY 30
DIRECTIONS TAKE 1 TABLET BY MOUTH EVERY 6 HOURS AS NEEDED

DOCTOR DR C. REVERTE

PATIENT ALLERGIES

DRUG DESCRIPTION

WHITE
FRONT: IP 464

INGREDIENT NAME: IBUPROFEN (eye-byoo-PROE-fen)

COMMON USES: This medicine is a nonsteroidal anti-inflammatory drug (NSAID) used to treat mild to moderate pain, osteoarthritis, and rheumatoid arthritis. It may also be used to treat other conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: WARNING: THE RISK OF SERIOUS AND SOMETIMES FATAL HEART PROBLEMS, HEART ATTACK, AND STROKE may be increased with the use of this medicine. This risk may be increased the longer you use this medicine. Risk may also be higher in patients who have heart problems or who are at risk for heart problems. THIS MEDICINE SHOULD NOT BE USED to treat pain before or after coronary artery heart bypass (CABG) surgery. THE RISK OF SERIOUS AND SOMETIMES FATAL STOMACH AND BOWEL PROBLEMS, including bleeding, ulcers, and holes in the stomach and bowel, is increased while using this medicine. These problems may occur at any time during therapy, with or without symptoms. Elderly patients are at higher risk for serious stomach problems. Ask your doctor or pharmacist for more information about this medicine and its side effects. Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking heparins or tacrolimus. ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking serotonin reuptake blocker medicines such as fluoxetine or citalopram, "blood thinners" such as warfarin, bisphosphonates such as alendronate or risedronate, cyclosporine, corticosteroids such as prednisone, high blood pressure medicines (including ACE inhibitors such as captopril, angiotensin II receptor antagonists such as losartan, and beta-blockers such as metoprolol), "water pills" (diuretics such as furosemide, hydrochlorothiazide, triamterene), lithium, methotrexate, or aspirin. DO NOT START OR STOP ANY MEDICINE without doctor or pharmacist approval. Inform your doctor of any other medical conditions including poorly controlled diabetes, dehydration, heart problems (such as heart failure or history of heart attack), swelling of the hands, feet, or ankles (edema), high blood pressure, history of stroke, blood clotting problems, stomach or bowel problems (such as bleeding or ulcers), history of tobacco use or alcohol use, kidney problems, liver problems, blood or bleeding problems (such as anemia), asthma, growths in the nose (nasal polyps), any allergies (especially history of angioedema with symptoms of lip, tongue, throat swelling), pregnancy, or breast-feeding. USE OF THIS MEDICINE IS NOT RECOMMENDED if you have a history of allergy to aspirin or other NSAIDs (e.g., naproxen, celecoxib). USE OF THIS MEDICINE IS NOT RECOMMENDED if you have history of severe kidney disease or if you are going to have or have recently had coronary artery heart bypass (CABG) surgery. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. This medicine may come with a medication guide. Read it carefully. Ask your doctor, nurse, or pharmacist any questions that you may have about this medicine. TAKE THIS MEDICINE with a full glass (8 oz./240 ml) of water. DO NOT lie down for 30 minutes after taking this medicine. The dosage is based on your medical condition and response to therapy. If repeat doses are needed, they are usually given 6 or 8 hours apart, or as directed by your doctor. When used in children, the dose is based on your child's weight. Read the product instructions to find the appropriate dose for your child's weight. Consult the pharmacist or doctor if you have questions or if you need help in choosing the appropriate dosage form. THIS MEDICINE MAY BE TAKEN WITH FOOD if it upsets your stomach. Taking it with food may not decrease the risk of stomach or bowel problems (such as bleeding or ulcers) that may occur while taking this medicine. Talk with your doctor or pharmacist if you experience persistent stomach upset. STORE THIS MEDICINE at room temperature, away from heat and light. Do not store in the bathroom. IF YOU MISS A DOSE OF THIS MEDICINE, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: THIS MEDICINE INCREASES YOUR RISK OF SERIOUS STOMACH OR BOWEL PROBLEMS (such as ulcers and bleeding). This risk is increased if you are elderly or are in poor health, if you have a history of smoking or drinking alcohol, if you take corticosteroid medicines (such as prednisone) or "blood thinners" (such as warfarin), or if you take this medicine for a long period of time. THIS MEDICINE MAY ALSO INCREASE YOUR RISK for certain serious heart and blood vessel problems (such as heart attack and stroke). TAKE THIS MEDICINE EXACTLY AS PRESCRIBED BY YOUR DOCTOR, at the lowest possible dose for the shortest time needed. Talk with your doctor or pharmacist for further information. DO NOT TAKE THIS MEDICINE IF YOU HAVE HAD A SEVERE ALLERGIC REACTION to aspirin or any medicine containing aspirin or to a nonsteroidal anti-inflammatory drug (such as Feldene, Motrin, Naprosyn, Clinoril). A severe reaction includes a severe rash, hives, breathing difficulties, or dizziness. If you have a question about whether you are allergic to this medicine or if a certain medicine is a nonsteroidal anti-inflammatory drug, contact your doctor or pharmacist. DO NOT EXCEED THE RECOMMENDED DOSE or take this medicine for longer than 10 days for pain or 3 days for fever, unless directed by your doctor. Laboratory and/or medical tests, including blood counts, liver function tests, and kidney function tests, may be performed to monitor your progress or to check for side effects, especially if you are taking this medicine for a long period of time. KEEP ALL DOCTOR AND LABORATORY APPOINTMENTS while you are taking this medicine. DO NOT DRIVE, OPERATE MACHINERY, OR DO ANYTHING ELSE THAT COULD BE DANGEROUS until you know how you react to this medicine. ALCOHOL WARNING: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take this medicine or other pain relievers/fever reducers. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. If you are also taking aspirin, as prescribed by your doctor for reasons such as heart attack or stroke prevention (usually these dosages are 81-325 mg per day), continue to take the aspirin and consult your doctor or pharmacist before using this medicine. CAUTION IS ADVISED WHEN USING THIS MEDICINE IN THE ELDERLY because they may be more sensitive to the effects of this medicine, especially the risk of stomach or bowel effects (such as bleeding or ulcers), or kidney effects. FOR WOMEN: USE OF THIS MEDICINE DURING PREGNANCY has resulted in fetal and newborn death. If you think you may be pregnant, contact your doctor immediately. THIS MEDICINE IS EXCRETED IN BREAST MILK. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS, that may go away during treatment, include nausea, vomiting, diarrhea, gas, constipation, indigestion, dizziness, lightheadedness, drowsiness, or headache. If they continue or are bothersome, check with your doctor. CHECK WITH YOUR DOCTOR AS SOON AS POSSIBLE if you experience ringing in ears. CONTACT YOUR DOCTOR IMMEDIATELY if you experience rapid or pounding heartbeat; easy bruising or bleeding; very stiff neck; or mental/mood changes. CONTACT YOUR DOCTOR IMMEDIATELY if you experience sharp or crushing chest pain; sudden shortness of breath; sudden leg pain; sudden severe headache, vomiting, dizziness, or fainting; changes in vision; numbness of an arm or leg; slurred speech; one-sided weakness; sudden unexplained weight gain; change in amount of urine produced; severe or persistent stomach pain; vomit that looks like coffee grounds; black tarry stools; itching, reddened, swollen, blistered, painful, or peeling skin; yellowing of the skin or eyes; dark urine; right-sided tenderness; severe or persistent tiredness; fever, chills, or sore throat; severe or persistent nausea; swelling of hands, ankles, feet, face, lips, eyes, throat, or tongue; difficulty swallowing or breathing; or hoarseness. AN ALLERGIC REACTION TO THIS MEDICINE is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash, itching, swelling, severe dizziness, or trouble breathing. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include severe stomach pain, coffee ground-like vomit, unusually fast or slow heartbeat, trouble breathing, extreme drowsiness, loss of consciousness, and seizures.

ADDITIONAL INFORMATION: DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. KEEP THIS MEDICINE out of the reach of children and pets. IF USING THIS MEDICINE FOR AN EXTENDED PERIOD OF TIME, obtain refills before your supply runs out.

Call your doctor for medical advice about side effects.
You may report side effects to FDA at 1-800-FDA 1088.

Do not flush unused medications or pour down a sink or drain.

WIC# 957300

KEEP OUT OF REACH OF CHILDREN: STORE IN SAFETY CONTAINER OR SECURE AREA.

YOUR PERSONAL PRESCRIPTION INFORMATION

POWERED BY Walgreens pharmacy network

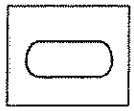
Your Duane Reade Pharmacy Location
2864 Broadway
New York, NY 10025
(212)316-5113

PATIENT ANTON PURISIMA
BIRTH DATE 12/15/51
MEDICATION MECLIZINE 25MG RX TABLETS
QUANTITY 15
DIRECTIONS TAKE 1 TABLET BY MOUTH THREE TIMES DAILY AS NEEDED FOR VERTIGO.

DOCTOR DR C. REVERTE

PATIENT ALLERGIES

DRUG DESCRIPTION



YELLOW
FRONT: TL 121

INGREDIENT NAME: MECLIZINE (MEK-li-zeen)

COMMON USES: This medicine is an antihistamine used to treat and prevent nausea, vomiting, and dizziness caused by motion sickness. It is also used for vertigo (dizziness) caused by certain inner ear problems. It may also be used for other conditions as determined by your doctor.

BEFORE USING THIS MEDICINE: Some medicines or medical conditions may interact with this medicine. INFORM YOUR DOCTOR OR PHARMACIST of all prescription and over-the-counter medicine that you are taking. DO NOT TAKE THIS MEDICINE if you are also taking sodium oxybate (GHB). ADDITIONAL MONITORING OF YOUR DOSE OR CONDITION may be needed if you are taking perampanel. DO NOT START OR STOP any medicine without doctor or pharmacist approval. Inform your doctor of any other medical conditions, including lung or breathing problems (eg, asthma, chronic obstructive pulmonary disease / COPD, chronic bronchitis, emphysema); stomach, bowel, or bladder blockage; kidney or liver problems; an enlarged prostate; glaucoma or increased pressure in the eye; allergies; pregnancy; or breast-feeding. Use of this medicine in CHILDREN under age 12 is not recommended. Discuss with your doctor the risks and benefits of giving this medicine to your child. Contact your doctor or pharmacist if you have any questions or concerns about taking this medicine.

HOW TO USE THIS MEDICINE: Follow the directions for using this medicine provided by your doctor. TAKE THIS MEDICINE by mouth with or without food. IF YOU ARE TAKING THIS MEDICINE TO PREVENT MOTION SICKNESS, take it at least 1 hour before activity or travel. USE THIS MEDICINE EXACTLY AS DIRECTED on the package, unless instructed differently by your doctor. If you are taking this medicine without a prescription, follow any warnings and precautions on the label. STORE THIS MEDICINE at room temperature, between 59 and 86 degrees F (15 and 30 degrees C), away from heat, moisture, and light. Do not store in the bathroom. KEEP THIS MEDICINE out of the reach of children and away from pets. IF YOU MISS A DOSE OF THIS MEDICINE and you are using it regularly, take it as soon as possible. If it is almost time for your next dose, skip the missed dose and go back to your regular dosing schedule. Do not take 2 doses at once.

