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

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

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

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

>> MAZEN BASRAWI: Good morning, everyone. My name is Mazen Basrawi. I'm Counsel to the Assistant Attorney General Tom Perez. On behalf of Assistant Attorney General Perez, I'd like to welcome you to our third and final hearing on our Advance Notices of Proposed Rulemaking.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I did a study and I found as you all know that the population of we hearing-impaired are at least 36 million and supposedly increasing by one million per year. Thirty-six million new potential customers to the movie industry would offset any undue burden for the industry, and would increase the ability of my people, my hearing-impaired people, to enjoy the benefits of what you all enjoy without trouble.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The majority of our population are young individuals that are into activities and exercise. And what we are trying to do is help identify ways that they can keep going with those activities after rehab and after they finish with our program.

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

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

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

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

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

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

Gyms need to provide equipment that has simple changes like larger seats, swing away seats, things that can be operated from, from a wheelchair or with simple assistance. Color contrasted controls, treadmills with lower speeds, lifts. There should be a lift on every pool. Raised mats. If you want to be able to stretch out, it's a lot easier to get onto a mat than it is to get onto the floor. And all of this, like I said earlier, should not be stuck into a corner.

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

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

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

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

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

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

of Sage Associates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Although in reality some movie theater owners and operators may not be financially able to equip all of its theater screens at this time, the largest, wealthiest movie theater operators who are already spending massive budget amounts to upgrade to digital screens could provide access on a 100 percent of the screens for a de minimums additional cost to the upgrade.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Being involved in health and fitness industry for the last 30 years, I've been able to walk in and out of numerous environments, and was only recently as the owner of a business that is in the supply of exercise equipment, facility design and equipment maintenance, that I came across the opportunity to provide inclusive fitness environments in a variety of locations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I'm fortunate, because of my insurance, I have worker's comp. And I realize that I get a lot more benefits than many of the people in my same situation. I do have a trainer now that helps me. And I haven't let these road blocks stop me from working out. I've been able to adjust my workouts and still come up with a routine. However, these simple things are often enough of a roadblock to keep most people from going into the gym.

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

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

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

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

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

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

>> JOHN WODATCH: Thank you very much for your public service, first of all, and for coming forward and sharing your story with us. We appreciate it. Our next commenter

is going to be on the telephone. And it's Marilyn Piepho.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

>> JACKIE HUNT CHRISTENSEN: Yes, good morning. Thank you for this opportunity to testify. I will be speaking to the issue of nondiscrimination on the basis of disability by

state and local governments and places of public accommodation, and also furniture.

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

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

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

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

By the way, this is a problem with many places. Information kiosks at museums and stores, on smart phones, music players and many other new widgets that are becoming available every day. To cope with some of my motor symptoms, I underwent deep brain stimulation surgery, or DBS, in January of 2006. I have an electrical lead going into each side of my brain that is connected to a neural stimulator on each side of my chest.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

>> JOHN WODATCH: A minute, please.

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

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

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

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

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

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

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

>> JOHN WODATCH: Mr. Park--

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

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

Next we are going to hear from Michael Fiorino.

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

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

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

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

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

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

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

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

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

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

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

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

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

>> BONNIE LEWKOWICZ: Yes. Thank you.

>> JOHN WODATCH: Please proceed.

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

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

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

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

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

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

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

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

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

I'm confident that this practice is not an intentional act to keep people with disabilities from staying at hotels. Rather, it's a response to the perception and marketing strategy by the bed industry that bigger beds equates to greater comfort. But where is our comfort when we are being forced to sleep in our wheelchairs because we can't get in a bed or move around in it because we’ve sunk so far into the pillow-top. On the positive side, there is an easy remedy and one that would not pose an undue burden on the lodging industry. Require places of lodging to have beds that measure 20 to 23 inches as they previously did from the floor to the top of the mattress in at least some of their accessible rooms. These beds already exist on the market. In fact, the micro hotel chain uses a lower bed in their accessible rooms that does not compromise comfort for access. And, I will submit my other specific recommendations because I've run out of time.

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

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

>> LUCIANA PROFACA: Hello. Thank you. My name is Dr. Luciana Profaca. I am the Chief Deputy Director for the California Department of Rehabilitation. And, first I would like to applaud the efforts of the U.S. Department of Justice to update and

strengthen the regulations implementing the act. This is a very important move and I'm extremely grateful.

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

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

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

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

Even some materials which were originally created in electronic form a few years ago do not meet current accessibility standards. The same general principles that govern physical access should apply. All new or substantially modified websites and content must be fully accessible. But, even existing sites and content should be made accessible to the extent this is readily achievable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

>> MICHELLE MILLER: Hi, I'm Michelle Miller with Safer Building. And, my company

has conducted hundreds of unbiased tests on nontoxic building materials and methods. And, as such, we hear from people all over the country that are interested in healthy home and office environments. Many of whom want a healthy life and many of whom are also chemically sensitive.

And, there are simple changes that will make a huge, huge difference to many people. Chemical sensitivity for the most part is an invisible disability. And so, if it were appropriate, leaders of various organizations could put together brochures that could help, brochures, people could carry cards that were signed by physicians so that if somebody were stopped by a police officer or ambulance or some other 911 responder, the person would immediately be able to identify that this is one such person with this disability via a card signed by a physician, and they would have brochures to indicate protocols that would be more helpful. For example, the exhaust from fumes of ambulance and police cars and tow trucks is an issue. People who have been injured by chemicals frequently will have a severe reaction to toxins at much lower levels, levels than most people. And so, even though those fumes are harmful to everybody if they’re closed in a garage and harmful to everybody at the low level, the reaction at the low level is what the difference is.

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

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

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

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

Of course, the police officer needs to do his or her job, and so perhaps a solution, there is a lot of solutions but one solution would be once again, if a chemically sensitive person carried a card to show the officer and the emergency responder had a brochure, they could designate, for example, a safer area with fresh air, and have the designated fragrance-free person meet there so they could do their business in an area that doesn't put the chemically sensitive person at risk.

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

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

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

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

So, I would hope that we could have you back soon. But again, thank you all for being here and taking the day to have this hearing. I hope you are enjoying your stay at the most accessible city in the country, San Francisco. I should first say that I, for those of you that don't know me, I started in this business, I guess you could say, over 30 years ago when I was trimming a tree at home and fell and became a paraplegic. I opened an independent living center after leaving my vocation and avocation, the restaurant business, because I was told I wouldn't be able to come back as the manager and be in the dining room or the bar when the public was there, because in 1978, people didn't feel comfortable seeing people like me in restaurants.

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

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

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

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

Can everyone including those in our aging population operate all doors in an accessible route including exterior doors? Presently, ADAAG requires interior doors to have a maximum force to operate of five pounds, which is considered accessible. Should exterior doors that can't meet the five pounds force requirement be required to use power operators to make them accessible? I was part of a very small group of people, three people that created new code a number of years ago, requiring exterior doors to be accessible at five pounds, if they weren't able to, for various reasons, they are required to put in a power operator. Are there other systems that should be required that would be, that would make the built environment more accessible to seniors and people with disabilities? That is what I'm going to talk about now.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Another recreate the wheel issue, WCAG is already being used by covered entities and has been so for many years. Examples from my own work and that of my co-counsel, Linda Dardarian include the following. In 2000, Bank of America with the California counsel of the blind signed the first agreement in the country referencing WCAG. That’s 2000, over 10 years ago. Many other banks followed suit. In 2008, the three United States credit reporting agencies began using WCAG to guarantee accessibility of free online credit reports. Online financial information involves heightened security and privacy, including captchas. WCAG has worked well as a technical standard in these environments. In 2009, we worked with CVS and Rite Aid and got signed agreements to use WCAG on those complex retail sites. And, in 2010, Major League Baseball began using WCAG 2.0 level AA for both MLB.com and the websites of all 30 major league baseball teams. WCAG is already rooted in the public and private sector in the United States and abroad. And, the Department should not recreate the wheel and develop a new or use a different technical standard.

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

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

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

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

1997 was 14 years ago. In many ways, the Department is playing catch up with these regulations. Today in 2011, the Department has a historic opportunity to make the promise of the Internet a living, breathing reality. I urge you not to let the opportunity pass. Thank you very much

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Congress intended. Thank you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This recent study used, and I will be handing you a power point later on that details more of what is in the study. The study used 2,389 reviews of primarily urban sites, primary care providers. The primary care providers surveyed had specialties in general medicine, internal medicine, family practice, pediatrics or obstetrics and gynecology. The questions addressed a variety of elements, including architectural ones but I'm going to be focusing on the questions relating to exam tables and weight scales and examination rooms space. The findings on the availability of accessible equipment are stark. Across all primary care specialties and locations surveyed, 8.4 percent have an accessible exam table and 3.6 percent have an accessible weight scale.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Technology has evolved. Movie studios had movies captioned for years. The accessible product is there, and has been there in front of us. The movie theaters are not showing them. Department guidance must recognize the difference between limited captioning technology that existed in the '90s, and the captioning technology that is available today.

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

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

This captioning is then seen by everyone in the room. The third term I wanted to describe is individual captions that refer to captions that require the use of ancillary equipment by the individual viewer. This includes system such as rear window captioning, RWC, and other systems in use and under development
>> JOHN WODATCH: Ms. Kashar, could you summarize the rest of your comments for us please?

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

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

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

>> ANN CUPOLO-FREEMAN: Hello.

>> JOHN WODATCH: Good morning.

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

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

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

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

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

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

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

I can rarely help them with this request because virtually none of the physicians in our community had or even have height adjustable tables. Or the staff willing or able to significantly help many of them get onto the exam tables that were too high. Many people were told to bring their own assistants to put them on the table. We had an accessible wheelchair scale in our rehab department. Our scale was well used because wheelchair users who weren't even our clients came to us to get weighed because no one in the local medical community had one. My own physicians did not have a height adjustable exam table or scale. Patients who couldn't transfer to a too high table were again here told to bring someone to lift them. Because of my small size I was able to be helped onto tables if they weren't extremely high. But that wouldn't work for the average size wheelchair user. I would continually nag them to get height adjustable tables. I brought written information about tables that were on the market. And, I also brought information about tax incentives for purchasing them. One of my providers actually did finally purchase two tables, and told me that they worked really well for other patients as well, like pregnant patients. If there were regulations about these things, we wouldn't have to get into adversarial relationships with our providers and we could just be patients like everybody else.

In regards to bed heights and accessible hotel sleeping rooms, many of us, as you have heard, who reserve accessible hotels rooms are finding upon arriving that we can't get on or off the bed. This is happening more frequently because the lodging industry has been installing luxury mattresses which raise bed heights to about 25 to 30 inches, which is of course notably higher than the beds previously found in hotels.

With the average wheelchair seat height being around 19 to 20 inches, this clearly makes these beds inaccessible. So, people of short stature such as myself are at a significant disadvantage when we encounter them, unable to transfer into such high beds. This was also raised by some of our rehab clients.

So, I'd recommend that the beds in accessible rooms measure between 20 and 23 inches from the floor, that there is maintained a 7 inch clearance under the bed for lifts, required beds be movable rather than attached to a wall or on a stationary platform so they can be moved to create an accessible pathway to the bed and to have information about heights of the beds readily available on the property's website and with reservation department at the front desks. As our population ages, accessibility in all these areas will be needed by more and more people. Thank you today very much.

>> JOHN WODATCH: Thank you very much. Our next commenter will be on the phone, Elizabeth Barris.

>> ELIZABETH BARRIS: Yes. Hi, this is Elizabeth Barris. And, although I'm sort of unclear exactly of what the hearing is for, I was asked to testify about the American disabilities in relation to my own illness of electro sensitivity. And I'm not sure if you are thinking of bringing a bill to provide new wireless technology for people with disabilities. I'm not really clear on what this is. However, I will speak to my own illness and my own disability.

If you are thinking of bringing wireless technology to help people with disabilities, you should actually consider the people that have disabilities due to wireless technology.

So, I used a cell phone for about 15 years. I have become very, I had an MRI and they didn't see anything. I know the latency for cancer is about 30 years. So, I'll still worried. But, I've had really bad problems on the left side of my head, where I used my cell phone and I stopped. And, the pain went away. It still comes and goes intermittently when I get around things like Wi-Fi and other people's cell phones.

However, it started to come back about in the past six months, and I didn't know why I was getting constant ringing in my ears and constant pain in my left ear. I went to the doctor. Actually, I have precancerous cells somewhere. Anyway. And then, I noticed the plants outside of my door were dying. And, I put it all together. And, I said, this cannot be.

So, I measured the radiation in my apartment and it's very high. It turns out that, and I looked all over. I couldn't find it. Finally, I got a friend to help me. There is a cell tower about a block away from my apartment that has 25 transmitters and antennas. I was never notified because I'm not in the 50 to 100 feet from it. By the way, there is no federally established RF regulation for this stuff. It's a free-for-all right now.

These things are being installed, irregardless of human health, only looking out for the cell phone industries profits and of course the government taxes on everything that they make a lot of money. There is a lot of money here. And, public health is not being considered at all.

I can no longer go into, because of this cell tower, I have now become even more electro sensitive than I was when I was just using my cell phone. I can't go into places with Wi-Fi now like Starbucks and things like that. I can't stay there for more than a very short amount of time or I get very bad pains in my ear and I have to leave.

Now, because of my situation with my apartment, because I'm being constantly bombarded by this radiation, and by the way, non-thermal effects are completely unregulated, not considered even cell phone safety standards of the SAR, the specific absorption rate. There is a lot of pulse modulation in my apartment, which, I don't know if I have time to explain what that is, but if you take a jackhammer and you put it on a block of cement and you press down, nothing will happen. If you turn the jackhammer on and it starts going up and down, it breaks the cement apart.

So, that’s what pulse modulation is to our cells. It's constant bombardment on the cell and eventually it will do something to it.

So, that’s just one non-thermal effect that is totally unregulated. Frequency is totally unregulated also. The only thing we are regulated about is heat that is your head baking like a potato if you live near a cell tower. It is really, really bad.

So, I really urge and beg for my own health and believe me, I know you may, you’re going to be hearing more and more of me, the more and more of the young, 3 to 5-year-olds are marketed to with cell phones. The more population is being exposed at an earlier age, the more that we’re going to be having this huge problem where people can no longer go into even public places that have this technology. It is becoming a -- okay. So, I have a minute.

So anyway, just the short term monetary gain that is from the rollout of this technology, the abandon, the Wild West type abandonment of all health concerns with this technology is going to be dwarfed in a major way by the impact that it has on the public's health. And, I really urge the committee not to roll out more wireless technology. Please consider people that are becoming electrically sensitive like myself, with the Americans with Disabilities Act. I don't know if it's considered a disability yet or not. I don't know anything about this part of it really.

But, I do have this disability and it has actually inhibited my lifestyle quite a bit. And, I also now have to put thousands of dollars that I don't have into buying protective shielding to protect the area where I sleep in my apartment, because when you sleep, your melatonin, it's a melatonin inhibitor. Okay.

>> JOHN WODATCH: Thank you very much. We appreciate you taking the time to speak with us today.

>> ELIZABETH BARRIS: Sure. Is that it?

>> JOHN WODATCH: Yes, thank you.

>> ELIZABETH BARRIS: Thank you. Bye.

>> JOHN WODATCH: Next we are going to hear from Andrew Phillips. Mr. Phillips?

>> ANDREW PHILLIPS: Hello, everyone. My name is Andrew Phillips. And, I'm here to speak on behalf of the National Association of the Deaf on the position of movie theater captioning.

I enjoy movies as much as anyone else. But, I, like other deaf people, experience very limited options than non-deaf people who can attend any showing at any time of the day, at any theater, at any day of the week.

I and other deaf people are limited to specific showings on limited days of the week and at very limited times. As an example, this past Thanksgiving while visiting my family in the L.A. area, we wanted to see the new release of the Harry Potter movie, but we could not find a captioned showing in the L.A. area. We had to drive over an hour to find a theater that was showing it with captions. I felt very bad putting my family through that, having to drive that such a long distance so that I could be part of the movie going experience. And this happened in Hollywood of all places.

Along with NAD we respectfully request that all movie theaters be required to provide captions in all theaters for all showings. I recently graduated from UC Hastings School of Law here in San Francisco. And, as I'm sure several of you, if not all of you know, the life of a law student is a very busy one.

And, it's not frequently that you have discretionary time to go to movies. The movies that I most wanted to see did not have captions showing playing during the time that I had free to see movies. This is another example of how limited our choices are, as people who are deaf or hard-of-hearing.

It isn't just having captions that make a movie accessible. In order for the captioning to be successful, it has to be clear, visible, high quality, and with high contrast to its background.

Just as an example, a few years ago, a group of friends and I went to see the sequel to the Matrix movie, Matrix Reloaded. And, there were 15 minutes there when we could not understand the captions. There is a very famous speech given by the guy who is referred to as the architect of the matrix. It just so happened that his costume was completely white. The lettering in the captions was completely white, with no shading or outline around the letters to distinguish them from the background. So, my friends and I were even more confused than the other audience members when we left the theater, not knowing what had happened.

We feel the Department should also require movie theaters to implement policies and practices that would include training of employees in use and maintenance of the captioning equipment or the caption displaying equipment.

Not long ago, a friend of mine and I went to watch a movie, down in the peninsula, south of San Francisco, and on-line it was announced that rear window captioning would be provided. So, we decided to go but we did double-check with the theater. We called ahead of time and they confirmed that they had rear window captioning. This is about a 30-minute drive to get there.

The movie started, but the rear window captioning did not. The equipment was not on. So, I went to the theater staff to ask what was going on and they said oh, well nobody here is trained to turn the machine on. I'd like to thank you for the opportunity to provide testimony today on behalf of the National Association of the Deaf.

And the NAD will be providing further comment in written form. Thank you

>> JOHN WODATCH: Thank you for coming and sharing your experiences with us. I have to point out that I saw that movie, and I got to listen to the speech and I'm still not sure what it meant. So, maybe we can get together and discuss that. (Chuckles).

Our next commenter is going to be on the phone, and is Daniel Grover. Mr. Grover?

>> DANIEL GROVER: Yeah, hello, can you hear me?

>> JOHN WODATCH: Please proceed.

>> DANIEL GROVER: Thank you. I'm a wheelchair user and travel extensively for 25 years. I'm a wheelchair user, and since I'm on the phone and all you have to go by me is my font there and my name, I just want to assure you that I'm wearing a suit and tie and look very, very professional today. I just want to say that transfer height has already been established in numerous 2004 ADAAG chapters. Transfer height does not affect, oh and I'm talking about the ADA bed height in hotels and places of public accommodation. So, I want to say that transfer height does not affect the usability for the non-disabled population that may end up using a hotel room that is not in use by somebody with a disability.

And currently, if I stay in a hotel, I can transfer to the toilet. I can transfer to the shower. And, I can transfer to the swimming pool, but the main reason why I'm there to sleep in a bed, I can't transfer to it.

And, in the 2004 ADAAG chapters, chapter 6, water closets, seats, bathtub seats, shower compartment seats, benches, amusement park rides, play areas, swimming pools, wading pools, they all have established transfer heights already. So, since transfer heights have already been established for accessible elements, it just seems only reasonable that they should apply to a bed.

And, I don't see that there was, like I said, I don't think that it affects the nondisabled population that would end up using the hotel room. With a bed, there is consideration for the fact that a bed gives and fluctuates with weight, when you are attempting to transfer on it unlike all those other elements which whatever height they are, they are fixed and solid.

So, but that being said doesn't mean that you should not establish a transfer height for a bed. It's been my experience in the industry that there's a superficial look of a high bed that for cosmetic reasons equates to quality. I've run into that numerous times when staying somewhere.

The function of a bed should not be high, you know, for cosmetic reasons.

And, the other thing along with transfer height in beds is, I also experienced very often that in smaller hotels that have one room that’s accessible, they put in one king-size bed. And, today we are not talking about the size of the bed. We are talking about transfer height. But, when there is not a two-bed option, then when I stay with four people in a room, it makes it very difficult. That's a side note.

So, my main point is to implore that transfer height has already been established in numerous ADAAG chapters, so it should certainly be applied for transfer heights in beds. And that's all I have to say today.

>> JOHN WODATCH: Thank you very much. We appreciate you commenting with us today. We are going to conclude our morning session with one more commenter, who appears to be appropriately named for this function. We will turn this over to Carrie Finale.

>> CARRIE FINALE: Thank you. I just want to thank the panel for allowing me to speak today.

Just a quick introduction. My name is Carrie Finale and I was injured in a car accident in '97. And, I suffered a spinal cord injury. And, it took me, so I'm paralyzed from the waist down. And, for the ten years post injury, I struggled physically and emotionally and mentally. And I was an athlete my entire life so there was a big hole missing for me for ten years, until I discovered wheelchair sports. So, for the last four years, my life has completely turned around in a positive direction because of being fit and wheelchair sports. So in order for me, and in fact, I'm on the U.S. Para-Olympics cycling talent pool team and I travel a lot in various hotels. So, having access to equipment in gyms is very important to me in my fitness, in order to perform at races.

