

Position of Targeted Justice on RF and EMF Exposure and Civilian Health

Comments to the U.S. Department of Health and Human Services

Submitted by Ana L. Toledo, Esq.
Counsel for Targeted Justice, Inc.
October 2026

Docket HHS-OASH-2026-0397

Request for Information on Electromagnetic Fields (EMFs),
Radiofrequency (RF) Radiation, and Wireless Radiation Exposure



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91 Fed. Reg. 59792-59794 (September 21, 2026); FR Doc. 2026-19252

1 Statement of position

RFI questions 2, 3, 16, 17, and 18

Targeted Justice, Inc. submits these comments to state its position on the public-health implications of radiofrequency (RF) and electromagnetic field (EMF) exposure, including reported civilian anomalous health incidents (AHIs), often called Havana Syndrome.

Targeted Justice has been forced to submit these comments through its counsel, Ana L. Toledo. Because attempts by Richard Lighthouse were blocked by the system. See attached screenshot/Exhibit 1.

Our position is that civilian health protection must encompass pulsed and directional exposures, reported auditory effects, burns and painful episodes, the potential misuse of wireless infrastructure, and the safety and harm perpetrated through connected or implanted devices without the carrier's consent. See Exhibit 2, pictures of burns caused by EMFs being pulsed within the United States.

Clinical recognition, appropriate treatment, and access to research must be available to affected civilians without requiring them first to establish the identity or intent of a suspected source.

These comments adapt Targeted Justice's October 19, 2026 FCC submission concerning towers and beamforming to the public-health issues presented by HHS. Exhibit 3.

We also adopt by reference Dr. Len Ber's comments in full, identify the relevant Targeted Justice newsletters, and set out our conclusions and policy recommendations. The numbered references identify the materials supporting this submission; the question numbers below identify the corresponding portions of the HHS request for information. Exhibit 4.

Our central positions are that a clinical presentation must be evaluated separately from attribution; that a general assertion of regulatory compliance cannot resolve every question about the health effects of a particular exposure; that intentional harmful uses and device interference fall within the health concerns relevant to this proceeding; and that civilians require a coherent clinical, reporting, and research framework. Recommendations for implementing these positions appear in Section 9.

This submission draws on published research, government assessments, Dr. Ber's clinical and scientific analysis, and newsletters containing individual accounts and organizational allegations. The newsletters' descriptions of attacks, weaponization, torture, and undisclosed devices are presented as reported experiences or allegations. Established physical effects, proposed injury mechanisms, diagnoses, and attribution to a particular source have different evidentiary foundations. Our policy position does not depend on treating an unverified source attribution as an established fact.

2 Adoption of the comments of Dr Len Ber

RFI questions 4, 5, 6, 7, 8, 10, 11, 12, 16, 17, and 18

Targeted Justice adopts and incorporates by reference in full the 30-page Comment of Len Ber, MD, Medical Director, Civilian Registry for Diagnosed Havana Syndrome Patients, dated October 15, 2026, submitted for this same HHS docket as Exhibit 4 of this document including its references and nine Recommended HHS Actions. The complete document is designated Exhibit 4 to accompany these comments. Incorporation includes the distinctions Dr. Ber makes among clinical observations, published findings, modeling, inference, and unresolved questions. [3]

We endorse his separation of clinical phenotype from cause and attribution; his position that civilians require access to assessment, reporting, and research; and his concern that pulse characteristics deserve explicit consideration in exposure assessment. We support his proposed civilian case-definition and registry framework, clinical guidance, consideration of the September 2025 CDC and NIH petitions, measurement development, research on repeated pulsed exposures and vestibular structures, interagency coordination, and an identified HHS coordinator.