CAUTIONS: DO NOT TAKE THIS MEDICINE if you have had an allergic reaction to it or are allergic to any ingredient in this product. DO NOT EXCEED THE RECOMMENDED DOSE or take this medicine for longer than prescribed without checking with your doctor. BEFORE YOU HAVE ANY MEDICAL OR DENTAL TREATMENTS, emergency care, or surgery, tell the doctor or dentist that you are using this medicine. THIS MEDICINE MAY CAUSE DROWSINESS OR BLURRED VISION. Do not drive, operate machinery, or do anything else that could be dangerous until you know how you react to this medicine. Using this medicine alone, along with other medicines, or with alcohol may lessen your ability to drive or to perform other potentially dangerous tasks. DO NOT DRINK ALCOHOL while you are taking this medicine. CHECK WITH YOUR DOCTOR before you use medicines that may cause drowsiness (eg, sleep aids, muscle relaxers) while you are using this medicine; it may add to their effects. Ask your pharmacist if you have questions about which medicines may cause drowsiness. THIS PRODUCT MAY CONTAIN TARTRAZINE DYE (FD&C Yellow No. 5). This may cause an allergic reaction in some patients. If you have ever had an allergic reaction to tartrazine, ask your pharmacist if your product has tartrazine in it. BEFORE YOU BEGIN TAKING ANY NEW MEDICINE, either prescription or over-the-counter, check with your doctor or pharmacist. CAUTION IS ADVISED WHEN USING THIS MEDICINE IN THE ELDERLY because they may be more sensitive to the effects of this medicine. FOR WOMEN: IF YOU BECOME PREGNANT, discuss with your doctor the benefits and risks of using this medicine during pregnancy. IT IS UNKNOWN IF THIS MEDICINE IS EXCRETED in breast milk. IF YOU ARE OR WILL BE BREAST-FEEDING while you are using this medicine, check with your doctor or pharmacist to discuss the risks to your baby.

POSSIBLE SIDE EFFECTS: SIDE EFFECTS that may occur while taking this medicine include drowsiness, dry mouth, headache, tiredness, or vomiting. If they continue or are bothersome, check with your doctor. AN ALLERGIC REACTION to this medicine is unlikely, but seek immediate medical attention if it occurs. Symptoms of an allergic reaction include rash; hives; itching; difficulty breathing; tightness in the chest; or swelling of the mouth, face, lips, or tongue. If you notice other effects not listed above, contact your doctor, nurse, or pharmacist. This is not a complete list of all side effects that may occur. If you have questions about side effects, contact your healthcare provider. Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

OVERDOSE: If overdose is suspected, contact your local poison control center or emergency room immediately. Symptoms of overdose may include unusual excitability, drowsiness, hallucinations, very slow or shallow breathing, and seizures.

ADDITIONAL INFORMATION: DO NOT SHARE THIS MEDICINE with others for whom it was not prescribed. DO NOT USE THIS MEDICINE for other health conditions. CHECK WITH YOUR PHARMACIST about how to dispose of unused medicine.

Call your doctor for medical advice about side effects.
You may report side effects to FDA at 1-800-FDA-1088.

Do not flush unused medications or pour down a sink or drain.

WIC# 957300

KEEP OUT OF REACH OF CHILDREN: STORE IN SAFETY CONTAINER OR SECURE AREA.

EXHIBIT "TWELVE"

* Plaintiff's "E.R. Tag"
Acct: A00200539047
By: Enriquez MD, melissa
from: Hospital in Wilmington, Delaware

* Refused to treat the Dog-Bite of plaintiff who went forced to go to outside the state of NY because he cannot get proper Rabies 'x THIRD ~~Second~~ shot (Plaintiff's 3rd. Dog-Rabies-shot) in New York, due to problems at his 2nd. rabies shot at ST. LUKES E.R. HOSP. and at HOBOKEN University Medical Center, E.R. Hospital in HOBOKEN, New Jersey.

That plaintiff cannot get proper rabies shot that his paint in his body was getting worst due to Dog-bite on OCT. 09, 2013.

* Plaintiff incorporates this document in this action and to support thereof. KCP

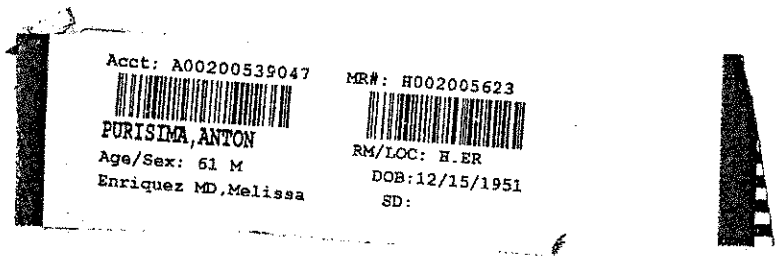

Acct: A00200539047
PURISIMA,ANTON
Age/Sex: 61 M
Enriquez MD,Melissa
MR#: H002005623
RM/LOC: H_ER
DOB:12/15/1951
SD:

EXHIBIT "FOURTEEN"

* Discharge Instructions for: Anton Punina
  Arrival Date: → Wed. OCT. 23, 2013
  from: Hahnemann University Hospital
  Philadelphia, PA

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

H-

Hahnemann University Hospital

Broad & Vine Streets
Philadelphia, PA 19102
215-762-7963

Discharge Instructions for: **PURISIMA, ANTON**

Arrival Date: **Wednesday, October 23, 2013**

Thank you for choosing **Hahnemann University Hospital** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: ,
Richards, Michael, RNP

Diagnosis: Otitis Externa; Vaccination For Rabies

DISCHARGE INSTRUCTIONS	**FORMS**
EXTERNAL EAR INFECTION (Adult)	Rabies Form Medication Reconciliation
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Emergency Department When: ASAP; Reason: Change in condition **Private Physician** When: 2 - 3 days; Reason: Recheck today's complaints	Cortisporin HC
SPECIAL NOTES	
None	

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Patient Copy

ANTON PURISIMA
MRN:

FOLLOW UP INSTRUCTIONS

Emergency Department
When: ASAP
Reason: Change in condition

Private Physician
When: 2 - 3 days
Reason: Recheck today's complaints

PRESCRIPTIONS

Cortisporin HC Otic Suspension
Instill 4 drop by OTIC route every 6 hours for 7 days; Quantity: 1 bottle

TESTS AND PROCEDURES

Labs
None

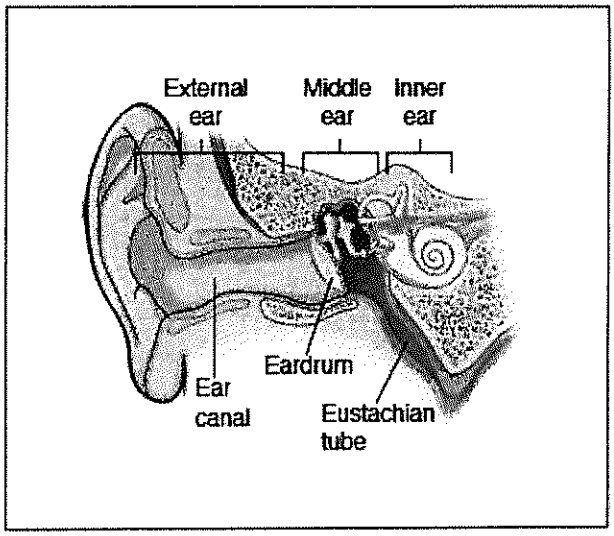
Rad
None

Procedures
None

Other
None

ANTON PURISIMA
MRN:

EXTERNAL EAR INFECTION [Adult]



This is an infection in the ear canal due to an overgrowth of bacteria or fungus. This often occurs a few days after water gets trapped in the ear canal (swimming or bathing). It may also occur after cleaning too deeply in the ear canal with a cotton swab or other object. Sometimes hair care products get into the ear canal and cause this problem.

There may be itching, redness, drainage, or swelling of the ear canal and temporary loss of hearing.

HOME CARE:

- Do not try to clean the ear canal. That could push pus and bacteria deeper into the canal.
- Use the drops prescribed to reduce swelling and fight the infection. If an EAR WICK was placed in the ear canal, apply drops right onto the end of the wick. The wick will draw the medicine into the ear canal even if it is swollen closed.
- Do not allow water to get into your ear when bathing. No swimming during this time.
- A cotton ball may be loosely placed in the outer ear to absorb any drainage.
- You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another medicine was prescribed. [NOTE: If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

PREVENTING FUTURE INFECTIONS:

You can usually avoid this problem by using an eardrop that removes the water from your ear canal when you feel there is water trapped there. You can get these drops over the counter (Swim Ear, Aqua Ear and other brands).

FOLLOW UP with your doctor or this facility in one week or as instructed by our staff.

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- Ear pain becomes worse or does not begin to improve after 3 days of treatment
- Redness or swelling of the outer ear occurs or gets worse
- Headache, painful or stiff neck,
- Feeling drowsy or confused
- Fever of 100.4Â°F (38Â°C) or higher, or as directed by your healthcare provider
- Seizure

ANTON PURISIMA
MRN:

RABIES VACCINE

What you need to know

1 What is rabies?

Rabies is a serious disease. It is caused by a virus.

Rabies is mainly a disease of animals. Humans get rabies when they are bitten by infected animals.

At first there might not be any symptoms. But weeks, or even years after a bite, rabies can cause pain, fatigue, headaches, fever, and irritability. These are followed by seizures, hallucinations, and paralysis. Rabies is almost always fatal.

Wild animals – especially bats – are the most common source of human rabies infection in the United States. Skunks, raccoons, dogs, and cats can also transmit the disease.

Human rabies is rare in the United States. There have been only 39 cases diagnosed since 1990. However, between 16,000 and 39,000 people are treated each year for possible exposure to rabies after animal bites. Also, rabies is far more common in other parts of the world, with about 40,000-70,000 rabies-related deaths each year. Bites from unvaccinated dogs cause most of these cases.

Rabies vaccine can prevent rabies.

2 Rabies vaccine

Rabies vaccine is given to people at high risk of rabies to protect them if they are exposed. It can also prevent the disease if it is given to a person *after* they have been exposed.

Rabies vaccine is made from killed rabies virus. It cannot cause rabies.

3 Who should get rabies vaccine and when?

People at high risk of exposure to rabies, such as veterinarians, animal handlers, rabies laboratory workers, spelunkers, and rabies biologics production workers should be offered rabies vaccine.

The vaccine should also be considered for:
- People whose activities bring them into frequent contact with rabies virus or with possibly rabid animals.
- International travelers who are likely to come in contact with animals in parts of the world where rabies is common.

The pre-exposure schedule for rabies vaccination is **3 doses**, given at the following times:

Dose 1: As appropriate
Dose 2: 7 days after Dose 1
Dose 3: 21 days ***or*** 28 days after Dose 1

For laboratory workers and others who may be repeatedly exposed to rabies virus, periodic testing for immunity is recommended, and booster doses should be given as needed. (Testing or booster diseases are not recommended for travelers.) Ask your doctor for details.

Vaccination After an Exposure

Anyone who has been bitten by an animal, or who otherwise may have been exposed to rabies, should see a doctor immediately.