And, I find that at home here, I'm limited to the amount of pools that I can swim in. I can't just transfer down to a pool deck. I need an actual lift that I'd like to be able to operate independently. I've been to pools where they pull, you have to ask someone and they have a portable lift that they roll over and you transfer into. For me, that's, I'm not able to operate that independently. So independence is huge for me.

Another issue I have with gyms is, okay, so I do find a pool, but there aren't any exercise equipment in the fitness room that I can use as far as strengthening my upper body. And, the gyms still wants to charge me full price.

So, if I had access to everything in the gym, I could understand paying the full price. So, the other thing I want to say is that the showers, the showers aren't always accessible in there. The levers to control the water in the shower heads are usually a little bit too high for someone who is sitting down or way too high. And, I also and lastly, I just want to say I spoke to one of my friends who is quadriplegic, and he said add in there changing tables for the people who can't dress and undress in their chairs. A changing table with an accessible stall for them to get in and out of their bathing suits would work.

And with that, that's what I want to say. Enjoy your lunch.

>> JOHN WODATCH: Okay, thank you very much. We wish you good luck in your competitive career. We will conclude now the morning session. We will reconvene at a different time. We are going to reconvene at 1, because of the unprecedented demand of people who would like to comment. We will be back here at 1:00. Thank you all very much.

(Break).

DEPARTMENT OF JUSTICE HEARING

JANUARY 10, 2011

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>> I understand that some of you are still finishing your lunch and that is okay, so are most of our panelists. We are going to begin in a few moments. But if you are in the room, please don't forget to turn your cell phones to silent or vibrate. We will begin in a few moments. Thank you.

(Pause)

>> JOHN WODATCH: Good afternoon, everyone. We are going to proceed. Thank you for returning so promptly.

I neglected to mention earlier this morning that this event is also being streamed live on the Internet simultaneously with the event itself so your remarks are going well beyond the hearing room today. And we will, for a short time after this, keep the hearing on our website, ada.gov.

We will continue again this afternoon. We ask everyone to try to keep their comments within the five-minute period of time. We have a large number of people who are going to testify.

The device here will tell you -- the yellow light will go on when you have a minute left to go. There will also be a beep and the red light will come on at five minutes. We ask, if that happens, that you conclude your remarks at that point.

Why don't we begin? We are going to start with Jessie Sandoval for the Marin Center for Independent Living. Mrs. Sandoval.

>> JESSIE SANDOVAL: Thank you for the opportunity to speak today. My name is Jessie Sandoval and I'm an attorney as well as a system change advocate and

community organizer with the Marin Center for Independent Living.

I'd like to speak today regarding some of the rules and regulations as they relate to the accessibility of medical equipment and of furniture. I will relay some of my personal experiences as well.

I'm a wheelchair user as well as somebody who is visually impaired. I can tell you throughout my years that the accessibility of medical equipment in physicians’ offices is definitely something to be desired. It's so limited. It has sort of become a fact of life for many of us with disabilities.

I frequently visit optometrists as well as ophthalmologists. I can say that those offices are very difficult for someone who is a wheelchair user. Often, the exam chairs are too high, and it makes it nearly impossible for us to transfer safely to and from the examination chair, which then requires us to bring somebody with us to the appointment.

So one way to relieve this would be to have exam chairs that are adjustable so that we can safely transfer as well as provide a bit of training, which I think other people have mentioned, so the staff can assist us in transferring as well. And for folks that are not able to transfer to and from an exam chair, it would be ideal to have a chair that is easily movable so that individuals can receive services in their wheelchairs.

Also, often, many of the more advanced exams that you receive in an eye doctors’ offices are not accessible. I have had, often, to have someone help me to do some photography that is required, and I have to sit in chairs that are extremely tall. So again, to have chairs that are adjustable or movable as well.

Additional accessibility issues are presented at dental offices. Often, certain types of X-rays are not accessible for people with disabilities. This includes panoramic X-rays, the type of X-rays that go all around your head.

I actually haven't had one since I was a teenager and had braces. I didn't even realize that they still gave those X-rays to adults, because, actually, it's never been offered to me as an adult. So that tells you how –- a problem that is. And again, a way to remedy that would be to make it so that it’s accessible and add adjustability so the folks can receive the X-rays in their wheelchairs or have the opportunity to have assistance if needed for them to receive the X-ray.

So the fact that it's never been offered to me as an adult shows one of the common consequences of not having accessible equipment in doctors' offices. The doctors and employees think it's not a big deal and they just don't provide, you know, the same care that other individuals receive who don't have disabilities.

Another accessibility issue related to equipment is general accessibility in physicians' offices as well. This includes accessible exam tables. I can't even begin to tell you the last time I was actually able to transfer onto a table because it was low enough.

The result is that people with disabilities often receive exams in their chairs and as such, they don't receive the same examinations that they would otherwise receive or the doctors might not evaluate them in the same way. They’ll just look at you and prescribe something as opposed to really, you know, doing that physical overview that they would give other patients.

And again, this could be easily remedied by providing adjustable height exam tables so the individuals can transfer as well as, as I said before, having staff that are available to assist with transferring.

Often medical staff are not very comfortable with helping out patients with disabilities. They expect you to bring someone to the appointment with you, which for some people works but for others, you can't always bring somebody with you. It's important to have staff that are aware and can help you facilitate your medical appointments as they would be for everyone else.

Then lastly, another need is for accessible scales. I can't tell you the last time I've seen a set of accessible scales, which is something that doesn’t happen for us with disabilities.

Knowing a person's weight is really critical to administering medication as well as reducing secondary disabilities that may result from people who are wheelchair-users or have other disabilities. This is something that's sort of gone unnoticed. And having an accessible scale, is something that's cost effective and can easily be put in doctors' offices and can be used by others as well.

I believe that wraps up my five minutes. So thank you for your time and taking this opportunity to hear comments from the community today.

>> JOHN WODATCH: Thank you for being here and sharing your views with us.

>> JESSIE SANDOVAL: Thank you.

>> JOHN WODATCH: Next, we’ll hear from Jack Castle. Mr. Castle?

>> JACK CASTLE: Thank you. I'm here to talk particularly about closed captioning for movies. I am not a hearing-loss person. My wife says I suffer from selective hearing but my wife is the one who has lost her hearing.

In 2000, my wife came down with meningitis. After 10 days in a coma, she awoke and she had lost all of her hearing in her left ear and 80 percent of her hearing in her right ear.

Our lives changed dramatically. We had never been aware of any of the problems that affected the hearing loss community in our area or, let alone, in the country. My wife got very active in the Hearing Loss Association. It’s formerly called Self Help for Hard of Hearing.

Since that time, we have made a lot of adjustments. One of the things that we particularly enjoyed doing, prior to her hearing loss, was going to the movies. We’ve tried to do that since then. We have found that the movie theaters do not give you a system that works.

They have tried the rear captioning. You can't watch a movie and look at the rear captioning in your lap. They have given us hearing devices that just make the static louder. The only thing that has worked for us is closed captioning.

It's interesting to note that the movies that we do enjoy are foreign movies and they’re all captioned. And they are successful, very successful. If you have gone to the movie houses, you have seen that the foreign movies are usually fairly full, if not totally full. And they, like I said earlier, are all closed captioned.

One of the points that I'd like to make is that somewhere between 14 and 17 percent of the population has some form of hearing loss. When you hear the movie theaters talk about not being able to afford to make the difference and put in the closed captioning, I think they’re being shortsighted. When you take a look at the 14 percent, all those people go with someone else. I don't go without my wife; therefore, you can double that. Twenty-eight percent of the population is affected by hearing loss.

Families are affected by it, the people you work with, so it seems good business and good practices to me that the hearing -- not the hearing, excuse me -- the movie theater operators are excluding a good percent of the population from their marketing.

When you take a look at some other things too -- you see the academy awards and other awards shows, there is a large portion of the population that does enjoy foreign films, so the captioning does work. All of the DVDs that are put out by movie producers now have captioning. If you go to Best Buy, Netflix, any of those -- not Best Buy. Excuse me. What’s the one that’s –

>> MAZEN BASRAWI: Blockbuster?

>> JACK CASTLE: Thank you. Blockbuster or Netflix. They all have captioning available in different languages.

It would seem to me that the movies are in one part of the industry very aware of what is available, and make it available to the broad spectrum, where the operators do not. And I think that closed captioning solves that problem, not only for the hard-of-hearing, but for their families. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate you taking the time to be

with us today. Next, we will hear from Kathy DeRenzi.

>> KATHY DERENZI: Thank you. I have a chronic digestive disease. I have ulcerative colitis. There’s no known cause and no cure. I need access to restrooms frequently and sometimes urgently. When I'm away from home, I worry about finding and having access to restrooms. Many people with this disability –- with this disabling condition prefer to stay home, as I often do.

Many businesses will not let you use their restrooms. They say, our restroom is not for public use, or they tell me to go next door offering another business's restroom facilities.

I'm here today to encourage that we revise regulations in California and nationwide to allow access to restrooms at public places of business that are now denied to people with disabilities. This restroom access has become law in some other states, and needs to become law in all states immediately. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate you coming and spending the time with us. Our next Commenter is Richard Ray. Nice to see you.

>> RICHARD RAY: Thank you. Good to see you as well. Good afternoon, and thank you for having me. My name is Richard Ray and I’m an Americans with Disabilities Act compliance officer with the City of L.A. I’m also on the chair of the Accessibility Committee with the National Emergency Number Association, and a member of the National Association of the Deaf Civil Rights Committee.

And I'm here to address two issues: accessibility of 911, and emergency alerts. Regarding accessibility to 911. With today's expanding technologies, such as text messaging, video phones, video cam and instant messaging via computer and wireless devices, more deaf, deaf/blind, hard of hearing people and people with speech disabilities are shifting to these technologies while fewer and fewer people are using TTYs. We have zero direct access to 911, using wireless hand-held devices.

Currently, PSAPs do not address the needs of people with hearing loss or speech disabilities who rely on emerging technologies such as text and video as their primary mode of communication. The current PSAP system is not able to receive direct text and video calls due to the system not being compatible and not being updated to accommodate these emerging technologies.

Individuals with hearing and speech disabilities will have to use a third party such as an Internet relay-based service to reach 911 using text or video. This is not considered direct access. Using a third party for communication could lead to a time delay.

For example, during the recent National Emergency Number Association annual conference, several 911 test calls via Internet-based relay services were placed. With IP relay service, it took over four minutes to connect to the PSAP and it was through an emergency line.

Also with video relay service, it took over five minutes to connect to the 911 center and it went through an administrative line. Both of these calls were supposed to have gone through a 911 line, which would have shown the caller information such as the physical address and the call-back phone number.

Last August 19th, another series of test calls were made to 911 utilizing various VRS providers. While a couple of relay service providers appear to have connected the calls to the appropriate PSAP 911 line, the others were either routed to another city, such as the City of Azusa, or the local PSAP administrative or emergency lines. A couple of calls were dropped and no callbacks were made.

Based on these tests, I've died more than seven times. A few minutes delay has shown that it could have led to death. Again, every second counts. Please support this next generation 911 upgrade to the 911 system so consumers can call 911 directly and receive assistance in a timely manner.

So the NENA slogan is: Call 911 anytime, anywhere, and with any device. Turning to emergency alerts.

Access to emergency warnings and information is important for the general population as well as for people with disabilities. People in the United States rely on siren, television, radio, and telephone for information whenever a crisis or emergency occurs. However, this type of technology is inaccessible and not reliable or workable for deaf, deaf/blind and hard of hearing people.

On December 23, 1985, I was at the lower level when a twin-engine plane crashed through the Concord Sun Valley shopping mall's roof, igniting a fireball that burned everyone in its path. Seven people died and 77 were injured.

I had no access to the announcements that were made about what was going on. In fact, I didn't learn about the situation until I arrived home. It's critical that people with disabilities receive messages at the same time as hearing people in order to meet their needs. Technical development may be necessary to create a system that provides equal communication access to receive notification.

It is crucial that options with redundancy for emergency alerting systems that are accessible to individuals with disabilities such as 911 mass notification systems, using electronic reader board, e-mail, SMS, video clips and various emerging technology in addition to the analog phone system. Furthermore, mass mandatory testing on a regular basis should be conducted to ensure that all types of alert modes are working. They should be corrected immediately if an issue arises.

Again, every second counts. Thank you.

>> JOHN WODATCH: Thank you very much. Let me introduce -- we have different

panel members joining Mazen and myself. Returning, again, is Kathy Devine, an attorney in the Disability Rights section. And joining us now is Felicia Sadler, who is another senior attorney in the Disability Rights section who will be working on these rules.

Our next commenter will come through the phone system and will be Jo Firpo.

>> JO FIRPO: Hi everybody. I have two points. I'll be pretty brief. I have severe electromagnetic frequency sensitivity. I want to speak on Internet accessibility. Basically, with this condition, Internet is not accessible by me pretty much at all at this point.

So, having the information available by paper or by phone – you know, a lot of times I'll call up and they'll say, oh, it's on the Internet. And I'm, like, well, I can't really get on the Internet. So that is something to think about. Also, there is an MIT engineer who has developed a shielded computer, which may be an option for people with electro-sensitivity to have Internet access.

The second thing I wanted to comment on deals with the furniture accommodation and this is actually more regarding light fixtures. Ninety-eight percent of public spaces are lit with fluorescent lights, and for me that's just like being in an experience of having acid poured into my nervous system, my mucus membranes and the dura around my brain.

In general, I avoid public places. But I had to go to the doctor recently and I knew if I sat in the waiting room and the examination room for 45 minutes, I would be dry heaving. I ended up bringing a parasol, and using that. And it worked fairly well, I would have to say. But it would be nice to have considerations regarding alternatives to fluorescent lights, safe places that electro-sensitive people could be in public places.

That's all.

>> MAZEN BASRAWI: I have just one question. Is this on? Now it is. I have one brief question. Is there any kind of energy saver light fixture that you find is not problematic?

>> JO FIRPO: Well, it's interesting. The politically correct energy saver light bulbs are actually worse. The ones that work the best for someone with this sensitivity is, like, the traditional incandescent bulb, maybe with an up -- like low to the ground up lighting so it's not shining directly on the body, like, indirect, low, up lighting.

>> JOHN WODATCH: Thank you. Our next commenter is also going to be done on the phone system, and we are going to hear from Andrea Berrin. We are connecting right now. Ms. Berrin, you may proceed.

>> ANDREA BERRIN: Thank you. Good afternoon, everyone, this is Andrea Berrin. Thank you for this opportunity.

I would like to be there with you in person, meeting with the Department of Justice representatives, and all you good people who have come to speak with concerns to improve the lives of those with disabilities so that they can participate with equal enjoyment of all the goods and services, the privileges, the accommodations spoken of in Title III and what the ADA is about.

I am not there with you, because I am disabled. I am not in a wheelchair. I am not blind or limited vision. I'm not deaf or of limited hearing.

I have what is referred to as radio wave sickness, or electromagnetic injury, or electro-hypersensitivity. This precludes me from being in just about any of the places listed in the 12 categories, the public categories, named in the ADA that should be accessible.

I am precluded because I get sick. So being in any building or office or restaurant or any of the places named, going to the market, the bank, the Post Office, my goddaughter's elementary school classroom, I am sick.

There are many others who will testify today or at your other hearings or are submitting important scientific findings about the effects of electromagnetic radiation, the radio frequencies, wireless technology on the population that you are attempting to offer the services of.

I will just add that the wireless technology being proposed, my concern is that it will only exacerbate health challenges of the vulnerable disabled population as well as the rest of all of us.

So I will tell you a little of my own personal story, which will weave into this big picture that you are looking at. I am like the canary in the coal mine. There is a fast growing population of people who are becoming more and more disabled, and unable to function in this society because of electromagnetic radiation, the radio frequencies and wireless technology.

In fact, it is becoming an epidemic, although many of you don't know about it because of the clever mass marketing of this technology to every business and every family. I was a court reporter for 27 years full-time. I wrote every word spoken in criminal trials, including murder trials, spending 13 and a half years at juvenile court, and taking many civil cases.

The precision of my transcripts may have made the difference between life and death, and everything in between for the people involved. I handled original documents, medical files, wills, birth certificates, etcetera.

I'm also by the way a Phi Beta Kappa graduate from UC Berkeley. Why am I telling you this? So that you understand that I was a highly functional person, carrying important responsibilities and a contributing citizen to this country.

Now, I am so affected by this electromagnetic radiation, I'm using that as a general category, that I have not been able to work for seven years. There is not a building, an office, a classroom, a store that I can be in without getting sick. I can't look at a computer without being sick. I'm telling you my story, but there are many more and continually many more that are being affected like I am.

I am affected by fluorescent lights. Especially the compact fluorescent lights, what they call the energy saving lights. I have spent tens and tens of thousands of dollars seeing all kinds of doctors, Western medicine, Stanford, doctors in San Francisco, clinics back East.

About three years ago, a friend brought me a 143-page document translated from Swedish called, *Black on White, Voices and Witnesses about Electro-Hypersensitivity, the Swedish Experience*.

I urge the members of the Department of Justice to look into this document. It contains over 400 testimonies of people, normal people, working under fluorescent lights, computers, cell phones, cell towers, Wi-Fi, etcetera. I think that was my one minute.

>> JOHN WODATCH: No, I'm afraid it was your five minute. But if you can conclude, that would be --

>> ANDREA BERRIN: I'm sorry. I didn't hear the one minute.

>> JOHN WODATCH: That's quite all right.

>> ANDREA BERRIN: I’m sorry. I will conclude. I will just say that -- okay. Let me conclude. I'm sorry. It goes pretty fast. People are buying into these technologies like the emperor's new clothes. The difference is when they found out the truth about the emperor, the people just felt foolish.

In our day and age, the truth about these electromagnetic frequencies is that more and more people are getting sick, even though it may start with just insomnia, aches and pains, anxiety, and lead to autoimmune diseases, cancer, heart disease, mental cognition problems, etcetera.

I urge you, please to look into this very, very carefully and I believe that what they are calling the epidemic of the 21st century, Alzheimer's, also has a strong connection to our exposure to these invisible frequencies. Thank you so much for your efforts, your good work and for listening to me. I appreciate it very much.

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

>> ANDREA BERRIN: Yes, thank you. The best to you all.

>> JOHN WODATCH: Next, we will hear from J.J. Rico. Mr. Rico?

>> J.J. RICO: Thank you. Good afternoon, my name is J.J. Rico. I'm the managing attorney for the Arizona Center for Disability Law. Our office presently represents two individuals in a lawsuit against Harkins movie theater. My office is part of the national protection and advocacy system. I'm here today to talk about captioning and description.

Five years ago, our office decided to represent two individuals with unique stories but common experiences. Rachel Lindstrom called our office and described her son, at that time, a 15-year-old boy who wanted to go to the movies. It wasn't that her son Ricky had never gone to the movies and in fact he had gone to the movies. He had gone to movies with his family and with his friends.

But what Ricky's experience was, was half of what most of us who can hear. Ricky could not hear the dialogue but Ricky still spent those high dollar ticket prices to go to be with his friends. That's a common story that we heard.

Our second client, Larry Wanger, recently moved from Michigan. And Larry is a person who is visually impaired and blind. Coming from Michigan, he had an experience of being an advocate and continues to be an advocate in his community. Through his advocacy in Michigan, he contacted the local movie theater and asked for and received a scripted narration.

However, Larry Wanger's experience in Arizona was not the same. To give you the statistics on what Harkins movie theater currently provides, when we started lawsuit five years ago, or we started our representation of these two individuals, Harkins movie theater had approximately 262 screens. One of those screens contained open caption, one. For descriptive narration out of the 262 screens, there was zero screens with descriptive narration.

Now, five years later, after litigation has been filed, after advocacy has continued, there are three movie screens, with descriptive –- excuse me -- three movie screens with captioning out of over 300 screens that Harkins now has. In the descriptive narration world, there are now 15 screens, again, out of 300.

In the minds of my clients and minds of their communities, that is not enough, especially when we look at the statistics and the financial incomes of these movie theaters. The National Association of Theater Owners has provided statistics that showed in the year 2009 alone, the box office hit record earnings of $10.6 billion in admissions, and 1.4 billion in concessions.

I think we always thought popcorn was a little bit pricey but maybe not quite that pricey. That year also marked the third straight 4 million-plus summer season. Admissions continue to grow five percent as movie theaters' owners and operators closed out the fourth consecutive decade of growth in ticket sales.

Per capita, ticket purchases grew by 4.6 percent. If we look at one of the big three, the “big three” being Regal, Cinemark and AMC, in 2009, if you go to their website, Regal generated $2.8 billion of revenue. And its net income was $279 million.

The profits of AMC and Cinemark can be found on their websites and readily accessible for anyone to view, and to see that, they too, have made a lot of money.

Furthermore, in addition to the profits that they’re making, the big three have secured alone for $660 million. And you might ask: What’s the $660 million for? It's to roll out 14,000 –- approximately, 14,000 digital screens.

So I had a question to myself, at least, that, well, after making all this money, what has happened nationwide? I know about Arizona and I can talk about Harkins movie theaters. But what’s happening nationally? What type of money are these other big three and other theaters investing in captioning description?