Dr. Ber reports 21 physician-diagnosed civilian patients in his registry as of October 2026. We rely on this as his report of the registry's experience, with its underlying diagnostic criteria and records relevant to evaluation. A self-selected registry is not a population prevalence estimate, and diagnosis of a clinical presentation does not by itself establish RF causation. Our position is that the reported civilian clinical experience belongs in the public-health record and merits consideration alongside the federal employee studies. [3, pp. 1-2, 21-24]

3 Auditory effects burns and painful episodes

RFI questions 3, 4, 7, 8, 10, 11, and 16

Microwave auditory effect

Targeted Justice's January 29, 2025 newsletter, *Does V2K Induce Brain Tissue Damage?*, discusses microwave hearing, pulsed exposures, and possible injury, using the term voice-to-skull or V2K. We include it as a statement of the concerns and scientific arguments raised in our publications. Our position is that the documented microwave auditory effect is relevant to HHS's consideration of pulsed RF exposure and should be addressed explicitly in the scientific record. [4]

Frey's experimental work and ICNIRP's discussion recognize auditory perception under particular pulsed RF conditions, including a thermoelastic mechanism. That finding supplies a basis for discussing a physical effect; attribution of an individual's sounds or voices to RF and a conclusion that an exposure caused injury require additional evidence. ICNIRP's assessment treats microwave hearing as a sensory effect without established adverse health effects. We support examination of the injury questions raised by Dr. Ber while accurately identifying this distinction in the existing literature. [3, 9, 13]

Our clinical position is that reported auditory experiences, associated vestibular symptoms, and functional impairment deserve careful documentation and appropriate assessment. Clinical care and research should distinguish microwave hearing from externally audible sound, tinnitus, and other auditory conditions, with exposure measurements considered where justified. A proposed mechanism should neither substitute for a diagnosis nor prevent care when the mechanism remains uncertain.

Reported burns and skin injury

The May 24, 2025 newsletter *More Microwave Burns...* contains photographs and an account of burning, blistering, and auditory sensations that the participant attributes to electromagnetic attacks. We present these reports as part of the civilian experience relevant to HHS's inquiry. Our position is that visible injury and reported recurrent burning warrant timely clinical attention and consistent documentation, irrespective of whether the source has been established. [5]

RF heating and burns are recognized hazards under particular exposure conditions. FDA's discussion of the MRI environment provides an established example, including heating and implant-related risks. The exposure conditions in MRI differ from ordinary telecommunications exposures; this example establishes a type of hazard, not the cause of the injuries in the newsletter. [16]

Public-health evaluation of reported skin injury should connect the clinical record, plausible exposure pathways, and any reliable measurements. It should document lesion distribution and progression and consider thermal, electrical, chemical, dermatological, and other causes. The need for source attribution does not diminish a person's need for treatment of an injury.

Painful episodes attributed to directed energy

Microwave attacks to the Head, dated October 25, 2024, and *More "Punching Bag" Attacks*, dated April 25, 2026, describe painful episodes attributed in those publications to directed-energy sources. *Can a Directed Energy Weapon (DEW) attack look like the flu?*, dated March 22, 2026, describes reported frequency measurements and a proposed tower-source connection. These publications state the experiences and allegations that Targeted Justice brings to this proceeding. [6-8]

HHS must also consider the use of the Reltron Directed Energy Weapon against U.S. persons within our nation. Exhibits 5, 6 and 7.

Our position is that recurrent pain, pressure or vibration sensations, disequilibrium, and associated disability should be captured in civilian health reporting and assessed clinically. An allegation of

deliberate harm should be recorded accurately as an allegation, with supporting clinical and technical information evaluated on its own merits. A detected frequency or a temporal association alone does not resolve source or causation. Care, standardized reporting, and sound exposure assessment serve distinct and complementary purposes.

This deliberate harm derives from the human experimentation program MK ULTRA that never ended. See Exhibits 8 and 9.

4 Civilian AHI and Havana Syndrome

RFI questions 4, 10, 11, 16, and 17

Targeted Justice's position is that civilian AHI-like presentations belong within HHS's clinical and research agenda. Federal employment is not a biological criterion for recognizing a clinical presentation. The scientific assessment of symptoms, findings, and possible mechanisms should therefore include appropriately characterized civilian cases, with eligibility for specific federal benefits treated as a separate matter.