- A person who is exposed and has never been vaccinated against rabies should get **5 doses** of rabies vaccine – one dose right away, and additional doses on the 3rd, 7th, 14th, and 28th days. They should also get a shot of *Rabies Immune Globulin* at the same time as the first does. This gives immediate protection.

- A person who **has** been previously vaccinated should get **2 doses** of rabies vaccine – one right away and another on the 3rd day. Rabies Immune Globulin is not needed.

4 Tell your doctor if...

Talk with a doctor before getting rabies vaccine if you:
1) ever had a serious (life-threatening) allergic reaction to a previous dose of rabies vaccine, or to any component of the vaccine,
2) are taking anti-malarial drugs,
3) have a weakened immune system because of:
- HIV/AIDS or another disease that affects the immune system,
- treatment with drugs that affect the immune system, such as steroids,
- cancer, or cancer treatment with radiation or drugs.

If you have a minor illness, such as a cold, you can be vaccinated. If you are moderately or severely ill, you should probably wait until you recover before getting a routine (non-exposure) dose of rabies vaccine.

If you have been exposed to rabies virus, you should get the vaccine regardless of any other illnesses you may have.

5 What are the risks from rabies vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions. The risk of a vaccine causing serious harm, or death, is extremely small. Serious problem from rabies vaccine are very rare.

Mild problems:
- soreness, redness, swelling, or itching where the shot was given (30%-74%)
- headache, nausea, abdominal pain, muscle aches, dizziness (5%-40%)

Moderate problems:
- hives, pain in the joints, fever (about 6% of booster doses)
- illness resembling Guillain-Barre Syndrome (GBS), with complete recovery (very rare)

Other nervous system disorders have been reported after rabies vaccine, but this happens so rarely that it is not known whether they are related to the vaccine.

NOTE: Several brands of rabies vaccine are available in the United States, and reactions may vary between brands. Your provider can give you more information about a particular brand.

6 What if there is a moderate or severe reaction?

What should I look for?

- Any unusual condition, such as a high fever or behavior changes. Signs of a serious allergic reaction can include difficulty breathing, hoarseness or wheezing, hives, paleness, weakness, a fast heartbeat or dizziness.

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your doctor, nurse, or health department to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or call VAERS yourself at **1-800-822-7967**, or visit their website at **www.vaers.org**.

7 How can I learn more?

Ask your doctor or nurse. They can give you the vaccine package insert or suggest other sources of information.

Call your local or state health department.

Contact the Centers for Disease Control and Prevention (CDC):
Call **1-800-232-2522** (English)
Call **1-800-232-0233** (Espanol)
Visit CDC's rabies website at: **www.cdc.gov/ncidod/dvrd/rabies**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Immunization Program

ANTON PURISIMA
MRN:

Discharge Information

Home Medication Form
Hahnemann University Hospital
Emergency Department

Name: ANTON PURISIMA
Age: 61 years **Gender:** Male
Physician: ,

Visit Date: 10/23/13 11:46
MRN:

Thank you for visiting Hahnemann University Hospital. This form contains information about your medications. It is important that you read and understand this information.

Home Medication(s) recorded during this visit

Drug, Route & Dose	Frequency	Reason	Continue
Meclizine Oral			Yes No PCP
Amoxicillin-Pot Clavulanate Oral			Yes No PCP

Medications you received during your visit:
No Medications were given during your visit.

Prescriptions you received during your visit:

Drug & Dose	Route	Frequency	Reason	Next Dose
Cortisporin HC 4 drop	Otic	every 6 hours		

Home Medications you should continue to take:

Drug, Route & Dose	Frequency	Reason

Home Medications you should STOP taking:

Drug, Route & Dose	Frequency	Reason

You should follow up with your primary care physician after discharge regarding continuation of these medications:

Drug, Route & Dose	Frequency	Reason

Notes
You will need to see your MD to get refills.

PLEASE GIVE THIS FORM TO YOUR NEXT PROVIDER OF MEDICAL SERVICE (DOCTOR, CLINIC, HOME CARE, ETC.)

Signature:

EXHIBIT "FIFTEEN"

* Discharge instructions for: Anton Punzina
Arrival Date → Thur. Oct. 17, 2013
from: Hahnemann University Hospital
Philadelphia, PA

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

H-

Hahnemann University Hospital

Broad & Vine Streets
Philadelphia, PA 19102
215-762-7963

Discharge Instructions for: **Purisima, Anton**

Arrival Date: **Thursday, October 17, 2013**

Thank you for choosing **Hahnemann University Hospital** for your care today. The examination and treatment you have received in the Emergency Department today have been rendered on an emergency basis only and are not intended to be a substitute for an effort to provide complete medical care. You should contact your follow-up physician as it is important that you let him or her check you and report any new or remaining problems since it is impossible to recognize and treat all elements of an injury or illness in a single emergency care center visit.

Care provided by: Samuels, Leonard, MD
Goldstein, Russell, MD

Diagnosis: Pain - upper extremity; Animal Bite Hand

DISCHARGE INSTRUCTIONS	FORMS
Animal, Farm - DOG BITE Contusions - CONTUSION, Soft Tissue	Medication Reconciliation
FOLLOW UP INSTRUCTIONS	**PRESCRIPTIONS**
Emergency Department When: 10/23/2030; Reason: Return for your final rabies shot. Return sooner if your symptoms worsen.	Motrin
SPECIAL NOTES	
An ultrasound of your right arm showed no blood clot. You should take Motrin and use ice packs as needed for the pain in your arm. If your pain and swelling become much worse or you develop numbness, weakness, color change, or temperature in your arm/hand then return to the ER to be evaluated. You should return to the ER on Wednesday 10/23 for your 4th and final rabies shot.	

X-RAYS and LAB TESTS:
If you had x-rays today they were read by the emergency physician. Your x-rays will also be read by a radiologist within 24 hours. If you had a culture done it will take 24 to 72 hours to get the results. If there is a change in the x-ray diagnosis or a positive culture, we will contact you. Please verify your current phone number prior to discharge at the check out desk.

MEDICATIONS:
If you received a prescription for medication(s) today, it is important that when you fill this you let the pharmacist know all the other medications that you are on and any allergies you might have. It is also important that you notify your follow-up physician of all your medications including the prescriptions you may receive today.

Patient Copy

FOLLOW UP INSTRUCTIONS

Emergency Department
When: 10/23/2030
Reason: Return for your final rabies shot. Return sooner if your symptoms worsen.

PRESCRIPTIONS

Motrin 800 mg Oral Tablet
Take 1 tablet by ORAL route every 8 hours As needed; Quantity: 30 tablet

TESTS AND PROCEDURES

Labs
None

Rad
None

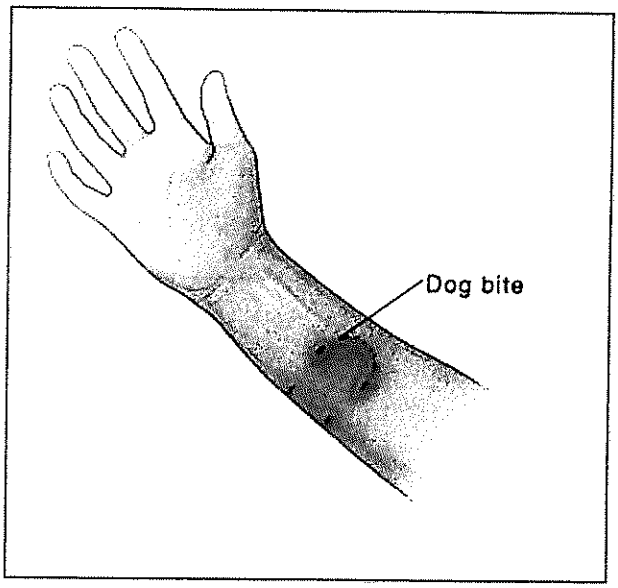
Procedures
Ultrasound

Other
Ice Pack

DOG BITE

If a dog has bitten you and the wound is deep enough to break the skin, an infection may occur. Therefore, you should watch for the warning signs listed below. The doctor may not close the wound completely. This is to allow fluid to drain in the event of an infection.

HOME CARE



- Watch the wound for signs of infection listed below.
- In certain types of bites, antibiotics may be prescribed. Begin taking these as soon as possible, as directed until they are all gone.

Rabies Prevention

If you live in an area where rabies occurs in wild animals, the rabies virus can be passed to cats and dogs. An infected animal can pass the rabies virus to you during a bite.

- If aÂ healthy-looking pet dog has bitten you, it should be kept in a secure area for the next 10 days to watch for signs of illness. If the pet owner won't cooperate with you, contact the county animal control department (or local law enforcement). If the animal becomes ill or dies withinÂ 10 days, contact your animal control department at once. The animal must be tested for rabies. If the animal stays healthy for the next 10 days, then there is no danger of rabies in the dog or you.
- Pets fully vaccinated against rabies (2 shots) are at very low risk for the infection. However, because human rabies is almost always fatal, any biting dog should be kept in confinement for 10 days as an extra precaution.
- If a stray dog bit you, contact the animal control department. They can provide information on capture, quarantine, and animal rabies testing.
- If you are unable to locate the animal that bit you in the next 2Â days, and if rabies exists in your region, you must be evaluated for the rabies vaccine series. Contact your doctor or return here promptly.
- All animal bites should be reported to the county animal control department. If you were not given a form to fill out, you can report it yourself by calling.

FOLLOW UP with your doctor as advised. Most skin wounds heal within 10 days. However, an infection may occur even with proper treatment. Check your woundÂ every 6 hoursÂ for 2 days, then at least once a day for the next two days for the signs of infection listed below.

GET PROMPT MEDICAL ATTENTION if any of the following occur:

- Signs of infection:
  - Spreading redness
  - Increased pain or swelling

- Fever of 100.4Â°F (38Â°C) or higher, or as directed by your healthcare provider
- Colored fluid or pus draining from the wound

- Headache, confusion, strange behavior, or a seizure (signs of a rabies infection)

CONTUSION,SOFT TISSUE

You have a CONTUSION, which is a bruise with swelling and some bleeding under the skin. There are no broken bones. This injury takes a few days to a few weeks to heal.

HOME CARE:

1) Keep the injured part elevated to reduce pain and swelling. This is especially important during the first 48 hours.

2) Make an ice pack (ice cubes in a plastic bag, wrapped in a towel) and apply for 20 minutes every 1-2 hours the first day. Continue this 3-4 times a day until the pain and swelling goes away.

3) You may use acetaminophen (Tylenol) or ibuprofen (Motrin, Advil) to control pain, unless another pain medicine was prescribed. [NOTE : If you have chronic liver or kidney disease or ever had a stomach ulcer or GI bleeding, talk with your doctor before using these medicines.]

FOLLOW UP with your doctor or this facility if you are not improving within the next THREE days.

[NOTE: If X-rays were taken, they will be reviewed by a radiologist. You will be notified of any new findings that may affect your care.]

GET PROMPT MEDICAL ATTENTION if any of the following occur:

-- Pain or swelling increases

-- Injured arm or leg becomes cold, blue, numb or tingly

-- Redness, warmth or drainage from the skin

IMPORTANT: HOW TO USE THIS INFORMATION: This is a summary and does NOT have all possible information about this product. This information does not assure that this product is safe, effective, or appropriate for you. This information is not individual medical advice and does not substitute for the advice of your health care professional. Always ask your health care professional for complete information about this product and your specific health needs.