And a little research from NATO's website, the National Association of Theater Owners and also the MoPix website has led me to the conclusion that little to nothing has been done.

In fact, of the top ten which possessed -- top ten movie theaters which possessed 21,000 screens, only 236 of those screens out of 21,000 possess either captioning or video description. So my question is: Why are the movie theaters continuing to fight?

As Judge Kuzinsky said in our 9th Circuit Oral Argument, “Why are you fighting this?” I thought that the fight might be over with the notice of public rulemaking but I listened to NATO and AMC's public comments. And all of you, if you haven't listened, go back and look at the Chicago transcript and listen to what they have asked DOJ to do.

As you probably recall, they asked you to wait, to wait two more years. And why do they want to wait? Because they say digital technology is not here. They say digital screens aren't here. But we’ve already shared with you that digital screens are here.

They’ve even gotten more money to roll out more screens. But they still want us to wait. They also contend that there is no technology but there is digital technology. In fact, there’s three companies that currently have something you can purchase. And maybe it's not at the Radio Shack, as AMC's attorney said, but it is available for purchase.

So my response to NATO and AMC and any other theaters that may say, suggest or ask, wait two more years, I say no more waiting. My clients and their communities have waited long enough. The time is now for all Ricky Lindstroms and Larry Wangers in this country to have an opportunity as I have and of those that have vision and those who can hear to see a movie. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony today.

Our next commenter will be on the telephone, Florita Toveg.

>> FLORITA TOVEG: Thank you. My name is Florita Toveg. I'm from Breast Health Access for Women with Disabilities. And thank you for your time today. Founded by and for women with disabilities in 1995, and, in '97, opened the first accessible breast screening clinic in the country, BHAWD, overarching goal is promote optimal health for women with disabilities.

We do this by reducing disparity to utilization of health promotion and screening services and diagnostic practices particularly in women's health services.

There has been a rapid upswing in efforts to improve healthcare service access for underserved populations, including women with disabilities. However, striking differences in healthcare accessibility, quality and utilization persist.

One under-addressed issue in the fight against breast cancer access is the inability of the imaging equipment to be accessible to women with disabilities. These include women who have limitations with balance, posture, muscle weakness, spasticity, flexibility, chronic pain and/or inability to walk or stand.

Mammography is used to help screen for changes in the breast tissue over time. It is an X-ray image of the breast that can detect 80 to 90 percent of breast cancers in women over 50. Mammography exams are an effective tool for diagnosis and possible prevention.

Breast imaging technologies have progressed the past several years to include, for one, digital mammography system that has offered advances in imaging exposure, processing and transmission. While screening mammography is recognized as an effective method for early detection of breast cancer, and there has been promising new technologies that has improved clinical applications, the equipment itself has not become more accessible to women with disabilities.

Breast cancer is the second cause of cancer death in women. And women with disabilities may be at higher risk for delayed diagnosis of breast cancer primarily for reasons of environmental, attitudinal and informational barriers.

For instance, in California, women with disabilities are less likely to receive routine screening mammography than women without disabilities. Instead, more frequently obtaining mammograms for a suspected problem or for breast cancer.

Women with disabilities are developing breast cancer at the same rate as all women; however, women with disabilities are one third more likely to die from breast cancer than women without disabilities. Later stage diagnosis typically result in greater functional impairment, poor quality of life and shorter survival rates.

Hopefully you have heard and received information to help develop standards for mammography units which would also assist in better visualization of breast tissue, greater flexibility for positioning, greater comfort for patient clients with disabilities and would also be helpful to the radiologic technologist, the RTs, that are performing the mammography exams.

A few of the features that our RT Committee has recommended is allowing height adjustment for the unit imaging receptor, or buckey, to go as low as possible. A maximum of 24 inches from the floor to the top-side of the receptor, or buckey, is appropriate.

Allowing adequate knee space for a wheelchair user as in distance to stand from the front edge of the imaging receptor buckey is also important to consider. Having an adequate and safe positioning chair when needed and addressing the issues and problems with some units' protruding platforms that can also interfere with positioning a person seated in a wheelchair.

The road from accessible regulatory imaging equipment innovation to accepted clinical practice is long, detailed and costly. Adoption of new accessible technologies may depend on whether healthcare providers and their clients find them usable and acceptable.

In the meantime, it is important to review existing successful healthcare provider education initiatives. Given the unique needs of the growing diverse disability population, education and training of healthcare providers is vital to increase healthcare access and address cancer care inequities that face women with disabilities.

For many women with disabilities, healthcare providers, especially radiologic technologists, RTs, represent a key point of contact in the breast healthcare continuum. A client who has one negative experience receiving a mammography, mammogram, may be deterred from returning for subsequent mammograms for years to come. On the other hand, an RT who is competent in communication and adaptive positioning for women with disabilities can encourage her to seek routine mammograms and if needed to take control of her own breast health.

Bearing in mind that essential functions of RTs especially those who conduct mammography, we have developed and carried out a series of trainings that promote routine mammograms and allow technologists to improve their imaging techniques and develop disability culturally competent skills.

Since 2004, we have conducted 10 trainings approved by the American Society of Radiologic Technologists for C E credits. All of the trainings have been attended at full capacity with waiting lists formed.

The training evaluations have consistently revealed increased confidence in providing mammograms to women with disabilities. The technologists also express the belief that this training should be mandatory for all first year radiology students, and at least one member of every breast imaging facility's mammography team. Several participants stated, quote, these are topics that have never been touched on in any seminars in my 30-year career, important for all RTs.

In conclusion, in addition to reviewing standards for radiology mammography equipment, we are asking DOJ to review existing provider initiatives and developing systems that includes cultural competency training and positioning techniques in order to increase access and accommodate women with disabilities. Thank you.

>> JOHN WODATCH: Thank you very much. Next, we will hear from Carrie Riordan. Ms. Riordan?

>> CARRIE RIORDAN: Good afternoon. I'm a member of the board of directors of the National Alliance for Accessible Golf, a nonprofit collaborative alliance of golf organizations, rehabilitation organizations, recreation and park associations and independent accessibility advocates. Our mission is to increase participation of golf -- of people with disabilities in the game of golf.

We believe that through the game of golf, individuals with disabilities can become actively engaged in the social fabric of their communities and derive health benefits that improve quality of life. Our three key initiatives are; one, gain golf accessible and inclusive networks. An alliance research-based inclusive program that uses golf as an effective vehicle for bringing people with disabilities into or back into the mainstream of the community.

Two, the alliance administers a grant-making process through the United States Golf Association that since 1997 has granted over $5 million to golf programs for individuals with disabilities.

And three, the alliance develops and provides technical and training resources as well as accessible golf guidelines and tool kits for golfers, golf professionals, rehabilitation specialists and golf facility operators. We applaud the DOJ and their continued efforts to enhance opportunities for individuals with disabilities and to develop rules designed to bring the ADA fully into the 21st century, especially as it relates to sports, fitness, recreation and wellness.

Our comments today relate specifically to questions 14 and 15 that address access for people with mobility disabilities and accessible golf cars. The alliance supports the position that the most effective means of addressing the needs of golfers with mobility disabilities has to first come with continued and enhanced education and training of the concept and application of a golf inclusive environment for programs, practice and play.

While accessible single-rider cars are just one solution to the needs of some golfers with mobility disabilities, we believe that mandating single riders reflects a very limited response to a multifaceted issue regarding accessible golf.

Many accessible accommodation options already exist and are in use and available at many golf courses, such as the use of traditional golf cars with access to tee and greens, using flagged golf car policies, hand controls on traditional golf cars, and sharing or pooling single rider cars, to name a few.

Golfers, owners, operators and professionals need continued education regarding inclusion and how to facilitate inclusion plans and policies that can reasonably accommodate all. These must be relative to the uniqueness of the disabilities as well as the uniqueness of the golf facilities and their resources. All golf facilities must have inclusive operations, customer service practices and programs and play policies that include access and availability of equipment and address the needs of people with a variety of disabilities.

The question is, whether it is necessary for all golf facilities to have single-rider cars or other accessible golf cars. Again, there are real examples of golf courses and municipalities with golf facilities that already have one, two or three or more accessible golf cars in use as well as other options to accommodate golfers with disabilities because over time, they have educated the golfers, operators, professionals in the community and offered programs reflecting a positive inclusive environment.

These are some of the best practices and inclusive operations models to share and use when developing rules and guidelines. Most golf facilities should have access to and availability of single-rider golf cars and other means of accommodation regardless of where the facility is in the process of developing an inclusive golf operations environment.

Regarding single-rider cars, many courses already buy, lease, share, or pool single riders and successfully and regularly make them available to customers. With that said, however, currently there are no safety standards governing single rider or accessible golf cars.

Safety is an issue that must be addressed for accessible golf cars with the same level of ANSI standards and regulations that exist for traditional golf cars. While accessible cars are in use without safety standards, we recommend that safety standards and safety testing for all single riders be in place before any ADA ruling that mandates their further use.

We also suggest that this is not just about developing a rule or policy and a mandate that all golf facilities have a specified number of single rider golf cars, and then people with disabilities will come. There is a larger more pervasive issue that needs to be addressed before any policy or rule will really work and be embraced in golf or any sport or recreational setting. That is the issue of education and awareness.

We need to educate people and make them aware about the many ways that allow people with disabilities, including those with mobility disabilities, to play and enjoy their best golf. Education, training and awareness of all options for accessibility programs must continue to be recognized -- to be a recognized priority at all levels of golf operations for ADA and golf for individuals with disabilities to truly become a reality in the 21st century. Thank you very much.

>> JOHN WODATCH: Thank you. We appreciate your testimony today. Our next commenter will be on the phone and will be Shivani Arjuna.

>> SHIVANI ARJUNA: Yes, hello. Shall I just go ahead? Hello?

>> JOHN WODATCH: Yes, go ahead and proceed.

>> SHIVANI ARJUNA: Okay. I am sensitive to radio and microwave frequencies so I'm going to be talking from that point of view. I have what is called radio wave sickness. We became aware of this in 2002.

I had been having increasing trouble with cardiac irregularity and was diagnosed with pre-atrial cardiac syndrome. I asked the doctors what that meant, and they said one chamber of my heart was beating out of sync with the others. And I said, why? They said the electrical signal of that chamber is off. I said why? They said, they didn't know.

Things got worse. I had pain and numbness on my left side, pain in the left side of my head, extreme insomnia, and finally had a couple of cardiac incidents that were so scary I went to the hospital in an ambulance. I had $18,000 worth of medical tests done, which could find no reason whatsoever for the symptoms that I was experiencing.

However, we were referred to people who were doing a study about radio frequency sickness because some of my symptoms sounded like that. And then we had our home tested for, quote, what’s called “dirty electricity,” which are radio wave frequencies being broadcast right from the wiring in your house.

And we had that done by an expert who was used in many court cases and He said our home had a very high level of this. And so we undertook remediation for that ourselves and, lo and behold, my symptoms went away.

So I became very interested in this topic. I’ve actually put up a website about it and that website is lifeenergies, l-i-f-e-e-n-e-r-g-i-e-s, dot com. There’s a lot of politics involved, because the electrical companies are responsible for the purity of their product, but no one enforces them to be. So people like me get very sick. And we have to undertake the expense ourselves of making our own homes safe.

So now, I'm safe as long as I'm in this environment that we have created for me. But when I go out, whenever I'm somewhere where I'm exposed to Wi-Fi and things like that, I immediately get symptoms again. So for example, our local library put in Wi-Fi, maybe two years ago or so, and I used to love to go to the library. The library is the center, its not just a library, it’s the center of all community activities in the small town we live near. I can't go there anymore. If I'm there ten minutes, I have terrible, terrible pain in my head.

And it goes away about 20 minutes after I leave the library. And that is my experience every time, ten minutes and terrible pain in the head. So I just cannot go to those activities.

And so you can tell, I'm limited to where I can go a great deal. I’m lucky that I can live in the country, in a quiet place. But more and more things are encroaching here. And one thing is that for instance, our utility company wants to put a radio frequency broadcasting meter right on our house and threatened to turn our power off if I wouldn't take it.

I would like to read you parts of a letter that my doctor wrote to the electric company about that:

“My patient, Shivani Arjuna, and her husband have asked me to write you regarding how she is affected by exposure to communication frequencies and quote "dirty electricity" frequencies. They are deeply concerned that placement of one of We Energies’ new radio broadcasting meters on their house would be harmful to their health, especially to Shivani’s and I share their concern. The immense proliferation of wireless technologies in the past few years has given rise to health problems that cannot be successfully treated medically as medicine cannot remove the underlying cause, the exposure.”

Does that mean I have a minute? Oh, my.

>> JOHN WODATCH: Yes, that’s correct.

>> SHIVANI ARJUNA: Okay then I'm not going to read his whole letter. But he goes on to mention that there are actually a list of radio wave sickness -- illnesses, and that you will find that on the website too, if anybody wants to read it.

So then he talked about some biological possible mechanisms and finally, he said, “Although it's not possible in today's world to completely avoid these exposures”, you know “we should not be forced to be exposed in our own homes.”

So besides the things like the radio broadcasting meters, another thing that should be not allowed to happen is broad band over the electrical wiring system because then it would go right through the entire house of all the radio -- people with radio wave sickness and we wouldn't be able to bear being in our own house.

So I feel very bombarded, you know, I have to stay at home. I hope that you will expand the ADA to include specifically radio frequency sickness, and also add a supplemental docket on radio frequency sickness.

>> JOHN WODATCH: Thank you very much. We appreciate your time with us today.

>> SHIVANI ARJUNA: Thank you for listening.

>> JOHN WODATCH: Next we're going to have a double testimony, Dr. Sandy Ross and Annie Cruz. The floor is yours.

>> SANDY ROSS: Thank you, John, and the rest of the panel. ADA has been incorporating hidden disability such as chemical and electromagnetic sensitivities but not fast enough to keep up with the influx of chemical use and deployment of electronic equipment, such as cell phones, Wi-Fi and smart meters.

Researchers are reporting many, many ways the human system is affected by electromagnetic fields, because we are electrical beings. Recently at the Commonwealth Club, Professor Mark Blank from Columbia University reported DNA is a fractile antenna, with different coils reacting to different EMF frequencies. No wonder people are getting permanently damaged and it can be passed on to the next generation.

A basic example of energenic interaction with electromagnetic fields is photosynthesis, the conversion of light to chemically stored potential energy for plant life, and thus for all of us.

Our brains, our hearts, our eyes, our muscles, our skeleton system and other organs all generate electromagnetic fields and communicate through them. The effective intensity of one, 10 millionth of volt is implicated in the interaction between cells. This is the same level found in the control of human biological rhythms, the level of EEGs in brain tissue, and navigation in fish, turtles, animals and birds.

Did you know that we have the same electromagnetic crystals in our brains which allow effects at low level electromagnetic field exposures?

Electric fields are bio activators of multicellular process. For example, electric fields from the sino atrial node control the entire vascular tree. In the human brain, all of the domains perform their various functions autonomously, and coupled together they generate a flow of patterns and cycles that function in coherent phase together. This is very important.

So you can understand that EMF disrupts brain function. Interconnection of neurons and cells with neurotransmitters bridging the gaps, is just one of the many electrical activities within the brain.

Electromagnetic fields affect not only the brain, but the entire organism through exchange of energies. Our bodies are electrochemical instruments of exquisite sensitivity. Orderly function and control are regulated by oscillatory electrical processes, each of a specific intensity and frequency.

External electromagnetic fields interfere with these and are deeply implicated in obesity, diabetes, cancer, infertility, neurological disorders and many, many 21st century medical problems.

Smart meters give off radiation ten times or more stronger than cell phones. Their presence on the line causes dirty electricity and interferes with electronic devices like computers and baby monitors. Dirty electricity, also called “electric noise,” is biologically active and disrupts how our bodies function.

Your board recognizes that chemical and electromagnetic sensitivities are disabilities, and several years ago was planning to closely examine the needs of this population and undertake activities that address accessibility issues.

You were supposed to develop an action plan to be used to reduce the level of chemicals and electromagnetic fields in the built environment. What has been done?

People with these disabilities practice avoidance. But with smart meters, there is no choice. We need you to change this. Installation of these devices is essentially prescribing treatment with electromagnetic fields and radio frequency radiation without a medical license.

It is inhumane to expose people to these frequencies, and without their informed consent. It violates the Nuremberg Code. Please take action immediately to provide for access to public places, including schools, for people with electromagnetic sensitivities.

>> JOHN WODATCH: Thank you.

>> SANDY ROSS: Shall I?

>> JOHN WODATCH: Yes, go ahead.

>> SANDY ROSS: Good afternoon. I'm speaking for Health And Habitat, a nonprofit organization that helps people with chemical and electromagnetic sensitivities. A few years ago, there was a project of the national institute of building sciences with funding supported from the Architectural and Transportation Barriers Compliance Board to help people with electro sensitivity.

The committee recommended, among other things, that NIBS provide or seek funding to develop a sample clean air room, complete with clean air symbol and gave specifications for design and construction. Conditions for this clean room included freedom from chemical, cell phones, computers, fluorescent lighting and other electrical equipment, Wi-Fi and smart meters would be included. Some conditions -- similar conditions should prevail on the path of travel and restrooms.

There are many un-addressed environmental barriers, some of which relate to specifics of this meeting. Medical equipment often has too strong an EMF field for people with electro sensitivity. This is a real problem when these people are hospitalized and must be mitigated.

Assistive listening devices must be offered hard wired, not just wireless, please. Electrical systems alterations to the house or building do affect the usability of the building by people who are electro sensitive.   And in your papers, it was indicating that this wasn't so.

You are dealing with a full variety of living places in this session. Accessing these places is increasingly difficult for people with electro sensitivity. They’re being driven from their homes, shelters and neighborhoods by radiation from cell phone, Wi-Fi, smart meters and similar equipment.

You have the obligation to protect people with this disability. One major way is to require their structures and buildings surrounding them have analog utility meters. You must also think how to protect from Wi-Fi radiating from residence and public places, cell phones, signals from smart meters, as people with this disability walk down the street, visit medical care facilities and other places.

Another problem for people with electro sensitivity is access to physical therapy and diagnostic facilities because of the number of electrical machines they have in here. These places must be prepared to provide their services in a way that does not harm these clients.

Under telephone booth section, please retain some landlines and old-fashioned telephone booths for people who can't use cell phones. Flashing lights are an access issue for growing number of people. These need to be mitigated in all instances, especially medical facilities where people are already compromised.

What we see happening with some of your proposals is that you are giving special consideration to the more traditional part of the disability community by providing services that will harm another part. This absolutely needs to stop.

In sections on lawn seating and golf courses, you need to require signage of what pesticides and herbicides have been used and when. These outdoor places are not accessible to people with chemical sensitivities unless they are organically maintained and pesticide free and we should have some of those.

Section 202.3 says swimming pools that are only filtered or chlorinated are legally accessible. Sorry, this isn't true either. They are not accessible to people with chemical sensitivities. The ones that use UV light for purification are tolerable and hopefully, that can be required.

As keepers of the Americans with Disabilities Act, you have the right and obligation to protect all people with all disabilities, especially those less visible and well-known as they are most subject to abuse.

We expect you to fulfill your obligations by directing staff to make the right rules for the right accommodations. Those with chemical sensitivity have learned to shelter in place as much as possible, but those with electro sensitivity cannot find shelter because of the increasing electro smog. Some of it is being directed by requirements for electronic access for people with other types of disabilities.

This has to stop and you can do it. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your comments. Next commenter will be from the phone, and will be Mary LaMielle. Mary, please proceed.

>> MARY LAMIELLE: Thank you and good afternoon. My name is Mary LaMielle. I'm executive director of the National Center for Environmental Health Strategies. Up to six percent of Americans are disabled by chemical sensitivities. An estimated three percent of Californians report electrical sensitivities.

Many people with environmental disabilities have multiple disabilities, including mobility impairments. People with chemical and electrical sensitivities are underserved, underrepresented populations who suffer greatly due to the failure of the Federal Government to address these disabilities in a collaborative and comprehensive fashion.

People sick or disabled with chemical sensitivities frequently have limited or no access to public and commercial buildings, to employment or educational opportunities, to knowledgeable and appropriate healthcare and medical services, to consumer products.

People with chemical sensitivities are frequently not treated with respect. They are not understood. Their civil rights are violated. They frequently face discrimination, whether at work, at school, in the community, in their families.

On July 28, 2010, the Department of Justice issued final rules, which included a discussion of multiple chemical sensitivities in the preamble. The Justice Department, again, declined to provide specific protections and noted that determinations must be made on a case-by-case basis. The failure of the Justice Department to recognize people with chemical sensitivities as disabled under the ADA continues its practice of discriminating against a significant population who are denied public access due to their inability to tolerate everyday exposures, typical to indoor environments.

This poses a great challenge to individuals with these disabilities. We urge the adoption of language in the ADA regulations that explicitly acknowledges access issues and delineates accommodations for those with chemical sensitivities in order to ensure that public spaces are accessible to them. We urge the Justice Department to recognize electrical sensitivities as a disability.

Equipment and furniture. The docket requests information to assist in determining accessibility requirements for non-affixed equipment and furniture. The ANPRM notes that without accessible medical equipment, examination tables, dental chairs, radiological diagnostic equipment, scales and rehabilitation equipment, individuals with disabilities do not have equal opportunity to receive medical care.

Individuals with disabilities may be less likely to get routine preventive care than people without disabilities because of barriers to accessing that care. Many people with chemical sensitivities go years or decades without basic medical services including dental care and other essential services because they do not tolerate indoor exposures.

These are serious issues and those with these disabilities have every right to access to medical care as others with disabilities that are visible or better understood.

Most indoor environments are not accessible for people with chemical sensitivities. This is in part, due to equipment and furniture that emits volatile chemicals, such as formaldehyde and other solvents. U.S. Access Board contracted with the National Institute Disability Sciences to examine indoor environmental quality access issues for people with chemical and electrical sensitivities.

In 2006, NIBS issued the *Indoor Environmental Quality Report*. The report references a California testing standard, CA-1350, a protocol for emissions testing of volatile and semi-volatile organic compounds. The Justice Department and other federal agencies should explore the use of CA-1350 to ensure the purchase of least problematic furniture.

Products and practices to enhance access for people with chemical and electrical sensitivities are available but not required by the Justice Department. We recommend the Justice Department examine these issues and join in a proposed interagency committee on chemical sensitivities.

Movie captioning and video description. We support making movie theaters accessible for individuals who are deaf or hard of hearing or who are blind or have low vision.

It's again important to note that movie theaters, as well as theaters and arenas with live performances, are not accessible for people with chemical sensitivities due to indoor contaminants. Furthermore, practices including use of smoke machines, strobe lights, smoking by performers and gunfire are also exposures that should require pre-notification to audiences together with use of alternative nontoxic or less toxic practices as available.

Thank you for your time. I'll also be submitting written comments.

>> JOHN WODATCH: Thank you, Ms. Lamielle. We appreciate your staying with us. We realize you weren't able to participate at our last hearing. We’re happy you were able to address us today.

>> MARY LAMIELLE: Thank you. I appreciate that.

>> JOHN WODATCH: Next, we’ll hear from Peggy Costor. Ms. Costor?

>> PEGGY COSTOR: Thank you very much. I appreciate the opportunity. Actually, listening to the lady about the electromagnetic fields, I'd like to really, really support what she said, because frankly, I have so many problems right now.

The last thing I need is for smart meters to come and really damage my life. I was against them before but now I really am against them. So I'm really advocating listening to them.

And I'd also like to say that I think we all know the biggest problem is going to be lobbyists. We all know that. Because whatever you try to do, the lobbyists will try to undo. And so The Supreme Court, frankly, is one of the biggest problems we have. Having said that, I'll go to what I really came to say today.

Issue number one, I have, is captioning. It's actually only a -- I'm sorry. It's actually a technical issue. I can't read, when they have foreign language –- you know, when they put the captions on. Half the time you can't read them because it's white on white. A technical solution to that is really simple. All you have to do is add full saturation and shadows to the writing and then you could read the white on white captioning.

So It's a technical issue but it’s an important one because what good is captioning if you can't read it?

Issue number two, furniture. I agree with the furniture issues because I always have problems with furniture. I can't get anywhere I need to be. I've tried for years to find computer furniture that I can use and I have not yet found it.

But my real issue that I came for is speech to text because this is a very frustrating area. The operating system developers and all software developers need to work with each other in making sure computers truly work for people who need hands-free speech to computer operation.

And there’s some very good reasons for that. Your life practically stops and you cannot defend yourself or get what you need or get information or do anything if you cannot use a computer these days.

Many government bureaucracies and corporations place forms on-line and have quit putting information out in written form and now either requires long waits or hang up on you if you call on the phone. If you wait, many menus repeat web information over and over and over prior to even giving the option of speaking to someone on the telephone, and it only happens after an even longer wait.

Medicare, and other programs, require written and printed appeals, which cannot be done if speech to text does not work.

Corporation. customer service personnel say a great deal over the telephone that they either are not allowed to put it into writing or refuse to put into writing. And we all know why.

So that means that if we need to document what was said and done, we need to be able to document it ourselves on the computer and so on. There’s all kinds of reasons, but life literally stops these days if you cannot use a computer. And you cannot defend yourself or do anything.

Yet, the dictation programs all cater to the able-bodied. Dragon is the best there is. And when it got to Vista, it worked perfectly. I mean, it was so good, it worked, the commands worked. The speech to text worked. But then they went to Windows 7 and they said, yes, it works on Windows 7, Dragon 10 does, and it does but very poorly.

I gotta tell ya, I quit using the Windows machine. I use Mac. I tried Dragon dictate for Mac. And it’s where Dragon was several years ago but it's better than nothing.

I've got a lot more in here, to be honest, because speech to text is so very, very important. It needs hands-free capability, it needs -- headings, text, whatever, to increase in size. And it needs to be speech to text programs to include excellent voice recognition. And Apple is very bad and has long been very bad.

And the last thing I would like to say is, and I hope nobody is offended, but, honestly, federal employees get 10 percent discounts on many computers and other things. And the problem with that is that it could appear, whether or not it does, but it could appear that since bureaucrats are the people who set up regulations and other stuff that regulates what can and cannot be done by companies, it could appear that they could be –- it’s kind of like lobbyists, you know.

>> JOHN WODATCH: Okay. No offense is taken.

>> PEGGY COSTOR: Thanks.

>> JOHN WODATCH: Thank you very much for your comments today.

>> PEGGY COSTOR Thank you.

>> JOHN WODATCH: Our next Commenter is going to be via the phone and Sudi Scull.

>> SUDI SCULL: Hi. My name is Sudi Scull and despite my disability, I'm committed to being able to work. I had a bad accident in 1991 when I came close to dying or else being paralyzed. I was unable to continue my work as an architectural photographer due to the physical nature of my job. And since symptoms began after my accident became more debilitating, intense chronic migraine, asthma, neuropathy and nighttime

seizures.

Still committed to working, I began graduate school in psychology. I am now a licensed marriage and family therapist and certified nutritionist. Through trial and error and seeing cutting-edge doctors, I've learned I have both chemical and electromagnetic sensitivity.

I receive Social Security, disability and have a small private practice. Finding an office with my disability was a needle in a haystack, so I work out of my home. I live a circumscribed life but have found emotional and physical stability within my tight parameters.

But in January of 2010, without my knowing it, our utility company PG&E installed two wireless smart meters in my house. I experienced dramatic physical and psychological symptoms immediately. My symptoms were pronounced enough that PG&E responded quickly and took my meters out, as they yet insisted that soon it would be mandatory for me to have both a gas and electric smart meter installed, once again, at my house.

With the meters out, I felt better. Although, my EHS became more heightened as I went into stores and was near cell phones.

But then this summer PG&E installed three smart meters adjacent to my house. And it turns out PG&E had, in fact, lied. They had given me instead two hybrid smart meters. Again my physical condition has deteriorated. Chronic migraine, ringing and pressure in my ears that become stabbing pain in my neck and shoulder, insomnia, increased neuropathy, nausea, etcetera.

When I go to the beach or hiking away from the EMS my symptoms quickly subside. The whites in my eyes have become alarmingly gray and pink. Most of my electricity is turned off. So you can see, I'm struggling. But enough on me.

In 1998, the California Department of Health took a comprehensive survey and found 120,000 Californians could not work due to electromagnetic sensitivity. While I'm sure like me, they soon will have no place to live let alone work. In 1990, the EPA cited EMS as a probable carcinogen but the utilities, Telecom and military bullied them out of it.

In 2008, Obama's cancer panel absolutely named EMS as a carcinogen. All of the in-depth scientific evidence is stacked against RF radiation. Whether it shows the blood barrier to the brain dangerously opens up or male sperm count drops dramatically. Or, finally, DNA strands break apart causing cell mutation and cancer. We live in ever increasing amounts of electro smog and cumulatively this puts all of us at risk, not just those with EHS.

But the smart meter takes the cake. It is the atomic bomb of RF radiation. They emit high, sharp, spike pulses every one to two minutes of microwave RF radiation. Electrical engineers have taken readings and believe it is 1,000 times stronger than a cell phone. That is the equivalent to 17 hours of cell phone use a day for each meter.

Business buildings and apartment building will have large clusters mounted close together. But PG&E continues to claim these meters are safe. There is no transparency, just this awful rush to put them in.

We have no choice. We cannot opt out. As I stated before, many many of us will probably get sick and have to move. But where are we to go? It seems unconstitutional and just plain unfair.

Every governmental agency we have gone to sends us spinning to the next. The California Public Utility Commission states that these meters are within the guidelines set by the FCC. In fact, president of PD&E, admitted these meters were not independently tested. They are taking the word of Silver Springs Network, the manufacturer.

But additionally, FCC regulations are very, very outdated and inadequate. We need the ADA to take a stand and be courageous and protect those like me with EHS but also the public at large. Or soon, the whole general population is going to be very, very sick, and disabled, unable to work, and with nowhere to go. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony today.

>> SUDI SCULL: Okay. Thank you for giving me the opportunity. I just really hope you can help all of us out, and especially someone like me.

>> JOHN WODATCH: Thank you. Next, we're going to have another telephone commenter, Terry Siemens. We're making the call now.

>> TERRY SIEMENS: Hello?

>> JOHN WODATCH: Is this Terry Siemens?

>> TERRY SIEMENS: This is.

>> JOHN WODATCH: We're ready for your comments.

>> TERRY SIEMENS: Thank you, members of the panel. And those who are listening in the audience, thank you for attending and thank you for listening to my presentation.

I wanted to take the opportunity to focus my remarks on CRT docket No. 110, and related to web access. And also CRT docket No. 113 related specifically to equipment and furniture.

I wanted to explain a little bit today how the increasing wireless radio frequency microwave radiation has made and will continue to make it more difficult for me in the workplace and also more difficult for me to access public facilities including universities, libraries, and government buildings.

These wireless Internet technologies, including Wi-Fi and web cams and their supporting structures, are increasingly difficult for me to avoid. As I, and others, access the Internet on web facilities in our communities and also in these buildings.

Specifically, I have a condition electro sensitivity that includes vasovagal episodes and has significantly affected me in the workplace recently.

Recently I was approved to participate in a full-time student teaching placement. Initially I was assigned to a school site with a cell tower located on the other side of the fence at the back of the school. I asked to be reassigned to a school site without a cell tower located nearby. Initially, I was turned down. I presented medical documentation from my physician and I was subsequently granted an alternate placement.

Next, I was placed at a school site with a wireless security system. Specifically, I was in a portable classroom that had a spherical-shaped object attached to the ceiling that pulsed a piercing type of energy that hurt my head. After as little as 15 to 20 minutes, I would experience nausea, difficulty concentrating or reading, short-term memory loss, slurred speech patterns, and finally, I would black out.

The classroom teacher and the students initially thought that perhaps I was falling asleep. I explained to the teacher that if I moved around the classroom that I could prolong the situation, typically for up to two hours. She watched and concurred that the movement helped me minimize the visible onset of my reoccurring symptoms.

I explained to the teacher and the principal and the university supervisor and the university department director that I had difficulty with Wi-Fi, and that I needed to be in a classroom without Wi-Fi.

They had specifically made arrangements that I would be in a classroom without any wireless technology near the computer equipment in the classroom. Unfortunately, no one, including myself, anticipated that there would be a wireless security system operating during the classroom hours as opposed to after the school was closed down for the day.

Unfortunately I was told by the principal that the wireless security system could not be dismantled in the particular classroom that I was in, that it would be across the entire campus and that was not an option. I was asked, eventually, to leave the school site after 4-1/2 weeks of a ten-week program.

I'm currently intending to start another student teaching assignment, and it would have begun today but they haven't been able to clarify my placement just yet due to my accommodations.

In addition to teaching, I'm required to take a state RICA examination. That too, I was assigned to a site with a cell tower and have subsequently asked for accommodation for that. They've told me that they have never had such a request for an accommodation. But there is no opportunity that I could complete a state examination sitting next to a cell tower.

I would encourage you to consider these -- thank you.

>> JOHN WODATCH: Okay. Thank you very much. We appreciate you taking the time to comment with us today.

>> TERRY SIEMENS: Thank you.

>> JOHN WODATCH: We are going to now have another commenter via the phone, Susan Molloy. I believe the call is being made now.

>> SUSAN MOLLOY: Hello?

>> JOHN WODATCH: Susan?

>> SUSAN MOLLOY: Yes.

>> JOHN WODATCH: This is John Wodatch. Welcome. We are ready for your comments.

>> SUSAN MOLLOY: Thank you, Mr. Wodatch. My name is Susan Molloy. I'm calling --

(Announcement interruption.)

I'm calling from Snow Flake, Arizona. I would -- by my count, I'm the 14th person today who has been planning to discuss barriers such as electromagnetic fields, Wi-Fi, cell, and chemicals.

(Feedback interruption.)

>> JOHN WODATCH: Susan? This is John. Could you -- you may be listening on the -- to the Internet and we're getting feedback from that. Could you --

>> SUSAN MOLLOY: Okay. We should be set now. Thank you. I don't have much to add to the 13 or 14 people who testified today about the barriers they face in the environment that go largely un-addressed.

The barriers I'm most concerned about would be the chemical and electrical barriers, also those that have to do with light and sound that we are including in our requirements under the ADA, and other laws, in architecture that are in fact creating barriers to many of us.

I am very curious to know, what are the prospects that we might have for Department of Justice to take a position in support of our issues? At this point, I think that there is an emergency in that the smart meters are being mounted on houses and apartments across the country, and many of us are absolutely defenseless in the face of these -- sorry -- in the face of these installations.

I did notice that there was one request for supplemental document that would be the focus on electromagnetic field, and Wi-Fi, cell, smart meter barriers. And I don't know if that’s a realistic expectation for us or if the Department of Justice has another way to possibly make some kind of a public statement or back our play in a legal action, for example, that would protect people with these disabilities.

Specifically, we need intervention by DOJ, or someone, or an equivalent agency that can secure for us an opt-out provision so that the power companies have to give us an alternate way to get power metered from our houses than the smart meters.

Just very quickly, I'd like to mention a couple points that have come up today. The treadmill for exercise, and the treadmills that are in hospitals for evaluation of heart performance, both of those, recreational and medical uses, are -- we can only obtain them in one form and that is the electrical form that causes severe pain.

I don't know what is possible procedurally but I would very much like to put the brakes on this whole process for now to get intervention by Department of Justice to consider some kind of supplemental document.

I think that we’re getting ourselves in trouble again, as we have before, by not looking in advance in a timely manner at the requirements -- by not looking in a timely manner at the requirements for safe access for people with certain disabilities and promoting good access or insisting on good access for people with other disabilities. Sometimes the requirements conflict and we’re not being mature if we’re not noticing that we need to coordinate our insistence for access for various groups.

(Pause)

>> JOHN WODATCH: Susan, your five minutes are up. if you will let me, respond a little bit to your question. We have started at our hearing in the District of Columbia, and certainly today, about these issues. I think, clearly, we have a lot of evidence to go forward and look at, especially the relationship of utility companies to Titles II and III of the ADA and looking at what options are open for us to further investigate and make decisions about whether they are regulatory choices or other choices.

Some of the comments -- we’ll have to look at in depth at some of the comments that we received that are written. Because a number of people can in a five-minute presentation only make really summary kind of presentations. We hope to look at the information we get in more depth and then make some reasoned decisions about whether or not it affects the rulemakings that we have proposed, working with other federal agencies, as has been suggested by several of the commenters or, as you are suggesting, other appropriate action that might be taken.

But we will consider all of those very carefully. Thank you. Our next commenter also by telephone will be Mitch Pomerantz who is president of the American Council of the Blind.

>> MITCH POMERANTZ: This is Mitch.

>> JOHN WODATCH: Mitch, this is John Wodatch. Please go ahead with your comments.

>> MITCH POMERANTZ: Surely. Thank you. My name is Mitch Pomerantz. I'm the president of the American Council of the Blind. ACB is a major, national grass-roots consumer advocacy organization with 70 state and special interest affiliates throughout the nation.

I wish to thank the United States Department of Justice and especially to you, John, for the opportunity to briefly address some of our general concerns relative to the recently issued ANPRMs. More extensive written comments addressing specific concerns will be forthcoming.

Regulations must be drafted, which recognize the convergence of Section 508 of the Rehabilitation Act, Section 255 of the Telecommunications Act, and the recently enacted 21st Century Communications and Video Accessibility Act. Incidentally, a bill sponsored by the American Council of the Blind and just signed into law by President Obama.

Without taking such laws into consideration, the Department will be developing standards, which will be irrelevant because effective communications will be thwarted. ACB would argue, it is time that the ADA acknowledge these federal laws, which have become -- which have begun creating standards of accessibility.

ACB recognizes the Department's efforts, to date, to clarify that the ADA requires access to web information and services. If blind and visually impaired people are to compete on equal terms with our sighted peers, regulations must be promulgated which guarantee access to websites operated by both Title II and Title III entities.

The Department should clarify that audio description is an auxiliary aid and service, which assures effective communications. It is not a fundamental alteration of a theater's service and should be acknowledged in the regulations.

Let me comment here that the term "video description" is wholly inappropriate given that since 1981, the generic phrase referencing the use of language to provide access to visual images has been audio description. It is essential that the Department adopt audio description as the only appropriate term to describe this method of effective communication.

ACB believes that DOJ should unequivocally state that the accessibility of equipment is an inherent component of making programs, activities and places of public accommodation accessible.

We are convinced that people with disabilities have waited long enough for a clear statement by the Department that there is an affirmative obligation to assure that equipment used to provide access to programs and services under Title II and equipment being deployed in places of public accommodation under Title III must, within the constraints contained in both titles, be accessible.

Further, since virtually every piece of equipment today makes use of computers or are directly connected to the Internet or accessed wirelessly or via remote control, we must go beyond looking at equipment in a stand-alone context.

The accessibility of computers, whether in home appliances or public kiosks, must be a basic consideration in any regulations developed for equipment accessibility. It is no longer appropriate to see the regulation of equipment, the web and audio description, as separate endeavors.

All three of the ANPRM areas overlap. It is time that the Department considers adoption of general principles that clearly articulate the convergence which the computer chip has created.

In conclusion, the Department of Justice must take this opportunity to absolutely articulate that there is a categorical requirement for equipment accessibility, which applies equally to state and local governments and places of public accommodation.

The Department must champion principals of universal design, which will within a reasonable time frame, require Title II entities to acquire equipment that is accessible. ACB is certain that if justice adopts this unequivocal general principle, we will get to a place where equipment accessibility will assume the place it should as a civil right for people with disabilities.

And I thank you very much for allowing us to participate today.

>> JOHN WODATCH: Thank you very much, Mitch. Next, our next commenter will be John Waldo. Mr. Waldo, please proceed.

>> JOHN WALDO: Good afternoon. And thank you all for the opportunity to have some input about movie captioning. My name is John Waldo. I'm an attorney representing plaintiffs in ongoing movie captioning litigation in both Washington and California.

I'm speaking here today on behalf of statewide advocacy organizations for people with hearing loss in the states of Washington, Oregon, and Utah, and also speaking on behalf of two national organizations, the Association of Late-deafened Adults and the Collaborative for Communication Access Via Captioning.

20 years ago, the Americans with Disabilities Act envisioned bringing people with disabilities into the mainstream of American life. For some people, and I think especially those with mobility disabilities, ADA brought about rapid and meaningful improvements. But for those of us with the very common but invisible disability of significant hearing loss, ADA is still far more promise than reality.

A particular source of frustration has been the movies, America's favorite night out. Technology today permits movies to be shown either with open captions superimposed on the print for certain showings and visible to the entire audience or closed captions visible only to patrons who request a viewing device.

Both methods fit squarely within ADA's definition of auxiliary aids and services because they are affective methods of making orally delivered material available to people with hearing loss.

As you note in the ANPRM, the vast majority of today's movie studio releases have captions prepared in cooperation with the studios. What has denied us the opportunity to fully enjoy movies has been the reluctance, if not the downright refusal of theaters, to purchase and install the equipment to enable us to view the captions.

That situation is finally changing. Guided significantly by a friend of the court brief that the Department filed, the 9th Circuit ruled last year that ADA requires theaters to show closed-captioned movies unless doing so would constitute an undue burden. Then three months later, this Department announced its proposed rulemaking.

We welcome DOJ's involvement and would urge you to make the 9th Circuit decision a nationwide rule to the effect that captioning is required unless it constitutes an undue burden.

That said though, we think the proposal that captioning should be required for only 50 percent of the movies phased in over five years is a giant step backward and is deeply flawed, both legally and factually.

Our legal objection is that ADA clearly states that auxiliary aids and services like captioning are required unless the entity, singular and specific, the entity can demonstrate that providing those aids and services would be an undue burden.