IBUPROFEN - ORAL

(eye-byou-PRO-fen)

COMMON BRAND NAME(S): Advil, Motrin, Nuprin

WARNING: Nonsteroidal anti-inflammatory drugs (including ibuprofen) may rarely increase the risk for a heart attack or stroke. The risk may be greater if you have heart disease or increased risk for heart disease (for example, due to smoking, family history of heart disease, or conditions such as high blood pressure or diabetes), or with longer use. This drug should not be taken right before or after heart bypass surgery (CABG).

This drug may infrequently cause serious (rarely fatal) bleeding from the stomach or intestines. This effect can occur without warning at any time while taking this drug. Older adults may be at higher risk for this effect.

Stop taking ibuprofen and get medical help right away if you notice any of these rare but serious side effects: black/tarry stools, persistent stomach/abdominal pain, vomit that looks like coffee grounds, chest/jaw/left arm pain, shortness of breath, unusual sweating, confusion, weakness on one side of the body, slurred speech, sudden vision changes.

Talk to your doctor or pharmacist about the benefits and risks of taking this drug.

USES: Ibuprofen is used to relieve pain from various conditions such as headache, dental pain, menstrual cramps, muscle aches, or arthritis. It is also used to reduce fever and to relieve minor aches and pain due to the common cold or flu. Ibuprofen is a nonsteroidal anti-inflammatory drug (NSAID). It works by blocking your body's production of certain natural substances that cause inflammation. This effect helps to decrease swelling, pain, or fever.

If you are treating a chronic condition such as arthritis, ask your doctor about non-drug treatments and/or using other medications to treat your pain. See also Warning section.

Check the ingredients on the label even if you have used the product before. The manufacturer may have changed the ingredients. Also, products with similar names may contain different ingredients meant for different purposes. Taking the wrong product could harm you.

HOW TO USE: If you are taking the over-the-counter product, read all directions on the product package before taking this medication. If your doctor has prescribed this medication, read the Medication Guide provided by your pharmacist before you start taking ibuprofen and each time you get a refill. If you have any questions, ask your doctor or pharmacist.

Take this medication by mouth, usually every 4 to 6 hours with a full glass of water (8 ounces/240 milliliters) unless your doctor directs you otherwise. Do not lie down for at least 10 minutes after taking this drug. If you have stomach upset while taking this medication, take it with food, milk, or an antacid.

The dosage is based on your medical condition and response to treatment. To reduce your risk of stomach bleeding and other side effects, take this medication at the lowest effective dose for the shortest possible time. Do not increase your dose or take this drug more often than directed by your doctor or the package label. For ongoing conditions such as arthritis, continue taking this medication as directed by your doctor.

When ibuprofen is used by children, the dose is based on the child's weight. Read the package directions to find the proper dose for your child's weight. Consult the pharmacist or doctor if you have questions or if you need help choosing a nonprescription product.

For certain conditions (such as arthritis), it may take up to two weeks of taking this drug regularly until you

get the full benefit.

If you are taking this drug "as needed" (not on a regular schedule), remember that pain medications work best if they are used as the first signs of pain occur. If you wait until the pain has worsened, the medication may not work as well.

If your condition persists or worsens, or if you think you may have a serious medical problem, get medical help right away. If you are using the nonprescription product to treat yourself or a child for fever or pain, consult the doctor right away if fever worsens or lasts more than 3 days, or if pain worsens or lasts more than 10 days.

SIDE EFFECTS: See also Warning section.

Upset stomach, nausea, vomiting, headache, diarrhea, constipation, dizziness, or drowsiness may occur. If any of these effects persist or worsen, tell your doctor or pharmacist promptly.

If your doctor has prescribed this medication, remember that he or she has judged that the benefit to you is greater than the risk of side effects. Many people using this medication do not have serious side effects.

Tell your doctor right away if you have any serious side effects, including: easy bruising/bleeding, hearing changes (such as ringing in the ears), mental/mood changes, swelling of the ankles/feet/hands, sudden/unexplained weight gain, unexplained stiff neck, change in amount of urine, vision changes, unusual tiredness.

This drug may rarely cause serious (possibly fatal) liver disease. Get medical help right away if you have any symptoms of liver damage, including: dark urine, persistent nausea/vomiting/loss of appetite, stomach/abdominal pain, yellowing eyes/skin.

A very serious allergic reaction to this drug is rare. However, get medical help right away if you notice any symptoms of a serious allergic reaction, including: rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing.

This is not a complete list of possible side effects. If you notice other effects not listed above, contact your doctor or pharmacist.

In the US -

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

In Canada - Call your doctor for medical advice about side effects. You may report side effects to Health Canada at 1-866-234-2345.

PRECAUTIONS: Before taking ibuprofen, tell your doctor or pharmacist if you are allergic to it; or to aspirin or other NSAIDs (such as naproxen, celecoxib); or if you have any other allergies. This product may contain inactive ingredients, which can cause allergic reactions or other problems. Talk to your pharmacist for more details.

Before taking this medication, tell your doctor or pharmacist your medical history, especially of: asthma (including a history of worsening breathing after taking aspirin or other NSAIDs), blood disorders (such as anemia, bleeding/clotting problems), growths in the nose (nasal polyps), heart disease (such as congestive heart failure, previous heart attack), high blood pressure, kidney disease, liver disease, severe loss of body water (dehydration), stroke, throat/stomach/intestinal problems (such as bleeding, heartburn, ulcers).

This drug may make you dizzy or drowsy. Do not drive, use machinery, or do any activity that requires alertness until you are sure you can perform such activities safely. Limit alcoholic beverages.

This medicine may cause stomach bleeding. Daily use of alcohol and tobacco, especially when combined with this medicine, may increase your risk for stomach bleeding. Limit alcohol and stop smoking. Consult your doctor or pharmacist for more information.

This medication may make you more sensitive to the sun. Avoid prolonged sun exposure, tanning booths or sunlamps. Use a sunscreen and wear protective clothing when outdoors.

Before having surgery, tell your doctor or dentist about all the products you use (including prescription drugs, nonprescription drugs, and herbal products).

Older adults may be more sensitive to the effects of this drug, especially stomach/intestinal bleeding.

Before using this medication, women of childbearing age should talk with their doctor(s) about the benefits and risks (such as miscarriage). Tell your doctor if you are pregnant or if you plan to become pregnant. During pregnancy, this medication should be used only when clearly needed. It is not recommended for use during the first and last trimesters of pregnancy due to possible harm to the unborn baby and interference with normal labor/delivery.

This medication passes into breast milk, but is unlikely to harm a nursing infant. Consult your doctor before breast-feeding.

DRUG INTERACTIONS: Drug interactions may change how your medications work or increase your risk for serious side effects. This document does not contain all possible drug interactions. Keep a list of all the products you use (including prescription/nonprescription drugs and herbal products) and share it with your doctor and pharmacist. Do not start, stop, or change the dosage of any medicines without your doctor's approval.

Some products that may interact with this drug include: cidofovir, corticosteroids (such as prednisone), high blood pressure drugs (including ACE inhibitors such as captopril, lisinopril and angiotensin II receptor blockers such as losartan, valsartan).

This medication may increase the risk of bleeding when taken with other drugs that also may cause bleeding. Examples include anti-platelet drugs such as clopidogrel, "blood thinners" such as dabigatran/enoxaparin/warfarin, among others.

Check all prescription and nonprescription medicine labels carefully since many medications contain pain relievers/fever reducers (including aspirin, NSAIDs such as celecoxib, ketorolac, or naproxen). These drugs are similar to ibuprofen and may increase your risk of side effects if taken together. However, if your doctor has directed you to take low-dose aspirin for heart attack or stroke prevention (usually at dosages of 81-325 milligrams a day), you should continue taking the aspirin unless your doctor instructs you otherwise. Daily use of ibuprofen may decrease aspirin's ability to prevent heart attack/stroke. Talk to your doctor about using a different medication (such as acetaminophen) to treat pain/fever. If you must take ibuprofen, talk to your doctor about possibly taking immediate-release aspirin (not enteric-coated/EC) while taking ibuprofen. Take ibuprofen at least 8 hours before or at least 30 minutes after your aspirin dose. Do not increase your daily dose of aspirin or change the way you take aspirin/other medications without your doctor's approval.

OVERDOSE: If overdose is suspected, contact a poison control center or emergency room immediately. US residents can call the US National Poison Hotline at 1-800-222-1222. Canada residents can call a

provincial poison control center. Symptoms of overdose may include: severe stomach pain, trouble breathing, extreme drowsiness.

NOTES: If your doctor has prescribed this medication, do not share it with others.

Laboratory and/or medical tests may be performed periodically to monitor your progress or check for side effects. Consult your doctor for more details.

Keep all regular medical and laboratory appointments.

MISSED DOSE: If you are taking this drug on a regular schedule (not just "as needed") and you miss a dose, take it as soon as you remember. If it is near the time of the next dose, skip the missed dose and resume your usual dosing schedule. Do not double the dose to catch up.

STORAGE: Store at room temperature away from light and moisture. Do not store in the bathroom. Keep all medications away from children and pets.

Do not flush medications down the toilet or pour them into a drain unless instructed to do so. Properly discard this product when it is expired or no longer needed. Consult your pharmacist or local waste disposal company.

Discharge Information

Home Medication Form
Hahnemann University Hospital
Emergency Department

Name: Anton Purisima
Age: 61 years **Gender:** Male
Physician: Samuels, Leonard

Visit Date: 10/17/13 07:36
MRN: 000959558

Thank you for visiting Hahnemann University Hospital. This form contains information about your medications. It is important that you read and understand this information.

Home Medication(s) recorded during this visit

Drug, Route & Dose	Frequency	Reason	Continue
Amoxicillin-Pot Clavulanate Oral			Yes No PCP
Meclizine Oral			Yes No PCP

Medications you received during your visit:

Drug & Dose	Route	Rate	Duration	Given At
Tylenol 650 mg	Oral			10/17 09:05
RabAvert 1 mL_1	IM			10/17 10:15

Prescriptions you received during your visit:

Drug & Dose	Route	Frequency	Reason	Next Dose
Motrin 1 tablet	Oral	every 8 hours		

Home Medications you should continue to take:

Drug, Route & Dose	Frequency	Reason

Home Medications you should STOP taking:

Drug, Route & Dose	Frequency	Reason

You should follow up with your primary care physician after discharge regarding continuation of these medications:

Drug, Route & Dose	Frequency	Reason

Notes
You will need to see your MD to get refills.

PLEASE GIVE THIS FORM TO YOUR NEXT PROVIDER OF MEDICAL SERVICE (DOCTOR, CLINIC, HOME CARE, ETC.)

Signature:

Samuels, Leonard

EXHIBIT "TWO"
for: "P.I. Claim form"

&

EXHIBIT "SIXTEEN" A & B
for: COMPLAINT

* Copies of "Bus Transfers"
(Going to Queens and coming back to Manhattan)
* w/ Descriptions & information

* Transfers given before & after the Dog-bite incident on OCT. 09, 2013
(TWO Q32 MTA Buses)

Please note:
Plaintiff hereby incorporates this Exhibit to every page in this Action.
ACP

ACP

10/09/13 05:11P Q32 S/W 4211

MAY BE USED ONLY BY PASSENGER TO WHOM ISSUED

Exceptions may apply subject to applicable tariffs and conditions of use.