Because captioning is technically available, we think the undue burden inquiry is purely financial and must be done on an individualized case-by-case basis probably by a court. We don't believe that substituting a broad performance-based standard, which may ask too much of some but require too little of others, is consistent with a statutory undue burden standard.

Our factual objection is that many of the larger corporate theater chains can in fact show 100 percent of movies in captioned form. Cinemark, the nation's third largest theater chain, has completed converting its Washington state theaters -- now, that’s only two multiplexes -- to full digital projection. It has also equipped every one of those auditoriums to show captioned movies. We now have two fully accessible theaters, complexes, in the State of Washington.

Regal, the nation's largest theater chain, has informed us that essentially the incremental cost of captioning the second half of its 6,800 theaters to show captioned movies would be about $3 million. That’s big money, but put it in context.

In 2009, according to publicly available documents, Regal paid over $110 million in dividends. Dividends. After the staff has been paid. After the leases have been paid. After the debt has been serviced. After you pay taxes on it. Dividends basically, according to some, are money that companies can't figure out anything else to do with so they pay it in dividends.

I would submit that three percent of your annual dividend cannot constitute an undue burden. Much more to say, I'll submit it in writing. Thank you very much for your time and for your effort on this.

>> JOHN WODATCH: Thank you very much, Mr. Waldo. We appreciate your testimony today. Next, we are going to hear from Shen Kuan. I hope I pronounced your name somewhat correctly.

>> SHEN KUAN: Hi, my name is Shen Kuan. I work at the Lighthouse For the Blind in San Francisco. I've been blind for more than 20 years. I want to talk about the web accessibility for blind people.

I want to emphasize how important it is for me, knowing that a website is accessible for me using my screen reader software, which reads the materials, the stuff on the website to me with synthesized speech.

It has been a challenge for me for many, many years to try to -- every time when I go to a new website, not knowing whether that site is accessible 50 percent, 100 percent or whether everything on there is readable to me or not.

Part of my job at the Lighthouse For the Blind is to help test out websites to find out whether it is accessible, and if not how to make it accessible. And having this set of guidelines can help me in knowing that all the websites out there are being compliant to these guidelines and making it accessible for not just anybody but also for visually impaired visitors to the site.

A couple of examples is; one, last year I attempted to purchase baseball tickets on-line. And when I got to the website, I found out that it was not accessible, because the choices for you to choose where you want to sit in a stadium are mapped out on a map on the screen. And that map was 100 percent not accessible to me.

So I had to end up calling on the phone to purchase my tickets. And if these guidelines had been available -- had been enforced, I think I would be able to make my purchases online independently.

Another example is when I purchase airline tickets online. With so many websites, different airlines have their own websites, and they all have different ways of purchasing tickets online. Not all the forms available online for you to purchase, for you to fill out your information, to choose where you want to sit, are standardized.

So every time when I go to a website, I always have to spend the first maybe 45 minutes getting myself oriented, learning how to use it, assessing the website, trying to find out whether it's accessible to me. And if not, then I would have to make that phone call asking to purchase the tickets on the phone instead.

So I think if the DOJ can adopt these guidelines for web accessibility, it will make all the websites standardized and make them all accessible for visually impaired people so that we don't always have to constantly struggle with our screen readers, trying to find out whether this thing is accessible or not before we can do what we need to do, purchasing tickets, buying online, or browsing the Internet, researching information. Different things are not always the same.

I wanted to ask that the DOJ consider adopting the web content accessibility guidelines for its standards for the websites. And that's it. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your comments today. I'd like to point out that we have been joined at the front today -- Mazen and I have been rejoined by Christina Galindo-Walsh and Bob Mather.

Next, we’re going to hear from Lisa Maria Martinez.

>> LISA MARIE MARTINEZ: Hi. My name is Lisa Marie Martinez. I, too, work for the Lighthouse For the Blind and Visually Impaired in San Francisco. And today I'd like to talk a little bit about the accessibility of equipment and furniture. In particular, the topics and areas that are near and dear to my heart, which is exercise equipment and furniture.

I really strongly believe that all exercise equipment should be accessible to those with disabilities. Many general cardio machines such as treadmills, elliptical machines and row machines require the operator to interact with the screen in order to set up the appropriate exercise program.

Blind and visually impaired people are at a disadvantage when it comes to the general health maintenance that they require since these screens are usually touch screens, with no tactilely discernible buttons. And they have no audio feedback, which can aid in the independent setup of daily routines.

As we all know, there's an obesity crisis in America. And different people have different reasons as to why they want to stay fit. Should people with disabilities be excluded from slimming down and taking control of their own lives, to prevent life threatening diseases such as diabetes and heart disease?

I've been an athlete the majority of my life, whether it was as a judo athlete, a track athlete or some other sport I was trying out. And I've encountered many different types of cardio machines and exercise equipment that I cannot access without the help of someone there to help mark the equipment for me or to tell me how to use it or just to get the machines started.
And then I'm limited to what I can do. If I wanted to change my program because it was too much for me, I'd have to either stop the machine and ask someone to reprogram, for instance, a treadmill program for me or yell for someone, hey, can you change this for me while I'm in the middle of trying to run.

Through simple technology such as audio feedback, similar to those technologies that Apple uses for their iPhones, blind and visually impaired people can access flat screens. Tactile buttons and high contrast buttons can aid in the quick search of a particular button. These little small solutions can make a big impact in someone's health.

I have yet to find a totally accessible treadmill or cardio machine. Oftentimes, I have blind people come to me and ask me how can they go to a gym and get fit. And I encourage them to talk to the managers at the gyms and explain to them that with a little bit of innovation, they can possibly mark up the machine and make it semi-accessible. But a lot of times they are faced with resistance.

The gym folks don't understand that we’re not going in trying to destroy their machines and change them all up by putting a little Braille dot on it, or marking it so that we can at least know how to start and stop the machine. And even if they are welcomed with open arms to tactilely mark a button, oftentimes they are taken off. So what do we do?

I know I would like the choice to improve my health and my general welfare by incorporating exercise into my life. It has been a huge part of my life. And I hope it to continue to be a huge part of my life. I don't require a different piece of equipment to get healthy. I don't want to have to pay extra for a machine that comes with accessible features.

If simple accessibility standards are considered from the beginning stages of design, then accessibility doesn't have to mean different or expensive. With the last minute I have, I want to talk a little bit about electronic and information technology.

I use ATMs and POS machines every day and kiosks every day. And I have to debate just how much personal information I want to give to a complete stranger just to finish a transaction.

If I want to pay using my debit card for a sandwich that I purchase during lunch, I have to give my pin number to a complete stranger. What if I drop that card and the person behind me overheard my pin number, picked up my card, and didn't do the right thing, which would be to give me back my debit card? But instead they went to my bank and cleaned out my account?

I cannot independently do this. And every American has the right to privacy. I can't go to an airport and check out -- or independently check out using a kiosk. I cannot do self-checkout at a grocery store. I have to rely on someone else to do that for me.

So thank you for listening to my comments today and taking the time and consideration to change things.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony. Next, we’re going to hear from Beth Berrenson.

>> BETH BERRENSON: Thank you for giving me the opportunity to comment on the importance of audio described movies. I'm a movie addict. I'm also a person who is partially sighted. My vision is 20/200.

What I see and what a person -- what a person sees -- a person who is 20/20, would see at 200 feet what I see at 20 feet. For me, I need to get close to that movie screen.

I also have a challenge when I'm seeing something on the screen that is obviously nonverbal. Lots of times, the nonverbal action is advancing the movie plot. I miss it. If it's not audio described, I've missed it.

This is perplexing to me, since this is moved along in a nonverbal way. Living in San Francisco, I have access to two screens that have audio description capabilities. Very often the staff at these theaters does not know about these facilities or they are not having audio described movies playing in them.

I urge the panel to consider training all staff to be familiar with audio description, and make it mandatory for each auditorium to show audio-described movies. The content is available to fill these auditoriums. More movie distributors are including audio description tracks with their new productions.

As the information and resource coordinator for Lighthouse For the Blind and Visually Impaired in San Francisco, I put out a weekly listing of all audio described movies in the nine-county Bay Area. Considering there are over 200 screens in the area, there are usually only about 10 screens that have audio description.

Those of us who are blind or visually impaired want the same opportunities to view movies as the rest of the seeing public. Being a baby-boomer, I grew up going to the movies. As we boomers age, more of us will be affected by vision loss. It just makes good business sense for the movie industry to include the blind and visually impaired in the number of the movie-going public.

I urge you to consider making all movie screens accessible for the blind and visually impaired through audio description. I also want to make one other comment about audio description when we go to buy movies.

More and more distributors are putting that content on a DVD or a BluRay. The challenge with that is that the menus on the DVD and BluRay are not audible. So even though the information is there for us, we cannot access it. To me there is something missing in that equation.

And I know that is part of the what the 21st Century Communication Act talked about also, and I urge you to consider making the menus on DVDs and BluRays audible so that we can listen to movies without having to include someone else. Thank you very much.

>> JOHN WODATCH: Thank you. We appreciate your testimony this afternoon.

Next we are going to hear from F. Ross Woodall.

>> F. ROSS WOODALL: Yes, thank you. I want to thank the Department of Justice for being here in San Francisco, saving the best for last, and I also want to acknowledge the panel, that it is one of the most austere and good looking panels that I have ever seen. With that said, I am blind.   (Chuckles).

>> JOHN WODATCH: You are terribly accurate.

>> F. ROSS WOODALL: As I said, my name is Ross Woodall. I am the co-chair of the Mayor's Disability Council for the city and county of San Francisco, California.

The Mayor's Disability Council acts as a liaison and a reference and gives input to the mayor, to the mayor's office on disability, and to the board of supervisors on any matters that have to do with disability issues.

We will be presenting our findings to you in writing after the meeting is over. As for the web content, we, since the web continues to be the medium in which most information is disseminated right now, and especially information that is of time sensitive nature, of an emergency nature, we on the Mayor's Disability Council are very happy and will heartily recommend that the provisions of WCAG 2.0 AA be utilized and put into force by the Americans with Disabilities Act by the Department of Justice. We feel that this is the best way to keep people informed, who oftentimes are shut out from watching TV and other means of communication that are simple for other people.

We also, I also want to talk about forms. Forms are of great interest to the council members, because they all realize that so much of our lives for those of us who are blind especially, we deal with forms on-line, ones that are inaccessible. Forms that will help us to get a job, and of course we have one of the highest rates of unemployment of any segment of the population. And anything that can be done to help the blind get back to work is necessary. These forms sometimes are very, very daunting. But we are very happy to see that the DOJ has agreed, even into the simplest forms of what might be approved today, in the level A comments, that forms would have to be able to be filled out on-line. And we definitely applaud this, and we are behind this 1,000 percent.

As far as personal use of the Internet, it has become my way of life. That is where all my information comes from. It is how I communicate. It's how I pay bills. Not able to write checks anymore. It is how I find out what is going on in the world, be able to find things out instantaneously, to be able to enlarge my network of friends and family. So the accessibility by people with vision loss and who are blind is not only important, it is mandatory.

I know of 85-year-old grandmothers who have gone blind and learned the Internet, and are now able to work with their -- talk with their grandchildren and great grandchildren on the Internet. They have actually become techies. And so this is a medium that I think can help so many people to regain their quality of life and their independence.

I'm actually going to be turning it over now to the next speaker who is the other co-chair from the Mayor's Disability Council, who is Jul Lynn Parsons.

>> JOHN WODATCH: Ms. Parsons, you may proceed.

>> JUL LYNN PARSONS: Welcome to San Francisco. I'd like to echo my co-chairs' sentiments in saying everyone sounds wonderful. But I should first probably let you know that I'm deaf, and I'm reading the captioning that you are offering here which has offered the most effective type of communication in this situation, and allows us inclusion and equal access, and that is why we are all here. The common ideal is we need, we want universal access, and what forms and components does that come in?

So I'm delighted to be here today. We did have a hearing in December available on the city and county website, where we addressed these proposed rules. We asked our constituents what their feelings were about them. And so in that context, I'm here to reveal some of those findings to you.

In respect to the next generation 911, equal access to 911 services do not currently exist for people who are deaf or hard-of-hearing, and I can give you a personal example of that. I use a land line phone to call my recently widowed mother, and it takes several minutes to get through. That's annoying, with the relay operator. And in the event of an emergency, as you heard previously this morning, I believe, that could be life threatening, a matter of minutes.

So this already is discrimination against this particular class. And the clearest approach to web accessibility and at the same time not dependent on specific technology or programs, okay, I'm going by my notes and what I meant by that was WCAG 2.0 is primarily what we were advised to recommend by the experts that we heard. And that was level AA. Ross brought up one of the concerns which were formed, the other concern we had were captions and web streaming. And I'm proud of the city and county department of information and technology services, because they have archives of meetings that, click a little button and you get captions, or you get a little text right next to it.

So we need that, a lot of websites don't have that that Ross mentioned this is how we get our information. We can't go out in general public, unfortunately general public doesn't look like this room yet.

In regards back to WCAG, the guidelines have already been in place for some time, and will reduce confusion. Basically what I want to say on that was WCAG compared to 508 compared to standards of performance, and we chose WCAG. We just thought they were clearer. They left more room for improving technology, basically. That is the short story.

We will be giving you something in writing, because I will not go over my time. I've been sitting here all day with you folks too and I'm anxious to hear what everyone has to say just as well. 911, it's an archaic system, it's analog, which is what we discovered. That means that people who are deaf or hard-of-hearing cannot use the regular phone basically.

I have a portable TTY. I don't use it with my iPhone. I had an emergency last year. I had to text my daughter in Seattle, to have her call the police down here in the Bay Area. And I was lucky she was available, because if she wasn't, I wouldn't have had that access. And I know I'm not alone there.

So we really promote the idea of Internet protocol on the 911 system, with all deliberate speed, I might add. And that would include text messages, instant messaging, e-mail, and video communications.

I think you really need to be robust in your broadcasts like that. Timing, that would be affected by the state's ability to finance an entirely new network. We understand that. California may be prompt to do so because there is a mechanism in place and that is a tax increment on everyone's phone bill. So we encourage the Department of Justice to require no more than a five-year time line to implement the new system, especially in those states with a funding mechanism already in place such as California because this is a key access issue, and there are few issues that are more important than that. And it will literally save our lives to bring us into the 21st century with 911.

I see there is a little red light going on, tiny little light, I may have missed it for a second. We will be happy to submit our further findings to you and we're very pleased to have you come visit us today. We hope that you will return and we can work with you in the future. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your being here today. We also appreciate you reaching out to your community on our ANPRMs. Thank you for doing that.

Our next Commenter will be via the telephone, and is Mr. Mike Tinkey. Mr. Tinkey, go ahead.

>> MIKE TINKEY: Good afternoon. Thank you again for the opportunity to address you again in response to questions number 14 and 15 regarding addressing the needs of golfers with mobility disabilities, scoping requirements for accessible golf cars and questions 23 and 24 on the impact of small entities.

I'm Mike Tinkey, the deputy director of the National Golf Course Owners Association, NGCOA. We promote best practices in reaching out with to golfers with disabilities, through education, staff training, programming, and facility modifications, are large part of that focus. We proactively educate and inform through golf business magazine, seminars and member calls. We have found that a multi faceted approach is need to serve golfers with disabilities. One size doesn't fit all. As part of the process, we have sought to provide access to accessible single-rider golf cars through acquisition and pooling. Experience in the field has demonstrated there is no silver bullet or monolithic approach such as providing single-rider golf cars to address the needs of most golfers with disabilities.

Number one, pooling works. Starting approximately three years ago the NGCOA coordinated an accessible golf working group made up of representatives of the largest multi-course companies in the United States. We exchanged information on who had single-rider golf cars, where they were located, and coordinated a program where golfers are pooled among courses based on a request and reservation by golfers.

We expanded this program to our chapters and membership at large. Even with very few single-rider golf cars in circulation, we have been able to increase access to golfers by pooling and I can only think of a couple instances where the golfers was not accommodated. And these few cases they subsequently were.

Number two, pooling works in municipal facilities, companies like American Golfer, who operate many municipal facilities, the City of Indianapolis, courses and programs in Chicago and many others, pool their golf cars effectively. Number three, even at military courses, preliminary research indicates that the mandate they have two single-rider golf cars per course was an overreach.

Number four, among the general population, civilian population we found little or no demand for single-rider golf cars even where they are being aggressively marketed and promoted. In fact, in many cases disabled golfers prefer traditional golf cars with or without a chauffeur. Golf is a social sport and they prefer to ride with another golfer.

The number of golfers with mobility disabilities that are not being served by using a traditional golf car, traditional golf car with chauffeur or traditional golf car with hand controls or with access to tees and greens is very small. Where there is request for single golf car they can be served through pooling arrangements.

Technology is rapidly evolving and today many wounded warriors are able with prosthetics to have mobility that just a short time ago would have been thought impossible. Single-rider golf cars are just one form of technology and the need is diminishing as technology offerings alternatives. Finally and importantly, there are no ANSI safety standards or certification for single-rider golf cars although a new group has started the process to do so. Therefore, golfers, course owners and operators operate them at their peril. We need to understand the potential unintended consequences if there were to be a mandate.

Regarding 23 and 24, single-rider golf cars cause twice as much as traditional golf cars or more and they only can only be used by one, not two golfers. Thus they are much more expensive. Traditional golf cars easily pay for themselves because income is more than the cost of the cart. Given the limited demand, there is not a case for the single-rider golf car, mandating their purchase would pose a significant economic burden to small business owners of golf facilities at an already challenging economic time and would fail to address the need that is not currently being met by other means.

Single-rider golf cars do not provide a panacea for golfers with mobility disabilities that some alleged. Multiple examples for many years demonstrated that golfers with disabilities are playing and accommodated primarily using traditional golf cars. More than ever golf course owner and operators are reaching out to individuals with disabilities through education, staff training, inclusive programming, facility modifications and sharing the best practices including pooling.

On behalf of golf course owners and operators, I applaud your efforts to get it right relative to accessibility inclusion, for individual disabilities, and we look forward to working with you on solutions that accomplish your laudable goal in a realistic efficient and affordable way. Thank you so much for your time today.

>> JOHN WODATCH: Thank you for your participation today.

Are we going to proceed to -- we are trying to set up a videophone conference, but it looks like that isn't happening this second. So we will proceed with Dmitri Belser. Mr. Belser, please proceed.

>> DMITRI BELSER: Thank you. I thought at this time in the afternoon I'd start with the

four happiest words in the English language, I will be brief. (Chuckles)

I'm Dmitri Belser. I'm the president of the Ed Roberts campus in Berkeley, and I'm also the Executive Director for the Center for Accessible Technology. And the Center for Accessible Technology has worked in the area of website accessibility for about ten years. We provide consulting work and also work with individuals with disabilities, for access to assistive technology. Web accessibility is an incredibly important issue. Websites are the virtual front door for people these days. Most people don't go to businesses first; they are first going on the web and looking at sites. And for people who don't have access, it is a real problem.

I think there are people here and people you've been listening to all day who have described the issues of website accessibility in ways that are a lot more articulate than I am. But there are just two comments I want to make. One of them is that a mistake that people make around website accessibility, is that they think it's an issue for blind and low vision people, and as a person who is blind, I believe that. But I also want to say that there is a lot more to it than just that.

That web accessibility impacts a lot of people with other disabilities, for example people with mobility disabilities for whom multiple clicks and going through many pages may be difficult. There are a lot of things that can be done to make websites accessible for all people.

The other issue I just want to touch on, I think that a lot is often made around the cost of website accessibility and in fact, I don't believe the cost is a significant factor. Certainly in the same way that in architecture modifying an existing building is more expensive than building a new one that is fully accessible, modifying existing website can be hard to do, but with education, web developers can develop websites that are accessible and the cost would become virtually negligible.

So those are my only two comments. Thanks very much.

>> JOHN WODATCH: Thank you very much. You were true to your word.

>> DMITRI BELSER: As always.

>> JOHN WODATCH: Are we ready to proceed with the videophone call? No? Okay. Our next commenter, thank you for coming out, is Vera Hill. You may proceed.

>> VERA HILL: Thank you, good afternoon. My name is Vera Hill. I work with the City of Sacramento's police department. I am a supervisor in the communications division. I want to say first of all thank you very much for this opportunity to speak on behalf of the deaf community today regarding the issue of services. The Sacramento police department is dedicated to the service for all members of its community, and addressed the need for the direct contact with the emergency services with the device that we call the pager for the deaf.

Back in February of 2003, we were approached by a member of the community who asked us, what happens if my cousin or anyone else who is deaf is involved in a vehicle accident or some other sort of situation that requires them to need an emergency services? How does she access these services?

How many text messages must she send to friends or family in order to get a call made to the local police or fire or other emergency services for help? What other options are available for her to gain direct access?

Well, I can tell you that when I personally was involved in a vehicle accident, a bad vehicle accident, as I was the driver, drunk driver hit me, left me out with my car totally disabled, fled the scene, I as someone who is hearing pulled myself together, picked up my cell phone and called 911. Obviously I had direct access.

However, someone else finding themselves in that situation, someone who is deaf, doesn't have that access. So, what we came up with again is the pager for the deaf.

It's a direct avenue for someone who is deaf to make contact with our agency in the case of an emergency, and eliminating the need to notify any third party. Again, this is direct access, gained simply by dialing the number which can be programmed into the cell phone, to receive immediate assistance.

The dispatchers answer the pager for the deaf as they would a 911 call, and 911 calls are the highest priority, therefore, answered prior to any other lines.

Should a dispatcher be on the line with a nonemergency call and a 911 rings, the nonemergency caller is immediately advised that the, the nonemergency caller is advised the 911 call must be answered and that nonemergency caller is placed on hold.

Should the pager for the deaf sound off, while a dispatcher is on a nonemergency call, that nonemergency caller is told the same thing, and the pager for the deaf is answered.

It's treated as any other emergency caller would. The conversation between the caller and the dispatcher, it continues until the emergency services arrive, or there is otherwise no further need to remain connected.

Should the other sources need to be contacted, to render assistance, such as tow truck, the fire department, some other entity, the dispatcher does so via land line while conversing with the caller on the pager.

The caller on the pager is advised of what services are being given to them. Also, if the caller happens to be at an agency or area that is outside of the direct scope of responsibility for our department, we are not going to tell them, “No.” We immediately let them know that we are contacting that agency, tell the agency what’s going on, that we have someone who is deaf using our pager, and tell them exactly where they are. We again stay on the line with that person, stay on that pager until they get help.

Sacramento police department's motto of working in partnership with the community, protecting life and property, solving neighborhood crimes and enhancing the quality of life in our city is taken very seriously. This low cost method of holding responsibility to our community, specifically deaf members of our communities, is an invaluable tool which serves to potentially save lives. Until the next generation 911 provides the ability for those who are deaf to gain immediate direct access to emergency services, this pager system is an essential element which allows us to provide the highest level of service to the deaf community, in the interim.

Again, I would like to truly thank you for the opportunity to provide you with an example of an existing service designated specifically for the direct access of those that are deaf and need emergency services.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony and your efforts to provide direct access for people who are deaf or hard-of-hearing in your community. Thank you.

Next we are going to hear from Richard Thesing.

>> RICHARD THESING: Is it possible to give these to the panel?

>> JOHN WODATCH: Sure. Thank you very much. Go ahead.

>> RICHARD THESING: My name is Rich Thesing and I represent mobility golf, which is a nonprofit corporation with a mission to increase golfing opportunities for those who can't walk. Due to the limited time, I would like to focus on the objections of the golf industry, safety, lack of demand and cost.

As a disabled golfer, I'm very concerned about safety. Last year mobility golf became accredited by ANSI and started the process of developing safety standards for accessible golf cars. We should complete the process by the end of the year. We have on our committee internationally recognized experts on golf car safety, and mobility device safety standards. Our committee also includes two golf industry representatives who appeared before you at earlier hearings and expressed their concerns about the lack of safety standards.

Lack of demand: First let me say that so-called lack of demand is not a defense to compliance with the ADA. For example, a restaurant can't refuse to put in a handicap bathroom, just because it hasn't yet had a customer in a wheelchair. That said, the lack of demand is due to three factors.

First, very few people know that accessible golf cars exist. The golf car industry has done no marketing.

Second, very few courses have the cars. Only about 5 percent of the courses. There are several states where not a single course has one. Would you learn to play golf if you could only play at 5 percent of the golf courses? Third, of the few courses that have the cars, very few let the public know. It is very rare that their website states that they have an accessible car. That goes for the courses that supposedly are part of this pooling arrangement. There is nothing on their website that would tell you, you could get a car on some kind of notice.

The bottom line is that there is not going to be a lot of participation until the courses get the cars, and let the public know they are available. Excuse me.

Cost: The costs of an accessible golf car ranges from $6,000 to $10,000. The average operating profit for a golf course is about $180,000. In this context, the cost burden is very reasonable. However, there is a way to totally eliminate the cost burden and make a profit. First, there is a small business tax credit. Most golf courses have fewer than 35 full-time employees. Suddenly a $10,000 car costs $5,000.

You can see from the pictures I gave you that an accessible golf car is quite similar to a regular golf car. It is universally designed so that you can use it, and I can use it. Every day, at every golf course, regular golf cars are rented to just one person when a threesome or one of a foursome wishes to walk. There is no reason why the single-rider car could not be rented rather than the regular two-person golf car. This has two economic advantages. The car will get revenue every day, and one two-person car can be deleted from the golf car fleet. Now we have the cost of a 10,000 reduced to zero, $5,000 tax credit and $5,000 reduction in the cost of the regular golf car fleet.

If the car were rented for 150 days at $15, there would be revenue of $2,250 per year. So now instead of a $10,000 expense there is no expense, and revenue of $2,250.

I'll say a few words about pooling. Every day at almost every golf course, many golfers show up without reservations and are able to play. I personally play 50 times a year. My normal practice is to call in the morning I want to play, and get a tee time later in the day.

Pooling would require me to know in advance when I want to play, which often involves predicting the weather. Requiring disabled golfers to provide advance notice is discriminatory. I'll be commenting further on this in my written comments.

In June of 2008, DOJ in deciding not to issue a regulation on accessible golf cars, stated that regulations weren't necessary because existing regulations were sufficient. The reaction of the golf industry was to continue to refuse to provide accessible golf cars. If DOJ again decides not to issue regulation, disabled golfers will be forced to bring lawsuits all across the country. This will be a tremendous waste of money, time and effort.

In conclusion, as I discussed earlier, we are about to solve the safety standards issue and I have shown how mandating accessible golf cars can make money for golf courses rather than cost money.

According to the U.S. census, there are 12 million Americans who use a mobility device. We have the right under the ADA to play golf. Please help us to attain that right. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate you taking the time and bringing this information. We will add the information you provided to us to the record.

Our next commenter will be Patrick Finlen. Mr. Finlen, please proceed.

>> PATRICK FINLEN: Thank you for the opportunity to provide comments on behalf of the Golf Course Superintendent's Association of the America, also known as GCSA. My name is Pat Finlen and I'm a certified golf course superintendent and a member of the GCSA Board of Directors.

GCSA is the professional association for the men and women who manage and maintain golf courses in the United States. As golf course management professionals, we work to make golf accessible to all by promoting policies and practices that consider the needs and safety of all golfers; promote the growth and vitality of the game and maintain the agronomic integrity of the golf course.

Regarding question 14, there is no one size fits all approach to accommodating mobility disabilities. Effectively addressing the needs of the golfers with disabilities requires a multi-faceted approach comprised of education for both golf course operators and golfers with disabilities. Facility programs and policies must be modified and golf course staff must be effectively trained on ADA requirements and customer service best practices.

Golf cars are readily available that are adaptable for the addition of hand controls and swivel seats. Kits to retrofit a standard golf car are available through adaptable equipment suppliers and some golf course product suppliers. Adapting standard golf cars is a feasible cost effective option. The cost to retrofit standard golf cars with hand controls is variable and ranges from 500 to $1,000.

The number of golfers unable to play by walking who require a specific single-rider golf car is low. Research and survey data shows most golfers with mobility disabilities can play if the facility provides a traditional golf car with access to tees and greens.

Standard golf cars in use today were originally intended to help people with disabilities navigate the golf course without walking. In essence, today's golf cars are readily accessible to all but a small number of individuals.

These golf cars are widely available and comply with existing standards as established by ANSI and national golf cart manufacturers association. Currently there are no safety standards for single-rider accessible golf cars. We agree with disability advocates and others in the golf community that safety is an issue, that must be addressed with the same level of ANSI standards and regulations that exist for traditional golf cars. Standards and safety testing for all single-rider golf cars must be in place before any recommendation or determination is made regarding their future use.

Regarding question 15, the U.S. Department of Defense mandates providing two to three single-rider golf cars at each of the 150 military golf facilities. Survey data gathered from these courses show that there is very little demand for this type of equipment. Only 16 of the facilities reported their cars being used more than ten times per year. Most of the 150 facilities have received zero requests for the use of these golf cars.

More than 80 percent of these facilities proactively promoted and marketed the availability of the accessible golf cars to their customer base, based on this data and similar data gathered from other golf operations around the country, some of which you have heard today, single-rider golf cars are not utilized by most golfers with disabilities. For those golfers who do require a single-rider golf car, the facility can make one available without having to own the car.

The pooling of single-rider golf cars in areas of the country has been an industry-led proactive model that successfully accommodates individuals with disabilities. Golf courses should not be required to purchase and own single-rider golf cars because pooling and sharing of such cars is an accommodation that is working and working well. Through cooperation among golf facilities, any demand for single-rider golf cars can and is being met.

Regarding questions 23 and 24, almost all golf courses in the U.S. are considered small business entities. Mandating that every golf course purchase one or more single-rider golf cars when there is little or no demand for such equipment, would impose a significant economic burden on these small businesses. The price of these golf cars ranges from 8,000 to well over 20,000 depending upon technology and design. This is a significant expense given the demand for such equipment.

GCSA is dedicated to achieving the mission of increasing participation of people with disabilities in the game of golf, and supports wholeheartedly that through the game of golf individuals with disabilities can become actively engaged in the social fabric of the community as well as derive health benefits that improve quality of life.

Everyone within a community benefits from inclusion and quality of life improves for all citizens when all activities are inclusive.

>> JOHN WODATCH: We appreciate your participation with us today. Thanks.

Next we are going to hear from Susan Mizner. Welcome.

>> SUSAN MIZNER: Thank you. Good afternoon. My name is Suzan Mizner, and I'm the director of the mayor's office on disability here in San Francisco. I want to thank you both for holding these hearings here in the bay area, the birthplace of the disability rights movement, as so many people have already thanked you, but also for holding the hearings in such an organized and accessible manner. You have set a very good standard and provide a good example for us.

I'm going to comment briefly on all four NPRMs, the advantage of being late in the day is that I will just try to fill in a couple of gaps and reemphasize some of what you have heard.

But my main message is that the mayor's office on disability supports moving forward with all four of these proposed rules, and we are very confident that they can be implemented and implemented quickly, largely because with the exception of next-generation 911, San Francisco is already implementing these requirements.

Taking them one by one, websites, our city, website while it is based on the Section 508 guidelines and WCAG version 1.0, is very eager to move forward with WCAG 2.0. We believe that is a clear standard that is well-known and flexible with technology as it evolves.

And I would respectfully but strongly disagree with my colleague Dr. Luciana Profaca who testified earlier today that we should grandfather in old websites, and not require them to be updated. I think she is confusing architectural access standards with communication access standards. And our websites are such an important living and dynamic entity, that is becoming so increasingly important in terms of the form of communication, that we can't grandfather in any websites.

We have one request from the IT department at, in San Francisco, which is that DOJ consider implementing WCAG 2.0 level A, and their interest is that in very widely-based web platforms, where we have one web platform but hundreds of people within the city that post to that web platform, they are concerned about being able to ensure compliance with double A or triple A. Nonetheless, as was testified earlier, we do a very good job of making sure that there is real-time captioning on media that is on the web, and we think that is a very important piece to include.

Moving on to movie captioning and video description, this isn't really a Title II issue, but, again, we have something that we have already, that is parallel that we have done in San Francisco which is require that in all public televisions that broadcast, in the bar upstairs, in the gym, in restaurants, that the captioning be on. This was required by our board of supervisors and we have had no complaints.

We really support the testimony that has come earlier in the day, in wondering what the concern is about just requiring opening captioning, for essentially all movie theaters. We do need to give a break to very small movie theaters that have old technology.

But, essentially all movie theaters all the time, that's what we need. I would echo Beth's support of audio description, Ken Stein in our office organizes a showing of super fest films at the ADA anniversary every year. And we have audio description and captioning for all of those. It's a very popular event.

Accessible equipment and furniture, again, we were able to install accessible scales and accessible exam tables, in all of our community clinics with essentially little expense, and we absolutely need your help with accessible kiosks. It's true we have had accessible ATMs but the airport, John Martin, the head of our airport has been fighting with the airline industry for years to make them make their websites, their kiosks accessible.

We need your help there. Next-generation 911, that is the one thing we don't have. My short answer to all of your NG 911 questions about whether to include instant messaging, e-mail, SMS, real-time texting, video relay service is, all of the above.

We have heard from the deaf and hard-of-hearing community who don't use text well, and that video relay is very important.

So I will just close by saying that while we do feel we are in the most accessible city in the country, we recognize there are more, there is much more work to be done. If you have any problems while you are here, please call our office, 415-554-6789. Thank you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony. Thank you.

And our next commenter will be by the phone and we'll be hearing from Soula Pulver.

>> SOULA PULVER: Hello? Am I on?

>> JOHN WODATCH: Hello, please proceed.

>> SOULA PULVER: Hi, this is accessible, under accessible equipment. The new so-called smart meters, are equipment that is not designed for people who have the disability called electro-sensitivity, nor for people who have implanted medical devices who must avoid Wi-Fi and RF emissions.

Utility meters are ubiquitous and unavoidable. Traditional utility metering equipment exists that can provide safe electrical and gas service. It should be required to be kept as an accommodation, and not changed for the new smart meters. Also, in all public buildings, traditional analog meters should not be replaced by wireless smart meters, which give off radiation that creates a barrier that people with electro-sensitivity cannot cross.

Now, about electro-sensitivity, also known as radio frequency sickness, which is caused by exposure to transmitted radio frequency radiation and electrical pollution, as a disability. Since this massive deployment of smart meters began in California this year, I have personally made the acquaintance of three people who were not at all electro-sensitive before their house had a smart meter put on it. And I have heard about many more cases just like this, people who never imagined such a thing could happen to them.

I urge you to recognize and address electro-sensitivity in the ADA. It is urgent and crucial that this emerging problem that is causing so much suffering be recognized. People are becoming electro-sensitive, because of smart meters, and there are also many people who already have this sadly unrecognized and therefore scorned and shaming condition, pre-existing, who have had it exacerbated by smart meters or who are trying to flee from the oncoming tsunami of smart meter installation. They are selling their homes and uprooting their lives.

I have met and talked with dozens of people in this situation in the past few months now. This is a real thing. It's a true physical disability. People's lives are being ruined. If they can get away from wireless radiation, electro-sensitive people are fine. But it is becoming impossible. The worst their electro-sensitivity becomes, some become unable to use a computer, and unable to communicate using modern technology.

Finding housing is a nightmare. People are becoming homeless. You can see video testimonials by Googling wounded by wireless, that's wounded by wireless. I know that you have already heard from at least one doctor who testified during the December hearing about electro-sensitivity as a true physical disability. There is science behind this, in spite of near nonexistent funding for independent studies. There are thousands of studies that show bio effects.

You can go to a website called prove-it dot CO. That's prove-it.co, not dot-com, to see a collection of studies. And please look up Sweden and the accommodations that Sweden makes for electro-sensitive individuals. That is an example to work towards. Again, finally, I urge you to add and recognize electro-sensitivity to the ADA, in the ADA.

It is urgent and crucial that this worsening problem that is causing so much suffering be recognized. That's the end of my testimony.

>> JOHN WODATCH: Thank you very much. We thank you for taking the time to be with us today.

>> SOULA PULVER: Thank you.

>> JOHN WODATCH: Next, we will hear from Luis Arteaga. Please proceed.

>> LUIS ARTEAGA: Thank you and good afternoon. My name is Luis Arteaga, and I'm director of emerging markets for the California emerging technology fund. The mission of the California emerging technology fund is to close the digital divide here in California

by celebrating the deployment and adoption of broadband to unserved and underserved communities here in the state.

We are going to be speaking about web accessibility today, lending our expertise on that issue. As you already mentioned our mission is to close the digital divide. First we had to address the issue of access. Fundamentally, we knew that we had to address the issue of lack of access for people with disabilities. When we first started to monitor polling and data looking at people with disabilities and access to broadband, what we found is that only 36 percent of disabled households had the technology at home. You have heard from many people today talk about, tremendous amount of benefits broadband provides and it's no surprise to anybody in this room that without it, life is fundamentally harder and different for you without that access.

We made people with disabilities a priority community for our investments. We are a $60 million fund. If we were going to close digital divide, it had to happen among people with disabilities, low income urban poor, as well as rural communities of the state.

We are fortunate to now two years later, the data shows that 55 percent of the people with disabilities now have broadband access at home. Overall, it's 70 percent in the state. Clearly there has been some progress. But lots of room for improvement, if we are going to close that divide.

The other area that was important for us if we were to do this, was to address the issue of web accessibility and content. Not just for people with disabilities serving organizations but really all the different digital inclusion, computer centers, grantees that we were going to fund to ensure they would also elevate their importance of web accessibility and accessibility in general.

As a condition of our grant, of our grant funding, we require the completion of what is called an accessibility plan, and the plan covers what changes need to be made in the organization's program content, their website, their facilities, their outreach and communications, their technology, and their etiquette.

The plan then has the organizations determine the person responsible which is really important for any type of accessibility work, who is the point person going to be. But also, what the cost of those changes were so we didn't provide an unfunded mandate. We wanted them to lay out their plan to get a good glimpse of what it's going to take to be fully accessible, and then slowly and surely we will provide the funds to address some of those key changes that were necessary.

In order to provide the training, we reached out to the experts. So we have as some of our grantees, for example, the World Institute on Disability, and the Center for Accessible Technology, you heard Dmitri Belser speak earlier, as the consultants that will help these nonprofits community-based organizations improve their accessibility.

As I mentioned, it is a condition of the grants so if they do not complete the plan, there will be no funding. So far, 98 percent of our grantees have submitted their plans, as you can see, it's very effective. I don't know who the 2 percent are that still haven't. But clearly, if it becomes a priority, you can act accordingly and change will happen.

We are also proud to say that accessibility continues to be a priority with our two NTA grants that were given for us to expand the broadband awareness and adoption efforts that exist in the state.

We knew and the grantees now know that they need to increase their services to people with disabilities and they found they improve their services across the board not just for anybody, but the more you are conscious about the perception with the new audience, the greater, the quality of the services are going to be. That is what they found. In addition CTF as well as the Center for Accessible Technology sponsors the California digital inclusion awards.

What these are, are awards that are given to organizations that voluntarily work with center for accessible technology to improve their websites. We have seen, this is the third year of the awards, phenomenal changes in websites that are, that serve the public. So public agencies, nonprofit agencies, private sector industries, like Intel and Gap have provided -- participate in this voluntary program.

The Stanford Accessible Technology will be hosting the third annual awards on January 26, and this really is a tremendous showcase for web accessibility and really get to see how voluntarily industry nonprofits, government have made this change happen.

To sum up, web accessibility in order for it to continue to thrive and prosper, it has to be made a priority for the organizations. I mentioned having a point person makes the big difference.

Two is working with experts. There is lots of software, things that will test websites and things like that. And working with the center for accessible technology, we found they are good but not great. Working with the experts can really help you improve those website accessibilities, but also give you a roadmap of things you may not have the money to do.

Third is provide support.

Four is monitor progress, making sure there is progress being made along the way.

Finally to move this forward, to acknowledge excellence in this effort. To really see the before and after of web accessibility, it makes a big difference. Thank you.

>> JOHN WODATCH: Thank you for sharing what you have been working on in the community.

Next we are going to hear from Steve Sarrens. Mr. Sarrens.

>> STEVE SARRENS: Thank you so much. I wanted to say that the panel looks pretty alert, which is pretty phenomenal seeing that it's, what time, 4:05 or whatever it is. Love seeing the smiles up there. It's a pleasure to be here. My first name is Steve. Last name Sarrens. I'm from New Step out of Ann Arbor, Michigan. I had the opportunity to fly out here today. I'm here to speak to furniture and equipment, specifically exercise equipment, inclusional fitness for fitness centers.

Earlier today, we heard from Kristina Ripatti-Pierce, the LAPD police officer who is paralyzed from the chest down. She has been a spokesperson of New Step for the past four years. For those that saw her today, you saw a very determined young woman, but there is more to the story that I'm very familiar with.

Kristina Ripatti was an athlete before she was injured and she still is an athlete. In my dealings with her, and I've been to her home and seen her exercising on our product, the New Step. After 45 minutes of exercise, she was with a young man who watches her during the day, and I was inspired to do something. I mean, to watch her exercise for 45 minutes just using her arms, with her arms helping move her leg is truly inspiring.

Kristina is one of many extraordinary individuals, in a day; for her to get here that morning, it took her probably two hours to prepare to be here for the presentation so when you look at people like this, they are beyond the norm.

As someone who is able-bodied, I just couldn't handle watching her exercise for 45 minutes, doing nothing. So I, asked the 10-year-old in the room, would you like to have a push-up contest? So we did. And the young man did, I think 20 push-ups, which is remarkable for a 10-year-old. I went up and did 42. Not bad for a 50-year-old. I'm 55 now. I think Kristina got off the New step and said I want to take part in this. She got off the wheelchair, she moved her body with her arms to a core ball. She balanced her pelvic area on the ball. I grabbed one leg. Austin took the other. She went ahead, pulled her arms out and did 52 push-ups.

There isn't equipment available in the clubs for people like Kristina. The integration of people like her going into the mainstream is only going to inspire able body people to do better. We are all here on the earth for a very short time. We are all going to get older. We are going to age, and we will eventually pass away.