I took this bus going back to Manhattan, NY in order to go to Hospital Emergency for "Treatment of Dog bite"

This transfer is valid only

- On other bus routes
- Within two hours of issue (time of issue shown above)

This transfer is not valid for

- Entry to subway
- Trip on same route transfer was issued (route shown above)

Keep dry. Do not fold.

In the event of a malfunction, pay fare and note

- Date and time
- Bus route and direction
- Bus number

MetroCard Customer Claims
130 Livingston Street, Brooklyn, NY 11201-9625.
Call 511 or go to eFIX at mta.info

B-02-13-JIHGFE

MAY BE USED ONLY BY PASSENGER TO WHOM ISSUED

Exceptions may apply subject to applicable tariffs and conditions of use.

10-09-13 4:53P Q32 N/E 6903

Bus Stop @ 61st/Roosevelt

The Bus operator Called the Ambulance and Police @ 16:05

This transfer is valid only

- On other bus routes
- Within two hours of issue (time of issue shown above)

This transfer is not valid for

- Entry to subway
- Trip on same route transfer was issued (route shown above)

Keep dry. Do not fold.

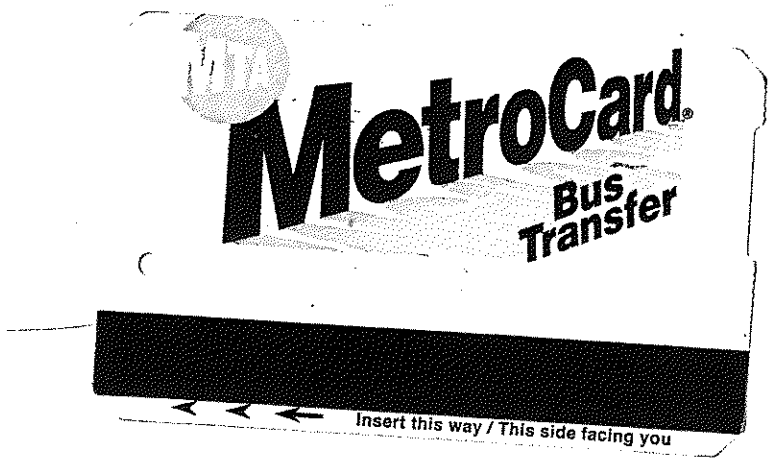
In the event of a malfunction, pay fare and note

- Date and time
- Bus route and direction
- Bus number

MetroCard Customer Claims
130 Livingston Street, Brooklyn, NY 11201-9625.
Call 511 or go to eFIX at mta.info

B-02-13-JIHGFE

Ex. 16-A


MTA
MetroCard
Bus Transfer
Insert this way / This side facing you


MTA
MetroCard
Bus Transfer
Insert this way / This side facing you

EX. 16-B

EXHIBIT "THREE"
for: "P.I. claim form"

&

EXHIBIT "SEVENTEEN"
for: COMPLAINT

* "MTA FORM" that was used as ("information sheet by MTA SUPERVISOR Given to plaintiff Anton Puricina on 10/09/2013 @ 61st Street/Roosevelt Ave. Bus stop, Queens, N.Y.

AC

Please note: plaintiff hereby incorporate this Exhibit to every page in this action.

AC

MTA BUS STOPPED IN FRONT OF Metro 718- 426-4060 Kitchen RESTAURANT

New York City Transit
Department of Buses

NEW YORK CITY TRANSIT
DEPARTMENT of BUSES

INFORMATION EXCHANGE

free Delivery

BUS INFORMATION:

DAY: _____ DATE: _____ TIME: _____ AM-PM

LOCATION: _____

BUS #: _____ LICENSE PLATE #: _____

BUS OPERATOR: _____

DRIVERS LICENSE #: _____ STATE: _____ EXP. DATE: _____

INSURANCE CODE: 994 MTA NYC TRANSIT is self insured as per NY State Law

OWNER:	FOR INSURANCE INFORMATION-CONTACT
NEW YORK CITY TRANSIT 750 ZEREGA AVE - 2nd FLOOR BRONX, NEW YORK 10473	NEW YORK CITY TRANSIT LEGAL DEPT. 130 LIVINGSTON STREET BROOKLYN, NEW YORK 11201 718-694-3950

OCT. 09, 2013 TIME 6 MTA BUS #'s 6903 AT 16105

ACPURISIMA@HOTMAIL.COM

AUTOMOBILE INFORMATION:

Q-32 MTA BUS N/E STOP@ 61 St. / Roosevelt STATION Police & AMBULANCE came

DRIVER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DRIVERS LICENSE #: _____ STATE: _____ EXP. DATE: _____

got off @ 61st. / Roosevelt LATINA LADY - 5'5" - 30 Yr. old (Owner of the Puppy Dog that bit my Right finger)

OWNER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

and RUN - she does not give information

VEHICLE MAKE: _____ MODEL: _____ COLOR: _____ YEAR: _____

VIN #: _____ LICENSE PLATE #: _____ STATE: _____

INSURANCE CO.: _____ POLICY #: _____ CODE: _____

Ex. 17

EXHIBIT "EIGHTEEN"

FACSIMILE: TO: Fax (212) 523-4956

* Letter from Anton Punzina, Patient @ ST. LUKES E.R. HOSP.
Dated: OCTOBER 14, 2013
Addressed to: MD AMY CAGGIULA

* Plaintiff herein was seen on: 10/12/2013, 13:27 @ ST. LUKES E.R. Hospital

RE: Medical Record # 200004713603
TWO (2) SHOTS of Medications Given on 10/12/2013, during the scheduled Appointment. But "NOT LISTED IN MEDICATION REPORT" as well as "SEVERE-SIDE-EFFECTS" to Plaintiff herein. Severe pains in his body.

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

Fax Cover Sheet

Date OCTOBER 21, 2013

Number of pages 4 (including cover page)

To: EMERGENCY ROOM
ST. LUKES EMERGENCY DEPT.
Name 1111 AMSTERDAM AVE., NY, NY 10025

Company ST. LUKES HOSPITAL

Telephone

Fax (212) 523-4956

From: ANTON PURISIMA

Name ANTON PURISIMA, PATIENT

Company SELF

E-MAIL: ACPURISIMA@HOTMAIL.COM

Telephone

Comments faxed Letter dated: OCT. 14, 2013 THREE pages attached herewith. NEEDS YOUR RESPOND IMMEDIATELY !! Please, this is an EMERGENCY. Medical Record# 20600471 3603. I am Hoping for your respond through my E-MAIL ABOVE.

ACP

7 90363 00711 1
Fax - Local Send

7 90363 00714 2
Fax - Domestic Send

7 90363 00720 3
Fax - International Send

22705

TRANSMISSION VERIFICATION REPORT

TIME : 10/14/2013 03:11
NAME : FEDEX OFFICE 0961
FAX : 646-366-9262
TEL : 16463669166
SER.# : 000L8J461357

DATE,TIME	10/14 03:10
FAX NO./NAME	12125234956
DURATION	00:01:00
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

Int. fax service page in our attachment only (indication page only)

ACP

TRANSMISSION VERIFICATION REPORT

TIME : 10/20/2013 22:49
NAME : ONE STOP
FAX : 201-858-3488
TEL :
SER.# : BROH6J520829

DATE,TIME	10/20 22:48
FAX NO./NAME	912125234956
DURATION	00:00:50
PAGE(S)	04
RESULT	OK
MODE	STANDARD ECM

x md. fax service
is with Two pages attachment only
medx. page and the page with
hand-written - note of Date of
next Appointment, that was
written by the NURSE WHO GAVE
ME THE SECOND-MEDICATION-SHOT
(INJECTION SHOT).

AC

ANTON PURISIMA
390 9Th. AVENUE,
NEW YORK, NY 10001
E-MAIL: ACPURISIMA@HOTMAIL.COM

OCTOBER 14, 2013

MD AMY CAGGIULA
E.R., ST. LUKES EMERGENCY DEPARTMENT
1111 AMSTERDAM AVENUE, NEW YORK, NY 10025
FAX: (212) 523-4956

RE: PATIENT ANTON PURISIMA
Medical Record #200004-713603
TWO (2) SHOTS OF MEDICATIONS GIVEN ON 10/12/13
BUT "NOT LISTED IN MEDICATION REPORT"
AS WELL AS "SEVERE-SIDE-EFFECTS"

Dear DOCTOR CAGGIULA:

I was given TWO (2) SHOTS OF MEDICATIONS DURING MY SCHEDULED VISIT ON 10-12-2013, BY TWO (2) NURSES after your visit or seeing me. The one that worried me so much is on "medication Report," it says "NO MEDICATIONS GIVEN" and "NO MEDICATIONS PRESCRIBED" as well as I am having SYMTOMS that I did NOT experience before in my whole life. Swollen nerve and painful Right elbow and left elbow but more painful my Right elbow as well as strange pains in my body.

What medications did you gave me (TWO (2) SHOTS by Two (2) nurses), Please e-mail as soon as possible.

I am very much concern about my safety, especially I was bitten by puppy dog owned by "strange-owner" that run and refused to give information about the dog.

Additionally, Two chinese (man & woman) taking pictures of my person at the Corner going to E.R. Room on oct. 12, 2013, before I went inside the Emergency Room.

I am attaching the "medication Report" that was given to me by the "second nurse" who gave me (the "second SHOT"), for you to review.

Please respond as I am in (an "EMERGENCY")

AS

Very truly yours,
Your Patient:

ANTON PURISIMA
E-MAIL: ACPURISIMA@HOTMAIL.COM

Attached: medication Report page

EmSTAT Report of Home Medications, Medications Given and Medications Prescribed

St. Lukes
1111 Amsterdam Avenue
NY, NY 10025

Emergency Department 212-523-3335

Name: **Purisima, Anton** Sex: **M**
MR #: **200004713603** Account #: **000486015035**
DOB: **15-Dec-1951** Age: **61** Weight:
Chief Complaint: **Rabies Shot**
Prim Diagnosis: **Requires rabies vaccination course (V04.5)**
ED Physician: **CAGGIULA, AMY - Emergency Medicine**
PCP: *** YOUR PRIVATE PHYSICIAN/CLINIC**

Our records indicate that at the time of discharge you are taking these medications.
Please share this list with the physician providing your follow-up care

Allergies:

NKDA

Home Medications

Recorded by AMY CAGGIULA, MD - 10/12/2013 13:27

Medication/Route/Dose/Frequency	Last Dose	Disposition	PCP Contacted
Meclizine oral		Continue	No
Comment:			
Ibuprofen oral		Continue	No
Comment:			
Tylenol oral		Continue	No
Comment:			
Amoxicillin-Pot Clavulanate oral		Continue	No
Comment:			

Medications Given in ED

No Medications Given

Medications Prescribed by ED Physician

No Medications Prescribed

Verified By: _____ PCP / EDMD (circle one) Date/Time: _____

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025

212-523-3335

****

please continue your rabies course 10/16/2013 Wednesday

****

ANIMAL BITE, RABIES-PRONE:
You have been bitten by, or exposed to, an animal that carries a risk of spreading rabies.