But the key thing while we are here, we want to be the best that we can. There is recent research out, and one of the big fears is with cognition, and losing cognition. There is a quote, I read this actually just this morning, and one of the key elements to help cognition and even to help ward off Alzheimer's is something as simple as exercise.

It's the one pill that all the side effects are positive. It says here, physical exercise is one of the great candidates for helping cognition, simple aerobic exercise such as walking 45 minutes a day three times a week improves episodic memory and executive control functions by about 20 percent.

This sounds so easy, 45 minutes of walking. Think of the people that are not able to walk. In the industry, we need to provide, which we are, is equipment that enables people to walk in a seated position, and to provide the benefits.

For the panel sitting up watching the presentations all day, I bet an exercise break would help your reasoning and condition right now, you are experiencing what it's like to be in a chair all day long.

Movement is critical.

The way the state of the industry right now, we have been selling our products to physical therapy market, and the way it is now, the PT stays are very short. And so when people leave the rehab setting, they are sent home or maybe they go to a nursing home. Otherwise, people either go home or they have to find somewhere to do their rehabilitation. The rehab is not done.

The majority of people go home right now, and they don't do anything. All the gains they made in the PT settings disappear.

We are proposing an initiative to make a requirement that there is equipment that is inclusional, and that means able-bodied or people with physical impairments can utilize the product. In that case, when people go to the clubs, as they work out, they can increase their physical functioning, rather than decrease.

I can go on and on this. Another specification was on obesity. And I would consider that another disability. Of all the disabilities, even people in a wheelchair look down on people with obesity. It is important to have equipment that is -- has a weight capacity of 600 pounds, and is easy on the joints. I could go on and on. I know the red light went on. But I appreciate the opportunity. I hope there is more times to discuss this. But I think this will make a -- it will help make our country strong in the future if we provide inclusional fitness equipment. Thank you very much.

>> JOHN WODATCH: Thank you. We appreciate you coming to San Francisco today to share your testimony.

Next we are going to hear from Jessie Lorenz.

>> JESSIE LORENZ: My name is Jessie Lorenz. I'm the associate Executive Director at the Independent Living Resource Center, San Francisco.

You have an opportunity today to help bridge the digital divide. Today I'm going to talk a little bit about access to technology, including technology which exists in the built environment, and access to exercise equipment.

Let me start off by telling you that I'm having a baby. And I'm telling you that because one of the things that's come up as I've received care from my Title III healthcare provider is an on-line messaging system, in which my doctor and I can communicate with one another. I can type messages to her. But when she types messages back to me, it comes back not in text that is readable by my screen reader, but in a text that is actually an image. I don't think my Title III healthcare provider wants me to repost what she says on my blog or something like that.

Nonetheless, what that means is that all of my private personal conversations that I'm having with my healthcare provider have to be read to me by someone else who can see.

I don't know if any of you have ever been pregnant before, there is a lot of funny things that happen to one's body. It's unconscionable and also a little embarrassing that I can't get that information independently, and by myself.

I also want to talk to you a little bit about destination dispatch elevators. I know that my friend Walter Park was up here speaking about this earlier today. I know that Mr. Park and myself have submitted information and comments on this issue to your office. Destination dispatch elevators are the next generation of elevator technology. Right now we are seeing them in San Francisco, New York, a couple in Washington, D.C. and in Toronto. But it won't be long until these are rolled out around the country.

We have worked with the industry to develop standards that allow people with all types of disabilities, including those experiencing vision loss, to use destination dispatch elevators and I urge you to study this issue because the train has left the station, and the regulations need to catch up a bit.

I encourage the Department to move away from 508 standards, as 508 compliance standards really have not kept pace with the dynamic, ever-changing world of technology. The standards that I would recommend you endorse should you be looking to create something that is standards-based, are the web content and accessibility guidelines level 2.

Technology access is crucial to full participation in society. Some companies have done a really good job doing what most people thought, what people used to think was impossible. I'm holding in my hand an iPhone with a flat touch screen panel on it.

When this iPhone was released on June 19, 2009, I was able to leave the Apple store completely able to use the features on this phone. I'm completely blind. Apple decided to go that extra mile and make their technology accessible to individuals experiencing vision loss. Other companies I believe because the regulations do not require it, in a stringent enough manner, other companies such as Google have kept people with disabilities particularly those with vision loss out of the marketplace. The Android platform and Chrome browser are not accessible. I'm hoping that as part of these hearings and these discussions, you can help remedy some of the digital divide that the people are experiencing right now.

Technology access is crucial for folks at all levels of our society. But as is access to gyms and fitness equipment, people with disabilities deserve to be able to access treadmills and machines within the gym. That includes products that have audio output for treadmills and it also includes taking into consideration path of travel requirements inside fitness facilities for those who use mobility devices.

You have an opportunity here, you have an opportunity to send a message to people with disabilities that says you belong. You belong in all aspects of society and the only thing that should stand in between you and the height of your achievement is your ability to work hard and your willingness to dream big. Thank you very much.

>> JOHN WODATCH: Thank you very much. We are delighted to have you come and testify and we wish you much joy and happiness when the baby arrives.

>> JESSIE LORENZ: Thank you.

>> JOHN WODATCH: Is our next commenter going to be via videophone? We are going to hear from Patricia Brantz.

>> PATRICIA BRANTZ: (through interpreter) Hi. You want me to give my name? I am Patricia Brantz and I reside here in San Diego. Should I go ahead with my comments?

>> JOHN WODATCH: Please do.

>> PATRICIA BRANTZ: Yes, my comments regard movie captioning. There is several different techniques that are used to achieve this. There is what we call black box captioning, basically subtitles that is used for most foreign films. There is also open-captioning, OC, which is the whole audience will be able to see the, it will be integrated with the rest of the audience. You have RWC, rear window captioning, where you have a device where you can see behind you and see the captions there.

I think closed captioning and black box captioning you need to look up and down, but it's acceptable.

Later, with open captioning, similarly, it had to be, with the open captioning, you had the black box, that was the old technique. Now they have changed to the integrated captioning, which is very nice but the down side of that is that it's, the background, it might make it difficult to see the actual words across the screen. It is not as clear because of the background. If they are in yellow, for example, you can't see. If it's dark, you see it fine but if the back ground is light, it's frustrating, we can't read the captions as easily.

Now, my first choice is open captioning, where the whole audience sees the captions. Or rear-window captioning. The first time I saw that, I went, I felt after a while a little funny about it.

You had good, you have to have good guest services. Before they had better services about the equipment and helping get it set up and getting it positioned accurately. But now, I find that a lot of people are taking aback, taken aback by it. It is hard to find the right positioning for it.

You have to find the correct seat in the house. You have to come early, if you don't come early, it doesn't work out. It's inconvenient. With rear-window captioning you sometimes have to let them know, you don't have a choice of the week or, you do have a choice of the time you can come, but with open captioning you don't. It is very limited in terms of your time opportunities.

You might only have it out of four or five days one evening or something at a specific show, or specific time of day. Early morning or late at night sometimes. It is not convenient for us.

Open captioning is my first choice. It's just the issue is the scheduling with that and the limited time availability.

That is basically it. I think that covers my comments.

>> JOHN WODATCH: Thank you very much. We appreciate your taking the time to testify today and give us your views. Next we are going do hear from Karma Quick. Please proceed.

>> KARMA QUICK: Good afternoon, ladies and gentlemen of the panel. It's a pleasure to be here today. My name is Karma Quick. I am currently affiliated with the National Association of the Deaf Civil Rights Committee; I'm also proud to be the president of the Board of Directors for the Independent Living Resource Center for San Francisco. I'm also an alumna and a mentor to those serving on the National Association of Law Students with Disabilities. With that said, I fully 100 percent support the position of the National Association of the Deaf on the movie captioning. I fully agree that 100 percent of the movies being shown in theaters should be captioned, and I fully support mostly rear window and also support some of the movies be shown open captioned as well.

In fact, with regards to that, a friend told me last night that in San Francisco, I can find two theaters in this city that are captioned and that is progressive. My thoughts, that's progressive in a small town in Iowa. Progressive in San Francisco would be 100 percent of those theaters being captioned.

Moving on, I'd like to discuss some accommodations and medical facilities for people who are deaf and hard-of-hearing. There must be absolutely any kind of captioning, video relay services, voice over Internet phone services and remote relay and interpreting services available for people who are deaf and hard-of-hearing, in emergency rooms and doctors' offices and in outpatient services.

It is incredibly important that we have these resources and accommodations available to us, because one word being left out of a sentence changes the entire meaning of what is being said. And that is absolutely critical when diagnosing a patient, when a patient is giving the doctor his or her symptoms, or when there is an emergency situation, and action must be taken immediately.

Without these accommodations, there is such a high risk of a misdiagnosis and mistreatment or even death, and I can tell you that the Department of Justice, your office, in the time span of fewer than three years, settled over 30 cases with medical facilities regarding the misdiagnosis, mistreatment and deaths of individuals who are deaf and hard-of-hearing because they were not granted their accommodations as requested in these situations.

I'd like to also discuss court accessibility. It is a fundamental right to access courts for all individuals in the United States. This is a right that is given to us by our constitution. Under Title II of the Americans with Disabilities Act, we have an absolute right to effective communication. Of course, as you all are aware, under Title II of the ADA, an ADA coordinator is required for all state and local entities.

I understand that these regulations require some sort of regard, some sort of equipment or functional purpose or what have you. But in terms of a state entity, before these equipments and furnitures can be given, you have to have an ADA coordinator at times who knows about these equipments and about these pieces of furniture and how they work with people with disabilities who are requesting them.

That means that these ADA coordinators also need to be trained. I can tell you from personal experience in the court system, as a law school graduate and someone who has been frequent, in frequent court proceedings and situations, I have had much difficulty getting my accommodations in courts, because of my communications with an ADA coordinator who is untrained.

Also in light of ADA Title II, the words "effective communication" mean a great deal. And effective communication is different in a doctor's office, when you are getting the flu shot, compared to when you are in the emergency room. I would strongly encourage this panel to look into finding some stronger wording or redefinition of effective communication, in these regulations that differentiate the particular conditions in which effective communication is used, because an entity cannot extrapolate the same meaning in a flu shot as they can in a cancer operation.

With that I would also like to finish my testimony by saying the deaf and hard-of-hearing communities wants TV monitors in gyms, banks, bars and restaurants to have captioning on those TVs. In San Francisco we are incredibly fortunate to have a city ordinance that already requires this. However I believe we are incredibly unique in that situation.

If I can simply add that captioning on YouTube, Hulu, and on certain network TV websites such as NBC and ABC, we also have difficulty accessing those TV shows as well. Thank you very much for the time and opportunity to present this to you.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony today.

Next we are going to hear from Constance Barker. Ms. Barker, please proceed.

>> CONSTANCE BARKER: Thank you. My name is Constance Barker. I'm president of the Environmental Health Network of California. We are a 22-year-old nonprofit-based in Marin county just north of here and we provide support advocacy and information to the chemically and electrically injured.

I believe that earlier in the day, you have heard from a few of my colleagues, including Susan Molloy, most probably, and Sandra Ross, PhD, and Cindy Sage, all of whom have spoken both generally and specifically about the need not to neglect and to for once include the parameter of indoor environmental quality in any and all access considerations. I don't want to rehash what they have said. And you will be receiving from us some very extensive and specific comments shortly.

Instead, what I'd like to do is provide you with a couple of very specific examples of the kind of impact that this sort of thing has. In addition to being a person who is chemically injured, although blessed now, quite recovered due to a little miracle call the ecology house which I would love to tell you about sometime, I'm also at this point in my life a full-time home care provider to my ill spouse who is decidedly not recovered from these illnesses and has been getting worse. In the last three months we have had three hospitalizations, two in life threatening situations.

One of the things that I believe has been mentioned to you is the guidelines on page 44, where it discusses normal maintenance, reroofing, painting or wallpapering, not being considered to be changes unless they affect usability of a building or facility.

Well, I can tell you that when my partner was in the critical care unit at Marin General Hospital recently, suffering from a double pneumonia and sepsis, and very much in danger of not surviving, one of the things that happened while we were there is that normal routine maintenance was performed on the building, and they began painting right outside of her window.

At the time that that began, she had pulled fairly far out of the bottom of this hospitalization, she was off of the breathing machine, she was breathing on her own again, with some oxygen. But when that painting resumed, she started to go back downhill.

I'm on the county health commission. I pulled every string I could. I called everybody I knew who I thought might be able to shake some tree and get something to happen. We did eventually get an air cleaner in the room and they did give me permission to use some painter's tape and to tape up the little cracks in the windows, the little places where tiny bits of air get in. And that did make some difference.

But she still, she plateaued at that point and never did quite get as better again as she had been at the point where the painting had begun. After a couple weeks, they released us home assuming she would not get much better and that this was just permanent. Well, slowly at home she went back downhill. A couple weeks later, we found ourselves back in the hospital.

This time, we were put on the other side of the same ward where there was not any painting going on. After four days on antibiotics in that ward her lungs cleared completely, and she came back home.

Now, I cannot strictly quote-unquote, prove this. But it seems to me that we had a whole second hospitalization here that would not have occurred, that was unnecessary, except for the fact that she was unnecessarily exposed to these paint fumes. These are the kind of things that we are talking about.

It is not just our civil rights here, not that our civil rights are not important. They most certainly are. But by the time you are disabled by something like this, you are living on government assistance on every level, including for your healthcare. She is a medi medi person. That's tens of thousands of dollars that the taxpayers paid for a second hospitalization that could have been avoided. It's just not good.

The second thing I will tell you about is the medical equipment involved. She had to be on breathing machines, biPAP machines, things like that, every single one of those machine has tons of plastic on it, all the air has to go through the plastic. She had to be fed through a tube that is plastic. There is very few requirements about out gassing. You don't look at the VOCs that are coming off those kinds of things. That is just a couple of small examples that I can give you, I can give you more but they are on my mind because they are what I've lived through personally in the last couple months. And anyone who deals with the critically ill person with chemical sensitivity would have similar stories for you where we would impact the healthcare system.

The broad recommendation is to look at the work that the access board did on indoor environmental quality, the Nibs website that I'm sure you have heard about. It was extensive, well vetted by our community and absolutely worth your consideration and attention on every level. Thank you.

>> JOHN WODATCH: Thank you very much. Thank you for being here today.

Next we are going to hear from Sister Ann Rooney. Sister Rooney?

>> SISTER ANN ROONEY: I want to thank you all for your patience, listening to all of us. We all want to be heard, especially the difficulties we have been experiencing in daily life. My name is Sister Ann Rooney, I'm a proud member of Hearing Loss

Association of America, formerly known as Self-Help for Hard-of-Hearing.

Hearing Loss Association had been assisting for over 30 years; I'm the president of the California state Board of Trustees. I want to give you a quote that I think is really important that will help people understand a little better what hearing loss is. And that is, captions for the hearing loss person is functional equivalent as a ramp is for a wheelchair user. We all know what a ramp is; we all know what a wheelchair is. But we don't know what the hearing loss people go through.

We can be in an audience, we are there, we don't understand the words. I can't tell you how thrilled I was to see so many captions around here. It's thrilling to be able to see the words as well as to then understand of the words. Many times we hear the word but don't understand the word.

But Hearing Loss Association of America organization assists about 30 years, we've (inaudible) 30 years; it's mostly an organization of advocacy and education not only for the hearing loss person, but for hearing people. And that's really important.

Also, another thing we are trying to do is audio looping, different rooms, so that the person can understand the words better.

The board does far more than what the following I'm going to say. We do health fair, support chapters, we have 26 chapters in California, we recently started the walk for hearing event. And all these things are, we are trying to educate people, we are trying to let people know that there are many, there are 36 to 38 million hard-of-hearing people. We want people to know that there is more than hearing aids for them. We are working with teachers in classrooms, we would love to have plays on. And helping -- trying to help the Viet Nam, the veteran people when they come back. One of the things they do, because of all the loud noise, they have lost their hearing. And once you lose your hearing, you cannot recapture it.

I would love to see if DOJ can do something about these iPods. The volume is so high, these young people are going to lose their, what happens is they lose their hearing gradually. Once they realize they lose their hearing, it doesn't come back. If there is some way we can limit the volume of some of these iPods and whatever other equipment people use.

Carrie mentioned a lot before me. We would certainly like to have captioning in movies. As some people have mentioned before, we wait until they come out in video. We would like to be among people that go to the theater and able to see the movies as other people do. By the time they come out, people have stopped talking about them and they talk about something new. We are always behind. We like to be with the mainstream of people.

I certainly hope that we go through the full 100 percent, not 50 percent, not five years from now, but today, as soon as we can, because we have -- how do I say it -- we are not forceful enough and I hope this department can help us to achieve what we need in order to maintain mainstream.

I also would like to see, okay -- let's see. I want to state this for a fact, there are more people hard-of-hearing under 60 years of age than over. There is a misunderstanding that most hearing loss people are over 60. There are more under 60. I really would like to emphasize this, that what we are doing with the cochlear implants and hearing aids is amazing to see these little ones talk.

I saw a little girl who had a cochlear implant, and she was around two or three, and I asked her mother how she is doing. Her mother says, she hasn't stopped talking. For someone who never heard a sound and now she's talking. Technology has done great, but we need more and we need more effective technology.

I really want to thank you all for being here and patiently listening to us.

>> JOHN WODATCH: Thank you very much. We appreciate your testimony today.

Next we are going to hear from Mary Lawrence. Ms. Lawrence, please proceed.

>> MARY LAWRENCE: Yes, I am a resident of a low income senior house in Oakland. What I have to say is very brief, but I think it's very important. I heard about this meeting for the first time last Friday afternoon. So I did not have much time to prepare. And it states that you wish to know what furniture and equipment would be helpful to those of us with disabilities. All the things I heard about would are wonderful things and we would be happy to have them but they are not going to fit into a place which isn't big enough, as my studio apartment. It is 14 by 14 including kitchen, bathroom and everything.

Please pass the word to builders and anyone you know who is interested, that we need all one-bedroom apartments in both HUD and private apartment buildings, no studios. Then we will certainly accept your offer of equipment suited to modern life. Thank you.

>> JOHN WODATCH: Thank you and we appreciate you taking the time to come and give us your testimony. I can tell you we have been through three hearings. That is the first time we have heard that. So welcome.

Next we will hear from Maya Cain.

>> MAYA CAIN: My name is Maya Kane. I've lived in San Francisco for 47 years and 31 of them in the same apartment. I'm a graphic designer and cultural exchange director. I'd like to list some of the health problems that are caused and exacerbated by smart meters.

For 30 years I had my tiny office, apartment office in one place, and it's across the street from a MRI hospital. It is 30 feet from the N Judith electric train going by outside that went outside the window 25 feet from a power pole. I was never an electrically sensitive person before. I was actually quite healthy.

Unknown to me, on the 30th of October, 2009, a smart meter was installed for one of my neighbors. Not even for my apartment. I began having terrible insomnia. I had less and less energy every day. I thought all these problems for a while was related to the insomnia. Then I noticed that I was a little bit dizzy all the time. Then I had strangely localized head aches. Then I thought that I had really horrific memory problems. It became worse and worse to the point that I finally could not even remember the most common words, and I couldn't speak. I couldn't spell. The speller on the computer said it was one thing. It looked just fine to me. It was really worrisome. I still thought that it was insomnia.

Then, this is the main thing about this condition that it was not mentioned in the big long article in the Chronicle, is that this is a very cumulative condition. It is a very slow cumulative thing. All these symptoms started slow and get worse. I noticed my hair was thinning quicker than before. The dizziness and memory problems were much worse, slowly worse. Then I started noticing that my face, if I happen to be in the bathroom, happen to look in the mirror, my face was bright, bright red. I knew that it was not the insomnia by then.

By absolute pure chance on Pacifica radio, the program is called Your Own Health and Fitness, Layna Berman, I just happened to hear her read a list of health symptoms caused by smart meters. I heard it. I ran downstairs. I noticed that one smart meter was 7 feet below the head of my bed.

It took me -- what I did after that, I got, I sent e-mail to her. She put me in touch with the EMF safety network in Sebastopol, and they helped me to get this smart meter taken out on the 3rd of March. I'm the only second person that has ever had one taken out.

After I found out what the cause was, but before they took it out, I was trying to avoid being near the smart meter, I was out on my porch potting a plant for half an hour one day and stood up and I couldn't walk. I was staggering. That is when I realized that my fuses had been blown, and I was fried and that I was now -- that actually I was close to the power pole, which was very close to my office, which meant I have lost my office now. Okay.

Here is another thing. My garage is occasionally used as a neighborhood theater, and one of the directors came by, upstairs, to tell me one time that as a person who never gets headaches, that he could not figure out why lately whenever he was in the garage, he got terrible headaches. Okay.

The process of getting the meter taken out was absolutely a bizarre experience with PG and E. They lied to me so many times. Three different lies to the same questions. They finally took it out. One of the things is, they told me they would send somebody to the apartment -- oh, gosh -- what you need to know is that it's cumulative and PG and E will tell you that they have permission to do this by the FCC. And that the frequencies are so low, they couldn't possibly cause health effects. But in fact, if you go to Cindy Sage's article, public health, implications of wireless technologies, it says on page 5, paragraph 2, that the lower the frequency, the more health effects. Okay?

I don't understand why they are -- why the government is allowing this, because ELFs have been used as a weapon by many countries, and I really can't understand why the U.S. is allowing these companies to radiate the entire population. What they did is swapped out my meter to a hybrid. The hybrid, they are going to throw all the switches on all the hybrids very soon, and many other people are going to be feeling the same way I was. Thank you very much for listening.

>> JOHN WODATCH: Thank you very much for coming and telling us your story.

Next we are going to hear from Ben McMullen.

>> BEN McMULLEN: Thank you. Good afternoon. My name is Benjamin McMullen, I'm a systems change coordinator at the Center for Independence of the Disabled located in San Mateo, California.

I would like to thank you for the opportunity to comment on places of public accommodation, equipment and furniture.

As we enter a new era of progressive, modern technology, we have seen more and more machines being utilized that had not even been thought of at the time of the passage of this groundbreaking legislation known as the Americans with Disabilities Act. Technology has made life much more convenient for countless numbers of Americans around the country today.

Technology touches our lives in so many ways, including using it when we travel, using it to communicate with each other across town, or across the country and even the world. We are also able to make purchases over the Internet and so on. In addition to being the professional advocate for people with disabilities, I'm also one who has lived with cerebral palsy since birth.

As a result of cerebral palsy -- as a result of cerebral palsy I've never experienced the convenience of driving. I have always had to depend on public transportation to get from place to place.

In addition to this, I have been one who has grown up flying as a result of having an extended family living in various parts of the country. While traveling has never been, has always been a bit difficult, I have always seemed to make it work out by the request of the wheelchair, to quickly navigate the airport, or asking if I can be allowed to pre-board in the case of the large volumes of people.

Once I moved from the rural South to the urban North, I became a more frequent traveler by trains. Train stations always seems to have high volumes of people one time. They did not help with the ease of getting from ticketing counters to train terminals.

As technology developed, we saw the emergence of kiosk machines. By and large, these machines worked wonders for the common traveler, and heightened the productivity in both airports and train stations. The trouble was, the airports and train stations became so reliant on these machines that they left behind a sector of travelers, those being people with disabilities. The problem was always a source of aggravation because I had to basically prove to the person behind the counter that I was unable to use the machine. I often found myself asking for help, which led to the person behind the counter explaining to me how to use the machine.

I would respond by explaining, my knowing how to utilize the machine, but my difficulty and the physicality of the process. My lack of manual dexterity made it difficult. I would often be instructed to a line where a ticket agent could process the ticket the old-fashioned way. This would require me to stand in very long lines. Eventually, after negotiating, they agreed to provide me with assistance utilizing the kiosk machine. My time is limited so I'll wrap up.

>> JOHN WODATCH: You can continue for another minute if you would like to finish your train of thought.

>> BEN McMULLEN: Okay. I firmly believe, I have another example in a train station here recently that you all can read later. But I firmly believe that my friends with disabilities and I should not be subjected to long lines just based on our disabilities. Or the struggle of using machines with such difficulty.

We should be given the same right as anyone else to expediency. My first suggestion would be the airport or train station could designate an employee to assist travelers with disabilities, to use kiosk machines. This could be accomplished with little to no cost.

Another option is that these machines could potentially be voice-activated, where individuals could provide their ticketing information verbally into the machine. Lastly, the screen could simply be enlarged, allowing more surface area to work with. For example, I have a tremor which makes preciseness difficult. The larger an area is, the easier it is to touch and therefore select a choice.

I hope these three options that I have laid out can be used as a base for exploration which can lead to finding ways to make this process easier for people with disabilities. I would like to thank the Department of Justice for holding these hearings on such important issues. The Americans with Disabilities Act has done much to put me where I am today. It is our responsibility as Americans to work together to ensure that we keep this important piece of legislation current with times as they evolve.

Again, it has been my honor to provide testimony to you today.

>> JOHN WODATCH: Thank you very much. We appreciate your taking the time to come here and give us your testimony. Thanks.

>> BEN McMULLEN: Thank you.

>> JOHN WODATCH: And next we are going to hear from Joseph Partanski, who has had incredible stamina because you registered early today and have been sitting here listening to the testimony throughout the day. We appreciate your willingness to stay to the end of the day with us.

>> JOSEPH PARTANSKI: My pleasure. I'm going to talk about a need for the Department of Justice to be more proactive, more collaborative and more able to, willing to enforce many of the things that have been talked today, particularly your new regulations. I have a particular message for Mr. Tom Perez and I appreciate if the counsel pass this on and you will get a contact in a minute.

I urge that the -- you look especially to study enforcement regarding each of the regulations that you will be putting forth. Issuing is not the same as enforcement. If published is one thing. DOJ should have a parallel staff, enforcement guide. In other words, whatever regulations are, of course existing ones, to have something that parallels that says, hey, how do you enforce it? What is the way? Who can do it?

And from the standpoint of collaborative, let alone proactive and let alone enforcement, I would think that some of these same guidelines for enforcement could be shared with local and state jurisdictions, who may also be interested in trying to enforce regulations in a way that might mediate and minimize your involvement from the standpoint of the Feds, keeping it down to local level. If you have some good ideas for enforcement, for your own staff, share it with the states and share it with the counties and local folks too.

Please give detailed observation to the suggestion presented by Mr. Richard Skaff, Mr. Walter Parks and Miss Bonnie Lewkowicz. These people are jewels, national treasures if not more than that. I really respect them. In fact, Miss Bonnie Lewkowicz is modest and didn't even show and tell you that she is the compiler with a team of wheelchair riders guide to the San Francisco Bay Area and nearby, and with the coastal commission, it's available on-line, both Northern California which is this copy, and Southern California for the website www.scc.ca.gov.

For activist issues that may come up later, my name is Joseph Partanski, I'm at accessjoep@yahoo.com; I teach a 12 hour course in accessing government information for advocates of various types as well the whole area of disability of access issues. I'm going to give two copies of this guide by Miss Bonnie Lewkowicz and let you know that her survey that she was modestly, just barely mentioned, I believe was one of the bases of the surveys of all the state parks in California that was sued; I think you may have been part of the case (inaudible), but anyway several years ago and Bonnie's efforts towards outreach for education, my county and city parks person was invited five years ago to one of her training sessions. We had one person from the national parks show up, to be part of the audience, what have you. My urging regarding enforcement is, hey, where are your own surveys of your own national parks and other related federal agencies?

There is a difference between having a judicial Attorney General kind of focus and having a real advocacy for the disabled federal-wide. So from the standpoint of the issues of training, and outreach, to the extent that you not only train your own staff but have all federal agencies who have, possibly neglected to identify their ADA coordinators and from the standpoint of the new regulations, please have an outreach to all federal agencies to make sure that your federal regulations as modified are getting out there in a meaningful fashion.

From the standpoint of the agencies, I particularly like to emphasize the Bureau of Prisons. As you probably know, your publication that summarizes the various federal laws for disabilities and one of them is the institutional situations, institutionalized laws which include mental hospitals and prisons and I'm in a situation where I've been attending the California Council on Individual Offender for the last two years as an observer and, let me tell you, the State of California, and other states probably likewise, may have a department of rehabilitation but they'll say, "Hey, we are responsible for providing technical assistance to state agencies. We are not responsible to you as a citizen for advocacy. We are not responsible unless I ask," what have you.

When you ask, is there somebody, advocacy for the disabled in the State of California for the ADA coordinator for the state, there is no ADA coordinator for the state. Where is the point person to be held responsible and an advocate for the (inaudible) and disabled at the ADA? That is something applicable for 58 counties, 476 cities, and there have been very few ADA coordinators. You can almost count on your hands in the State of California with 40 million people.

Somewhere along the way, the issue of advocacy and disabled enforcement, from the standpoint of the federal level, regarding where is your ADA coordinator for the Feds, I have a nice impression. Follow the advice of the president. But from the standpoint of the Department of Justice, you are not the ADA advocate. Consequently, I strongly recommend that you get a person like or status like the drug czar for ADA. That person is not an advisor to the President. That person is responsible for advocacy throughout the whole agencies. Department of Justice has not that role. You have demonstrated that in various ways over the years.

I strongly suggest, and Mr. Perez, this is a publication of the Department of Justice. It reads, ADA, know your rights, returning service members with disability. I took this to the Congressional office of the VA, back when we had had a birthday party for the ADA in July. They had never seen it nor heard about it.

When you read this on the ADA, know your rights, returning service members, there is not a single reference to the VA in the whole thing. From the standpoint of the cooperation and follow-up, I strongly recommend that if you have some way, shape or form have any revisions, that you talk and share with the VA because it's not there. I strongly recommend to Mr. Perez, if at all possible, to have a liaison with the Bureau of Prisons and the other federal agencies and have them noted so that once we as an advocate outside can say, hey, this is a lead person for the Bureau of Prisons, this is the lead person for the VA, you ain't got it, and we don't have a Presidential statewide national ADA advocate in your office.

>> JOHN WODATCH: Thank you. I can at least tell you in terms of that brochure, since it was done by our offices, that we have reached out to the VA and are having it distributed through their offices, and are working with them to try to get the information that is in there disseminated, so that veterans, particularly veterans who are returning now from the wars in Iraq and Afghanistan, have access to information about their rights as people with disabilities.

>> JOSEPH PARTANSKI: In July, they hadn't seen it. I gave them copies, on your behalf.

>> JOHN WODATCH: I appreciate that. Thank you.

>> JOSEPH PARTANSKI: Copies for yourselves. Thank you.

>> JOHN WODATCH: Next we are going to hear from Mr. Frank Welte.

>> FRANK WELTE: Good afternoon. Earlier this afternoon, you heard from Mitch Pomerantz, the president of the American Council of the Blind. I'm speaking in behalf of the California Council of the Clind which is the California State affiliate of ACB.

Since 1934, if California Council of the Blind has been working to improve conditions for people in California who are blind and visually impaired.

First let me turn to the issue of website accessibility. CCB is working for more than a decade in the area of website accessibility. Again you heard earlier from our attorneys, Lainey Finegold and Linda Dardarian, and over the course of our participation with them, we have had a great deal of success in making a variety of websites accessible, such as making websites, credit reporting websites, and various retail company websites. This has taught us an important lesson which is that website accessibility is both readily achievable and does not constitute an undue burden for organizations.

We think it's important that the ADA standards should follow the worldwide web consortium's ADAAG standards and also they should consider relative laws such as the section 255 and the recently passed 21st century Communications Accessibilities Act. These are important standards.

Also though, that the Department of Justice should allow the standards to be sufficiently flexible to address the changing web technologies that will occur in the future.

In my previous life, I was a website tester. This taught me that most website accessibility problems can be addressed by the use of properly developed website html coding, and that website accessibility is both readily achievable and it is also inexpensive.

Also, there are a variety of website accessibility testing tools that are readily available to assist website developers in making their sites accessible. Many of those tools are free.

One practice which has happened in the past, is that organizations have tended to create secondary text-only websites to provide what they thought was accessibility. We believe that such practices should be discouraged because as I've just said, making standard websites is, accessible is readily achievable, and therefore having secondary text-only websites is not necessary. In addition, we found that organizations that try to maintain text-only accessible websites tend not to keep those websites current, and they end up being less accessible than standard websites.

Turning to the issue of captioning and audio description, CCB is very much in support of stronger standards to require theaters to provide live and motion picture audio description. Indeed, all of the efforts that have been done making theaters physically accessible are incomplete, especially for people who are blind and visually impaired and hearing-impaired, until such time as there are stronger standards for captioning and audio description.

Turning to the issue of updated 911 services, to the extent that enhanced 911 services include text and video components, they need to be developed in such a way that they are accessible to people who are blind and visually impaired. And just with one more sentence, regarding the issue of equipment and furniture, we believe strongly that standards need to be in place to allow -- to require that kiosks and point of sale terminals should be accessible. Our work in making ATM machines and point of sale terminals accessible here in California shows that these technologies are readily achievable.

Thank you.

>> JOHN WODATCH: Thank you very much, Mr. Welte. We appreciate your testimony today.

Next we are going to hear from Jo Anna Frugali. Ms. Frugali, please proceed. Thank you for sitting out for the day with us. We appreciate it.

>> JOANNA FRUGALI: No problem. Good afternoon, ladies and gentlemen of the panel. First of all I would like to thank you for coming to San Francisco. It's a rare opportunity for us to be face-to-face and speak to you. I also would like to commend you on your patience and perseverance today, through all the difficult, various environmental temperature changes, and the multiple topics. You have quite the job cut

out for all of you, since you have heard so many, so much testimony not only from San Francisco but from the other sites you've been, that give you oftentimes conflicting advice, and conflicting instructions.

So, I would like to take the next couple of minutes to share some of my personal observations and experiences with you and try to tie everything together if I may.

My name is Jo Anna Frugali, and I'm the deputy director for programmatic access at the mayor's Office on Disability here in San Francisco. You have heard previously from Susan Mezner, our director, about all the great things the City of San Francisco is doing in terms of access. But I'd like to offer a little bit of my personal perspective. Being able to comment on the proposed updates on the ADA and the next generation of the ADA this past year is kind of significant.

I was not, I am not a naturally born American citizen. I grew up in Greece. And I first entered the United States barely a month after the ADA was first signed into law. I'm here before you today to comment on the new generation of ADA regulations.

As a person growing up in Greece, I was the first disabled person to go into mainstream school. I'd never had the opportunity to be included in any aspect of social life. So when I came here and there was such a thing as civil rights for people with disabilities, it was a strange phenomenon.

However, what I've begun to realize by spending several years and seeing and living and working in the United States and reaping the benefits of the ADA, I also realize that the ADA of 1990 opened the door and let us into the buildings. But really, didn't integrate us enough.

What is becoming so exciting with this new proposed regulations that you are considering is that we are taking the next step for saying that we don't just want entry into the door. We don't want for you to just let us in. We want to be included.

More specifically, I want to talk about furniture, non (inaudible) furniture and equipment, partly because in the first generation of the ADA, those were not covered. But as a person with a disability, I have had a very paradoxical relationship with the medical profession.

You would think that all of us, especially those of us who have grown with having a disability, we are very accepted in the medical world because we spend a big part of our lives there. But when you go to a doctor's office, and you have to be examined in the hallway because, or with the door open, because the room is not big enough to accommodate someone in a wheelchair; or as a mother, if you are taking your younger, as a mother in a wheelchair taking your younger child into an exam room for a shot and you are not able to be near them comfortably, because your wheelchair doesn't fit in.

But most importantly, trying to access medical care equipment, accessible exam tables, or even hospital tables -- hospital bedrooms. Several months, several years ago, I had an experience where I was in the hospital for an extended period of time, and during that time, I was never able to press the call button for a nurse, or to adjust the bed independently, because the buttons were so small, and so difficult to push. And there was no ancillary device to be able to do that when we know we have the infrared technology and all the other different methods of making things more accessible.

I would urge you to not focus on access. Access is not good enough. Access just gets us in the door. I would like you to think about universal design. You have heard about people who say that the bed heights in hotels are too high now. For some of us that works really well. For others, it doesn't. We need options. If the ADA promoted something, that was the issue of choice. And that is the spirit that you need to keep having. We need to look at more inclusive methods, and universal design, rather than just accessible design. Thank you very much for your time.

>> JOHN WODATCH: Thank you very much.

Now we come to, after a long and invigorating day, our last commenter. If you recall, the end of our morning session, our commenter's name was Carrie Finale. For those of you who speak French, this is also interesting, our last commenter today is Ms. Marilyn Finn. So you have the last word today.

>> MARILYN FINN: Yes, here I am. The last of the last. I want to thank all of you for all your hard work. I'm old enough that I was way before the ADA was passed, and I'm with the Hearing Loss Association of America. One of our founders, our primary founder, was on that committee that put together the ADA. So I lived a lot of years without the ADA, and saw the tremendous difference it made afterwards.

I was on the staff of the Hearing Loss Association of America, and I'm a recent volunteer president of the Hearing Loss Association of California.

I've a profound hearing loss, and captioning is how I watch television, how I use the Internet, and what I must have to comprehend a film in the theater. I'm late-deafened. I wasn't hard of, my hearing loss wasn't noticed until I was 14. I think I'm as tired as everyone else.

And I was so pleased in my 30s when FM and infrared devices were put in the theaters, slowly, slowly but they came along. And I could go to the theater with my friends, coworkers, family. I could understand meetings with devices. That was wonderful. But about ten years ago, those devices would no longer work for me, not unless the person speaking was facing the camera, facing me, not unless I knew who was talking in a meeting room, and you could imagine that my idea of the plot of a movie was very strange, because I could only get, if someone was facing me. If they turned away, oops, I once had a fight with my mother and sister about what the plot of the movie actually was. Nobody won. (Chuckles).

So, HLA has chapters throughout the United States, and when I lived in Maryland and worked for HLAA, local members attended a captioned film once a month at 2 p.m. on a Sunday. We are all working and our other choice was 11 a.m. on a Tuesday, which we couldn't do. We saw whatever they chose to feature on that day and at that time, because there were no other captioned screenings. Blizzards did not deter us. When there was a family film featured, the excitement of the deaf and hard-of-hearing children there was just wonderful.

My brother lost his hearing as a baby, and he is here in one of these shirts, by the way. He went for the first 30 years of his life to movies with his friends and family but he didn't know what they were about. He just went because everybody was going.

For our family, captioning and movies is extremely important.

The captioning that we used in the theater in Maryland was open captioning. Rear window certainly allows you to go anywhere you want to go with your family, but I too experienced the thing of getting to a theater that advertised rear window, that I phoned ahead and said they had rear window and the staff didn't know how to turn it on.

It's a long drive sometimes to get to one of these theaters. So rear window is wonderful for what it does. Open captioning is wonderful for what it does. And the ADA is wonderful for what it does.

I wanted to touch on the computer captioning, because this is also part of my life. The Internet is becoming more and more a part of my life than all the outdoor things that I used to love to do so much.

I really think that what our -- the speaker, one or two people before me said about the ease of getting captioning on the Internet, getting assets on the Internet, I urge you to do that. And in conclusion, thank you very much, for this day. This was an amazing day to participate in.

>> JOHN WODATCH: Thank you very much.

I will, I have a few closing remarks. I agree with you. It has been an amazing day. It has been an invigorating day, for those of us from Washington, to come and hear your heart-felt stories. You were very kind with your implicit criticism. We appreciate that. But we also heard you, and I can tell you that we will go back to Washington, consider what you have said to us today, look forward to the written comments that you have.

I should point out to everyone here and those listening on the Internet that you have until January 24 to provide us with formal written comments.

We hope that you will do so. We hope you encourage your friends to do so. Our ability to craft careful, important and good regulations depends upon the comments that we will get from all of you.

I'd also like to thank a number of people who made today possible. We have had volunteers from a series of other federal agencies from the San Francisco area, from the Social Security Administration, from the EEOC, from the Department of Homeland Security, the Department of Agriculture, our own U.S. Attorney's Office and the Department of Justice, from the Department of Justice's Executive Office for Immigration Review, and from the Department of Education, particularly alumna of our own office, Laura Welp, who was here with us today and we appreciate her time.

I'd be remiss if I didn't thank the staff from the Department of Justice who were here, the person in charge of this hearing was Zita Johnson Betts who is acting deputy chief in the disability rights section, who's worked tirelessly on this hearing and the other hearings. She's been very ably assisted by two people who were sort of the co-chairs, Kay O'Brien and Brandy Wagstaff, you have seen these people working the event all day today.

In addition, there are other people from the department who have been working very hard. Linda Garrett, Robin Deykes and Barbara Elkin, who was our hearing clerk today. We had interpreters who came from Washington, Beth Maclay and Anita Frelich. We also would like to thank the interpreters who were supplemented the hearing today from San Francisco. In addition, other staff Rex Pace, Scott Shea and Samantha Lewis were all here, and working behind the scenes. And you saw some of the other people from our department who took turns listening to you today, up on the front, Mazen Basrawi who has been an iron man here sitting throughout the day.

>> MAZEN BASRAWI: I'd just like to point out it wasn't as much as you, John. (Chuckles).

>> JOHN WODATCH: And Bob Mather, Christina Galindo-Walsh, Felicia Sadler, who is sitting here now, Sarah DeCosse and Kathy Devine. We also had a number of contractors who assisted us, X-Factor who has been here at this hearing, and at the other two hearings that we did, who have done unbelievable work in terms of making this event run smoothly and get it up on the Internet. Audio Description Associates for the audio description, and Caption First for the CART services.

This event would not have been possible nor run anywhere near as smoothly without their combined efforts. I'm very thankful for them. We look forward to your comments in the future and I really thank especially those of you who stayed with us throughout the day and listened to all the testimony. I hope you found it as enriching as we did.

Thank you and with that, I'll conclude the hearing.

(Applause)

(end of hearing at 5:05 p.m. PT)