Rabies is a deadly viral infection that causes fever, confusion, and death. Fortunately, it is very rare in the United States. Wild Animals accounted for 93% of reported cases of rabies in 2001. Raccoons continued to be the most frequently reported rabid wildlife species (37.2% of all animal cases during 2001), followed by skunks (30.7%), bats (17.2%), foxes (5.9%), and other wild animals, including rodents and lagomorphs (rabbits and hares) (0.7%). While uncommon, it can also be transmitted by dogs and cats.

Symptoms of rabies include pain or numbness at the bite site, headache, fever, nausea and vomiting, anxiety, agitation, confusion, and problems swallowing.

There is no effective treatment once rabies develops. People who are bitten by animals that can transmit rabies need to be vaccinated, according to the guidelines published by the Centers for Disease Control (CDC). This includes shots the day you sought treatment, as well as returning for vaccinations on days 3, 7, and 14 (which is 3 additional shots). Because untreated rabies is 100% fatal, it is extremely important that you return for the remaining shots. YOU MUST COMPLETE ALL OF THE SHOTS IN ORDER TO BE PROTECTED FROM DEVELOPING RABIES!

The shots that you received today are the first in a series of shots. You must complete the series in order to prevent the development of rabies. It is your responsibility to return for the scheduled series of shots in 3, 7, and 14 days from today. If you have a medical condition associated with a weakened immune system like HIV, you will require a 5th rabies shot 28 days from today in addition.

Keep your wound clean and dry. Wash it twice a day with soap and water. Apply an antibiotic cream (Neosporin or Polysporin) to the wound after you wash it. Cover it with a clean, dry bandage after each washing.

You have been started on antibiotics. Take them as directed. Even if your bite wound does not appear to be infected or clears before the antibiotics are gone, continue the prescription for the entire course. Watch your wound very closely for signs of worsening infection.

Wild animals should be captured and turned over to local health department authorities. DO NOT attempt to capture the animal yourself! Call your local Animal Control authorities. A test can be performed on the animal to determine if it is infected with the rabies virus.

Since the incubation period (time until symptoms develop) for rabies is long, if the animal is a dog or cat, it can be observed for abnormal behavior. If the animal is dead, they will have the animal's brain tested for the rabies virus.

Follow-up is EXTREMELY IMPORTANT for repeat vaccination 3, 7, and 14,days from today. Today is day 0, so day 3 is actually 4 days from today. For example if today is Monday day 3 is Thursday

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025

212-523-3335

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

· Unusual redness or swelling.
· Red streaks starting up the arm or leg.
· Foul drainage or odor from the wound.
· Pain with movement of the extremity and / or swollen lymph glands (nodules found along the neck, groin and armpits).
· Fever, chills, increasing pain and / or swelling.

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025

212-523-3335

Information about the Financial Assistance Program is also available on our website:
www.wehealny.com <http://www.wehealny.com>

St. Lukes Emergency Department

1111 Amsterdam Avenue NY, NY 10025
212-523-3335

Take-Home Instructions for the Patient

Patient's Name: Purisima, Anton **Date: 10/12/13 13:27:29**
Medical Record Number: 200004713603 **Date of Service: 10/12/2013 12:59**
Diagnosis: Requires rabies vaccination course (V04.5)
Emergency Attending Physician: MD AMY CAGGIULA
Emergency Resident Physician:
Emergency Physician's Assistant:
Emergency Primary Nurse: KRISTEN GONZALEZ, RN
Primary Care Provider: * YOUR PRIVATE PHYSICIAN/CLINIC - your MD

PLEASE NOTE: The examination and treatment that you have received in the Emergency Department have been rendered on an emergency basis only and are not intended to be a substitute for or an effort to provide complete medical service. A follow-up doctor or facility is named below. It is important that you be checked again as recommended below and report any new or remaining problems at that time, because it is impossible to recognize and treat all elements of injury or illness in a single Emergency Department visit. For patients receiving imaging studies, (e.g. x-rays), please be advised that all study interpretations are preliminary and are followed by a review and final report. If there is a significant change in interpretation you will be notified.

Referral/Appointment:
Refer Patient To:: * YOUR PRIVATE PHYSICIAN/CLINIC
PMD/Clinic not in list: your MD
Follow-up in: as needed

Call to arrange an appointment ***immediately***, to ensure you get an appointment for follow-up care within the indicated time frame. If for any reason the doctor you have been referred to cannot see you for a follow-up appointment, you can obtain additional referrals at 1-877-463-6362.

When you call for an appointment, say that you were referred from this Emergency Department.

If you cannot see the above doctor and your condition worsens so that you require emergency treatment, come back to this department.

PLEASE TAKE THIS WITH YOU WHEN YOU SEE DOCTOR LISTED ABOVE

****

If you smoke, you are encouraged to quit in order to live longer, feel better, and heal faster. Quitting will lower your chance of heart attack, stroke, or cancer. The people you live with, especially children, will be healthier. Please contact the following numbers for additional information:

At St. Luke's: (212) 523-4410 At Roosevelt: (212) 523-6056

****

FINANCIAL ASSISTANCE

If you are uninsured and unable to pay your hospital bill, you may qualify for Financial Assistance. Please call 212-523-3900 and speak with a Financial Counselor for more information.

EXHIBIT "NINE TEEN"

* Fax Letter of Anton Pereira, plaintiff
Dated: OCTOBER 15, 2013
Addressed to: Heather Koteski, MD (DR);
"ATTENDING: G 5".
"PRIMARY RN: JME1"
HOBOKEN U.M.C., Emergency Room
308 WILLOW AVE.,
HOBOKEN, NEW JERSEY 07030
fax: (201) 418-1913
* (mailed prior to fax service)
on: OCT. 15, 2013
* faxed on: OCTOBER 21, 2013,
Due to no response.
* with "Transmission Verification Report"

* Plaintiff incorporates this document to every page in this action, and to support thereof.

ACP

Fax Cover Sheet

Date OCTOBER 21, 2013

Number of pages 7 (including cover page)

To: HEATHER KOTOSKI, MD;
"ATTENDING: GS"
Name "PRIMARY RN: JMEI"
Company HOBOKEN UNIVERSITY MEDICAL CENTER
EMERGENCY ROOM DEPARTMENT
Telephone (201) 418-1900
Fax (201) 418-1913

From: ANTON PURISIMA
Name ANTON PURISIMA, PATIENT
Company SELF
Telephone E-MAIL: ACPURISIMA@HOTMAIL.COM

Comments Letter dated: OCTOBER 15, 2013 attached herewith 6 pages plus cover page. This is a fax service, as addition. Please respond as soon as possible, as this is an EMERGENCY!

7 90363 00711 1
Fax - Local Send

7 90363 00714 2
Fax - Domestic Send

ACP

7 90363 00720 3
Fax - International Send

22705

TRANSMISSION VERIFICATION REPORT

TIME : 10/20/2013 22:55
NAME : ONE STOP
FAX : 201-858-3488
TEL :
SER.# : BROH6J520829

DATE,TIME	10/20 22:51
FAX NO./NAME	912014181913
DURATION	00:04:01
PAGE(S)	07
RESULT	OK
MODE	STANDARD

ANTON PURISIMA, PATIENT
390 9Th. AVENUE,
NEW YORK, NEW YORK 10001.

By: FIRST CLASS MAIL (TWO STAMPS ATTACHED)

OCTOBER 15, 2013

HEATHER KOTUSKI, MD (DR)
"ATTENDING: GS"
"PRIMARY RN: JME;"

HOBOKEN U.M.C., E. ROOM
308 WILLOW AVE.;
HOBOKEN, NEW JERSEY 07030

RE: MEDICAL RECORD: 2005623
ACCT. # 200539047
[NOTICE OF FRAUD MEDICAL ("ACTS"); NOTICE TO STOP MEDICAL BILLS or CHARGES DURING THE VISIT on OCT. 14th, 2013 @ UMC; "OTHER" ILLEGAL ACTS DURING E.R. VISIT BY UMC EMPLOYEES TOWARDS PATIENT ANTON PURISIMA]

ACP

Dear DOCTOR KOTUSKI, and (the "ADMINISTRATOR") of UMC, and to whom it may concern:

Please take notice of the following:

①. The alleged employees above made WRONG MEDICAL RECORD REPORT in my record as a patient at HOBOKEN U.M.C., ON OCTOBER 14, 2013 — my Complaint in going to HOBOKEN UNIVERSITY MEDICAL CENTER (HUMC) IS MY RIGHT-HAND-ELBOW WAS AND IS SWOLLEN and VERY PAINFUL I cannot Bring it up (RAISE IT UP) DUE TO SO MUCH PAIN at well at I personally informed the alleged (Attending: "GS EMPLOYEE") and I informed all nurses (1st. 2nd. and 3rd. nurse who were assigned to help me that I WAS BITTEN BY A PUPPY (DOG) @ my Right Hand middle finger on OCTOBER 4th 2013 and I also informed all THREE EMPLOYEES and that I was given "Rabbies" shots started on OCT. 09, 2013 (FIRST Rabbies Shots). That the

"second shot" was held on OCT. 12, 2013. However, I informed these nurses on OCTOBER 14, 2013 @ HUMC that my nerves were swollen around ELBOW area of my right hand ("front and back of my Right elbow"), after (the "second shot") on OCT. 14, 2013 as well as I informed other around around my body and the medications I was taking, these were and are my purpose in seeing the Doctor @ HUMC (Hospital). My "ear-problem" was "just-added-at-the-end." I just requested to see (to "drain." It was just (an "ADDITION"), but the "Attending" "GS" was "forced" to see my left-ear (based on my interpretation, as she was saying: "your REGULAR DOCTOR SHOULD CHECK THIS AS THIS IS an E.R." Also, I requested a "REFILL OF MY "MECLIZINE" medication due to my Dizziness problem (Vertigo) but she refused to prescribe me through the nurses (2nd. nurse - who escorted me to the assigned space. ② This is relayed to me also (by "THE EXIT NURSE") (PREGNANT-NURSE) That handed to me the "Discharge Instructions." Additionally "I did not see" (The "medical Doctor" who signed the prescriptions in my case).

③. my "main symptoms" (Problem in going (PURPOSE) TO the Hospital were Disregarded (replaced w/ less important

④. I was Prescribed w/ CIPRO HC: Suspension: 0.2% - 1%: OTIC signed by: Heather KOTOSKI (I did not see) - "This medication is TOO expensive ($200.00 ea) and was denied by the insurance, due to Very Expensive. Relayed to me by the Pharmacist @ Duane Reade. See: attached Copy as reference.

(5). my swollen never around my right-elbow Disappeared in Discharge instructions!

6. The "Second-Double-Automatic-Door" closed (did not open as well as the ladies near the entrance were laughing at me, when I informed them the second-door were locked. Then, they opened it)

Please take notice, this is a complaint as well as an "Request for investigation" for the above issues. Therefore, Please respond as soon as possible Through E-MAIL: ACPURISIMA@HOTMAIL.COM

ATTACHED: PRESCRIPTION (COPY) & Discharge instructions - for you to REVIEW

Very truly yours,

ANTON PURISIMA,
Complainant
E-MAIL: ACPURISIMA@HOTMAIL.COM

PLS. NOTE:
* DO NOT CHARGE THE INSURANCE CO. THAT I GAVE TO YOUR OFFICE (CARD INFORMATION);
* YOU WILL BE COMMITING Additional fraud, if you charge.
Due to you are hereby notified THROUGH THIS LETTER.
* I WAITED TOO LONG as well as APPROX. TWO INCHES THICK OF OF MY DOCUMENTS are MISSING from my "Cart"
* ADDITIONALLY, you are in Violation of my Constitutional rights as (a "patient") and as (a "Customer") as well as (a "U.S. CITIZEN").
Due to these, I am DEMANDING PAYMENT OF $100 (DECILLION DOLLARS), if you do not pay me IN one (1) month it will go UP (to "PRICELESS DAMAGES") as well as I will file my claim in COURT ..... will see you there.

=Page THREE of THREE=

Same

Hoboken UNIVERSITY MEDICAL CENTER

Name: Purisima, Anton
Age: 61Y DOB: Dec 15, 1951
Gender: M
MedRec: 2005623
AcctNum: 200539047
Attending: GS
Primary RN: JMEI
Bed: ED ED 25B-FT

HOBOKEN UMC
DISCHARGE INSTRUCTIONS

You have been seen, treated and released from Hoboken University Medical Center. Please return to this ER, or to the nearest Emergency Department if your symptoms worsen.

FINAL DIAGNOSIS
Otitis externa (acute)

ADDITIONAL DIAGNOSIS
wound check

FOLLOWUP CONTACTS

physician NHC, Family Practice
122-132 Clinton Street
Hoboken NJ 07030
Phone: 201-418-3220
Comment: NHC - Neighborhood Health Center - formerly known as Center for Family Health

SPECIAL INSTRUCTIONS
Follow-up rabies vaccine on 10/16/13.

MEDICAL INSTRUCTIONS

EAR - SWIMMERS (OTITIS EXTERNA)
Swimmers Ear
(Otitis Externa)

You have been diagnosed as having otitis externa ("swimmers ear"). Otitis externa is a bacterial (germ) or fungal infection of the outer ear canal (from the eardrum to the outside of the ear). Swimming in dirty water may cause swimmers ear. It also may be caused by moisture in the ear from water remaining after swimming or bathing. Often the first signs of infection may be itching in the ear canal. This may be associated with pus like drainage from the canal.

HOME CARE INSTRUCTIONS
It is important to keep your ear dry. Use the corner of a towel to wick water out of the ear canal after swimming or bathing.
Avoid scratching in your ear. This can damage the ear canal or remove the protective wax lining the canal and make it easier for bacteria (germs) or a fungus to grow.
Make up a small bottle of equal parts of white vinegar and alcohol. Put three or four drops into the infected ear while lying down and keeping that ear pointed up. Keep drops in for two or three minutes. You may then turn over and let that ear drain and do the same thing with the opposite side even if that side is not infected. Drain this ear also after two to three minutes. Hopefully this will prevent infection on that side. Repeat this treatment three times per day. If it seems to be helping, continue the treatment for one month.
Sleeping with your head raised may help relieve pain.
Use a cotton tipped swab to dry ear canal after swimming or bathing.
You may use acetaminophen (Tylenol®), ibuprofen (Advil® or Motrin®), or aspirin as needed for pain and

Hoboken UNIVERSITY MEDICAL CENTER

Name: Purisima, Anton
Age: 61Y DOB: Dec 15, 1951
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Attending: GS
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Bed: ED ED 25B-FT

HOBOKEN UMC
DISCHARGE INSTRUCTIONS

inflammation (soreness) if your caregiver has not given medications which would interfere with this or advises otherwise. Take ibuprofen with food in your stomach or with a meal to avoid stomach upset.
If you have not improved within one week, see your caregiver.

SEEK MEDICAL ATTENTION IF:
You have pain that is not relieved by eardrops or heat.
An oral temperature above 102° F (38.9° C) develops, or as your caregiver suggests.
There is any discharge from the ear, the outer ear becomes red or swollen, or there is swelling behind your earlobe.
Your ear is still painful after 3 days or is getting worse.
You have problems that may be related to the medicine you are taking.
Document Released: 12/18/2006 Document Re-Released: 06/11/2007

PRESCRIPTIONS

Ibuprofen : Tablet : 800 Mg : Oral
Dispense: 15, Quantity: * Unit: , Route: Oral, Schedule: See Notes

Cipro HC : Suspension : 0.2%-1% : Otic
Dispense: 1 bottle, Quantity: 3, Unit: gtts, Route: Otic, Schedule: 2 times a day

Augmentin : Tablet : 875 Mg-125 Mg : Oral
Dispense: 14, Quantity: 1, Unit: tab, Route: Oral, Schedule: 2 times a day

Please read your instructions carefully. Return to the Emergency Room for any worsening signs and/or symptoms.

Please call the number below if you don't have a Primary Care or Consulting Physician:
HUMC Center for Family Health, Monday thru Friday 8am - 5pm
Tel: 201-418-3123 or 201-418-3100

Hoboken University Medical Center Emergency Dept: 201-418-1900

Hoboken
UNIVERSITY
MEDICAL CENTER

Name: Purisima, Anton
Age: 61Y DOB: Dec 15, 1951
Gender: M
MedRec: 2005623
AcctNum: 200539047
Attending: GS
Primary RN: JMEI
Bed: ED ED 25B–FT

HOBOKEN UMC
DISCHARGE INSTRUCTIONS RECEIPT

As Always, You are the most important factor in your recovery. Please follow these instructions carefully. If you have problems that we have not discussed, CALL OR VISIT YOUR DOCTOR RIGHT AWAY. If you can't reach your doctor, return to the emergency department.

FINAL DIAGNOSIS
Otitis externa (acute)

ADDITIONAL DIAGNOSIS
wound check

FOLLOWUP CONTACTS

physician NHC, Family Practice
122–132 Clinton Street
Hoboken NJ 07030
Phone: 201–418–3220
Comment: NHC – Neighborhood Health Center – formerly known as Center for Family Health

THE FOLLOWING SPECIAL INSTRUCTIONS WERE GIVEN
Follow–up rabies vaccine on 10/16/13.

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
EAR – SWIMMERS (OTITIS EXTERNA)

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

Ibuprofen : Tablet : 800 Mg : Oral
Dispense: 15, Quantity: *, Unit: , Route: Oral, Schedule: See Notes

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Dispense: 14, Quantity: 1, Unit: tab, Route: Oral, Schedule: 2 times a day

CONTACT YOUR PRIMARY CARE PHYSICIAN:

Please contact your PCP as soon as possible and inform them of this Emergency Department visit. Most insurance policies require this and you may be held responsible for your entire Emergency Department bill if you do not get your primary care physicians authorization for the ER visit.

Also, before calling to see any specialist you may have been referred to, you should also contact your PCP. Most

State of New Jersey

PRESCRIPTION BLANK

HOBOKEN UNIVERSITY MEDICAL CENTER

EMERGENCY DEPARTMENT

308 WILLOW AVENUE • HOBOKEN, NJ 07030 • TEL # 201-418-1900

FACILITY PROVIDER # HF 10908

FACILITY NPI # 1043475668

BATCH # PFL 13082102

SERIAL # 009518

PRINT CLEARLY: NAME & TITLE OF PRESCRIBER & IF APPLICABLE, SUPERVISING / COLLABORATING/VE PHYSICIAN

CHECK IF: ☐ APN ☐ CNM ☐ PA ☐ PRT ☐ RPD

LICENSE / CERT/ Rx AUTHORIZATION # 25MP00275500

DEA # MK2565678

MP# 1710256425

PATIENT Anton Purisima D.O.B. 12/15/1951

ADDRESS 390 94th ave DATE 10/14/2013

Rx

Cipro HC : Suspension : 0.2%–1% : Otic

3 gtts
2 times a day
Dispense: **1 bottle**

SUBSTITUTION PERMISSIBLE ☐ DO NOT SUBSTITUTE

DO NOT REFILL ☐

REFILL ____ TIMES

SIGNATURE OF PRESCRIBER Heather Kotuski

Use separate form for each controlled substance prescription

THEFT, UNAUTHORIZED POSSESSION AND/OR USE OF THIS FORM, ALTERATIONS OR FORGERY, ARE SEVERELY PUNISHABLE BY LAW

ACP

EXHIBIT "TWENTY"

ONE DOCUMENT for: THIS ACTION and ATTACHMENT "X-TWO" for: State Complaint

* Plaintiff incorporates this document to every page in this action, and to support thereof.

Copy of:

* A Letter from:
Care Point Health,
Hoboken University Medical Center
Dated: OCTOBER 21, 2013
Addressed to: ANTON PURISIMA

* UNSIGNED

* Copy of Letter & WITH Postmarked Envelope OCTOBER 21, 2013

ACP

CarePoint Health
Hoboken University
Medical Center

CarePoint Health - Hoboken University Medical Center
308 Willow Avenue
Hoboken, NJ 07030

October 21, 2013

Anton Purisima
390 9TH Avenue
New York, NY 10001

Dear Mr. Purisima:

Thank you for your letter describing the problems with the emergency department. I appreciate your candor and have reviewed your chart and discussed with all providers involved in your case. I understand your frustration and apologize for your inconvenience.

The chart does accurately reflect all of your problems and complaints, i.e. wound check for dog bite, chronic vertigo, lost prescriptions, and ear pain with drainage. All issues are documented appropriately. Cipro ear drops are an appropriate prescription, but are easily changed if insurance cannot cover the cost. Feel free to follow up with us, the neighborhood health center, or the physician who initially treated your dog bite.

Sincerely,

CarePoint Health – Hoboken University Medical Center
Emergency Department

CarePoint Health
Hoboken University
Medical Center

308 Willow Avenue, Hoboken, NJ 07030

$00.46

US POSTAGE

Anton Purisima
390 - 9th Ave.
New York, NY 10001

NOV 07

10001990190

EXHIBIT "TWENTY-ONE"

* HOBOKEN UMC
DISCHARGE INSTRUCTIONS for: PURISIMA, ANTON

Dated: OCTOBER 14, 2013

* THREE PAGES

* Plaintiff incorporates this document to every page in this complaint and to support thereof.

ACP

Hoboken UNIVERSITY MEDICAL CENTER

Name: Purisima, Anton
Age: 61Y DOB: Dec 15, 1951
Gender: M
MedRec: 2005623
AcctNum: 200539047
Attending: GS
Primary RN: JMEI
Bed: ED ED 25B-FT

HOBOKEN UMC
DISCHARGE INSTRUCTIONS

You have been seen, treated and released from Hoboken University Medical Center. Please return to this ER, or to the nearest Emergency Department if your symptoms worsen.

FINAL DIAGNOSIS
Otitis externa (acute)

ADDITIONAL DIAGNOSIS
wound check

FOLLOWUP CONTACTS

physician NHC, Family Practice
122-132 Clinton Street
Hoboken NJ 07030
Phone: 201-418-3220
Comment: NHC – Neighborhood Health Center – formerly known as Center for Family Health

SPECIAL INSTRUCTIONS
Follow-up rabies vaccine on 10/16/13.

MEDICAL INSTRUCTIONS

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Swimmers Ear
(Otitis Externa)

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It is important to keep your ear dry. Use the corner of a towel to wick water out of the ear canal after swimming or bathing.
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Make up a small bottle of equal parts of white vinegar and alcohol. Put three or four drops into the infected ear while lying down and keeping that ear pointed up. Keep drops in for two or three minutes. You may then turn over and let that ear drain and do the same thing with the opposite side even if that side is not infected. Drain this ear also after two to three minutes. Hopefully this will prevent infection on that side. Repeat this treatment three times per day. If it seems to be helping, continue the treatment for one month.
Sleeping with your head raised may help relieve pain.
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You may use acetaminophen (Tylenol®), ibuprofen (Advil® or Motrin®), or aspirin as needed for pain and

Hoboken UNIVERSITY MEDICAL CENTER

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HOBOKEN UMC
DISCHARGE INSTRUCTIONS

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If you have not improved within one week, see your caregiver.

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There is any discharge from the ear, the outer ear becomes red or swollen, or there is swelling behind your earlobe.
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You have problems that may be related to the medicine you are taking.
Document Released: 12/18/2006 Document Re-Released: 06/11/2007

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Please read your instructions carefully. Return to the Emergency Room for any worsening signs and/or symptoms.

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Hoboken UNIVERSITY MEDICAL CENTER

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HOBOKEN UMC
DISCHARGE INSTRUCTIONS RECEIPT

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ADDITIONAL DIAGNOSIS
wound check

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physician NHC, Family Practice
122-132 Clinton Street
Hoboken NJ 07030
Phone: 201-418-3220
Comment: NHC - Neighborhood Health Center - formerly known as Center for Family Health

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Follow-up rabies vaccine on 10/16/13.

THE FOLLOWING MEDICAL INSTRUCTIONS WERE GIVEN
EAR - SWIMMERS (OTITIS EXTERNA)

THE FOLLOWING PRESCRIPTIONS WERE GIVEN

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Please contact your PCP as soon as possible and inform them of this Emergency Department visit. Most insurance policies require this and you may be held responsible for your entire Emergency Department bill if you do not get your primary care physicians authorization for the ER visit.

Also, before calling to see any specialist you may have been referred to, you should also contact your PCP. Most

EXHIBIT "TWENTY-TWO"

* COPY ATTACHED HEREWITH WITH ENVELOPE

* Letter from: WILLIAM V. ROEDER, EXECUTIVE DIRECTOR NEW JERSEY OFFICE of the ATTORNEY GENERAL

Dated: NOVEMBER 25, 2013

ADDRESSED TO: ANTON PURISIMA

RE: HEATHER KOTUSKI, M.D.; (OTHER "ISSUES"); DOG-BITE INCIDENT TREATMENTS OF PLAINTIFF'S [WOUND BITTEN BY RABIES INFESTED DOG. DEFENDANTS REFUSED TO PROPERLY TREAT PLAINTIFF.]

ACP

* Plaintiff's Prior Complaint of (these "illegal acts of defendants") in this action filed by Plaintiff herein, issues during his E.R. visit on OCT. 14, 2013 (illegal acts conducted by employees against Complainant at Hoboken UMC).

* Plaintiff filed complaint to the State of New Jersey (Attorney General's office, and was referred by the alleged office to CONTACT (THE "NEW JERSEY DEPARTMENT OF HEALTH"), as alleged in the letter.

* Plaintiff incorporates this document to every page in this action and to support thereof.

ACP

New Jersey Office of the Attorney General

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

Division of Consumer Affairs
State Board of Medical Examiners
P.O. Box 183, Trenton, NJ 08625-0183

JOHN J. HOFFMAN
Acting Attorney General

ERIC T. KANEFSKY
Director

For Delivery Services:
140 East Front St.
PO Box 183 , 3rd Floor
Trenton, NJ 08608
(609) 826-7100
(609) 826-7117 FAX

November 25, 2013

Anton Purisima
390 9th Avenue
New York, New York 10001

RE: Heather Kotuski, M.D.

Dear Anton Purisima,

The New Jersey State Board of Medical Examiners (the "Board") is in receipt of your recent correspondence regarding the above captioned matter.

The Board is authorized to conduct an inquiry of alleged violations of the Medical Practice Act. The Board's administrative office carefully reviews all submitted material, and generally, forwards all complaints to a committee of the Board. Specific facts, however, must be present in order to make a proper assessment. Based on the information you provided, the Board is unable to identify any violation within the Board's jurisdiction.

The issues you mention in your complaint involving Cape Point Health and Hoboken University Medical Center do not fall under the jurisdiction of the Board. Therefore, you may wish to contact the New Jersey Department of Health.

The Board is aware that this matter is very distressing for you. The decision not to take any disciplinary action in no way minimizes your complaint. I wish more favorable information could have been provided to you.

The Board appreciates your understanding in this matter.

Very truly yours,

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

William V. Roeder
Executive Director

WVR/raz

Ex. 22

EXHIBIT "TWENTY-THREE"

* ARTICLE: USA TODAY FOR: ASBURY PARK PRESS
  Wed. APRIL 09, 2014
* TITLE: OBAMA, OTHER PRESIDENTS HONOR CIVIL RIGHTS ACT
  BY: David Jackson, USA TODAY
* Plaintiff herein incorporates this Exhibit "Twenty-Three" to every page in this action and to support thereof.

ACP

USA TODAY FOR: ASBURY PARK PRESS
Wed., APRIL 09, 2014

Obama, other presidents honor Civil Rights Act

David Jackson
USA TODAY

AUSTIN — President Obama and three of his predecessors — are paying tribute here this week to the man and the movement that in many ways made Obama president.

That man — President Lyndon Johnson — and the movement that forged the Civil Rights Act of 1964 are topics of a three-day 50th anniversary summit at the LBJ library that opened Tuesday. Obama and presidents George W. Bush, Bill Clinton and Jimmy Carter are all scheduled to discuss the series of civil rights laws that continue to change American life, politics and culture.

"Those laws did many 'wonderful' things, Carter said on the summit's opening day Tuesday, but the nation is still "falling short" on parts of the civil rights agenda, notably racial disparities in employment and education.

Obama, who delivers the keynote address Thursday, has previously discussed the personal impact of the Civil Rights Act of 1964 and its equally high-profile companion, the Voting Rights Act signed by Johnson in 1965.

In an August ceremony to commemorate the 50th anniversary of the March on Washington, Obama said that people demonstrated to open "doors of opportunity and education" for him and millions of others.

"Because they marched," he said, "city councils changed and state legislatures changed, and Congress changed and yes, eventually, the White House changed."

Passed over the objections of filibustering Southern senators, the Civil Rights Act of 1964 outlawed racial segregation at public accommodations that included hotels, restaurants, schools and public transportation. It basically ended what civil rights activist Julian Bond, attending the summit here, called "this petty apartheid that America had."

The next year, the Voting Rights Act of 1965 broke down barriers that Southern states and others had put on voting by African Americans. Those two laws became cornerstones of what Johnson called his "Great Society," federal legislation designed to expand economic opportunity

CIVIL RIGHTS ACT OF 1964

EXHIBIT "Twenty-Three"

EXHIBIT "TWENTY-FOUR"
copies of the following:

* AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO HIPAA (OCA OFFICIAL FORM # 960)

* for: ANTON PURISIMA
* MAILED ON: APRIL 08, 2014
* Signed & Dated: APRIL 08, 2014
* Letter from: NYC Transit Authority, Law Dept.
Dated: March 18, 2014, with "Instructions for the use of the HIPAA-compliant Authorization Form to Release Health Information for Litigation"

* Plaintiff incorporates these ("the "above Documents") to every page in this action, and to support thereof. And Copy of ENVELOPE Postmarked: APRIL 02, 2014

ACP

Instructions for the Use of the HIPAA-compliant Authorization Form to Release Health Information Needed for Litigation

This form is the product of a collaborative process between the New York State Office of Court Administration, representatives of the medical provider community in New York, and the bench and bar, designed to produce a standard official form that complies with the privacy requirements of the federal Health Insurance Portability and Accountability Act ("HIPAA") and its implementing regulations, to be used to authorize the release of health information needed for litigation in New York State courts. It can, however, be used more broadly than this and be used before litigation has been commenced, or whenever counsel would find it useful.

The goal was to produce a standard HIPAA-compliant official form to obviate the current disputes which often take place as to whether health information requests made in the course of litigation meet the requirements of the HIPAA Privacy Rule. It should be noted, though, that the form is optional. This form may be filled out on line and downloaded to be signed by hand, or downloaded and filled out entirely on paper.

When filing out Item 11, which requests the date or event when the authorization will expire, the person filling out the form may designate an event such as "at the conclusion of my court case" or provide a specific date amount of time, such as "3 years from this date".

If a patient seeks to authorize the release of his or her entire medical record, but only from a certain date, the first two boxes in section 9(a) should both be checked, and the relevant date inserted on the first line containing the first box.

New York City
Transit Authority
Law Department
Claims Investigation and Adjustment

March 18, 2014

In reply, please refer to:
BU 20131009 0035 - 001

ANTON PURISIMA
390 9TH AVENUE

NEW YORK NY 10001

To Whom It May Concern:

An action now pending against the New York City Transit Authority arises from an accident that occurred:

Date: 10/09/2013 Time: 4 : 5 P M Borough: Q
Division: QB Line/Route: Q32 Car/Bus #: 6903 Stairway:
Location: ROOSEVELT AVENUE & 61 STREET Direction:

Re: ANTON PURISIMA
390 9TH AVENUE
NEW YORK NY 10001

To aid in the completion of our investigation of this case, kindly forward the following information to the attention of the claim examiner listed below. We need:

AUTHORIZATIONS FOR RELEASE OF MEDICAL AND EMPLOYMENT RECORDS

Thank you for your cooperation in this matter.

Very truly yours,
Wallace D. Gossett, Esq.
Executive Assistant General Counsel, Torts

By: Sean A. Davis Claim Specialist II
Claim Specialist II
130 Livingston Street
Brooklyn, N.Y. 11201
Tel: 718-694-4822

Attachment

03 SAD SAD

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANTON PURISIMA	DEC. 15, 1951	570-75-6624
Patient Address: 390 9TH. AVENUE, NEW YORK, NEW YORK 10001		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
ST. LUKES EMERGENCY DEPT., 1111 AMSTERDAM AVE., NY, NY 10025

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here ACP (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	*
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form. DISCRETION OF NYC TRANSIT AUTHORITY, TO FILL AS DEEMS NEEDED THE ABOVE ITEMS. N

ANTON PURISIMA

Signature of patient or representative authorized by law.

Date: APRIL 08, 2014

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
ANTON PURISIMA	DEC. 15, 1951	570-75-6624
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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information: HOBOKEN UNIVERSITY MEDICAL CENTER, 308 WILLOW AVE., HOBOKEN, NJ 07030

8. Name and address of person(s) or category of person to whom this information will be sent:

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☒ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**
_____ **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☐ By initialing here AC (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

_____ (Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☒ At request of individual ☐ Other:	
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

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ANTON PURISIMA
Signature of patient or representative authorized by law.

Date: APRIL 08, 2014

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

130 Livingston Street
Brooklyn, NY 11201

New York City Transit

U.S. POSTAGE PITNEY BOWES
ZIP 11201 $ 000.48⁰
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0001380120 APR 02 2014

Anton Pursima
390 9th Ave
NY, NY 10001

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