The National Academies' 2020 assessment identified directed, pulsed RF as the most plausible among the mechanisms it considered for distinctive early manifestations in a subset of overseas cases, while recognizing other possibilities and heterogeneous presentations. The 2022 Intelligence Community Experts Panel likewise considered pulsed RF a plausible explanation for core characteristics, with information gaps. We regard those assessments as support for considering the mechanism in research; they do not establish a cause or perpetrator for a particular civilian case. [10, 11]

The 2024 NIH studies documented substantial symptoms but did not find significant MRI-detectable brain injury or differences in most clinical measures in the studied groups. Dr. Ber presents criticisms and a subgroup re-analysis. Our position is that the original findings and the proposed subgroup analyses should be assessed together, with study timing, comparison groups, statistical methods, and clinical heterogeneity made explicit. Neither a negative result on one set of tests nor a proposed mechanism resolves every clinical question. [3, sections 2 and 8; 12]

We endorse evaluation of the clinical phenotype Dr. Ber calls AHI1, transparent civilian inclusion criteria, prospective studies, appropriate comparison groups, and prespecified subgroup analyses. Recognition of a reproducible clinical presentation and demonstration of its cause are separate scientific tasks. A civilian pathway should provide clinically appropriate vestibular, audiological, neurological, cognitive, and other assessment without presenting an exploratory biomarker as a validated RF-specific test.

5 Beamforming infrastructure and alleged intentional harm

RFI questions 3, 5, 7, 8, 9, 13, 15, 16, and 17

Targeted Justice's FCC submission and The Cell Tower Movement describe concerns about a particular tier of four adjacent panels and allege misuse of wireless infrastructure. Our position is that the health relevance of a particular installation depends on its actual configuration, operating

modes, emissions, and exposure conditions. Beamforming has documented communications uses; the appearance or number of panels does not determine whether a particular installation has been misused. [2, 14, 15]

We distinguish three circumstances relevant to this proceeding: operation beyond applicable authorization or exposure restrictions; operation in a configuration or mode not covered by the safety assessment relied upon; and a reported harmful effect during operation claimed to satisfy applicable limits. Each raises a different technical question. A generic compliance statement does not identify which circumstances existed during a reported event.

Even within legal limits, EMFs are being used in illegal ways. Aside from the experimentation and torture of humans and their pets, EMFs are illegally used to communicate subliminal messages and create mass formation. See Exhibit 10.

The allegations presented in Targeted Justice's materials include deliberate use of electromagnetic energy to inflict severe pain or injury, described by those accounts as torture, and asserted links to civilian Havana Syndrome. Our position is that the possibility of intentional misuse should not be excluded from the public-health scope solely because the suspected infrastructure also serves lawful communications. Attribution to a transmitter or operator, intent, and the legal characterization of conduct require their own evidence. HHS's health responsibilities and the responsibilities of spectrum and investigative authorities are complementary.

We oppose deliberate use of electromagnetic energy to injure, coerce, or subject people to nonconsensual experimentation. Compliance with an emission or exposure limit is not an answer to the separate ethical questions of consent and intentional harmful use. An authorization to operate equipment should not be treated as a general endorsement of every use to which it might be put.

Meaningful assessment requires the quantities relevant to human exposure. Electrical service capacity, generator rating, transmitter output, effective radiated power, and absorbed exposure are distinct. Our position therefore rests on accurate characterization of equipment and exposure, including applicable bands, enabled modes, directional behavior, timing, and material configuration changes, rather than an inference of harm from a generator rating or panel photograph alone.

6 Exposure limits and pulse characteristics

RFI questions 5, 6, 7, 8, 11, 12, and 16

Targeted Justice's position is that a statement of compliance with existing RF limits does not, standing alone, resolve the scientific questions raised here about pulse structure, localized exposure, repeated exposures, or a particular health endpoint. We support Dr. Ber's position that the assessment must account explicitly for relevant temporal and spatial characteristics. This position identifies issues for standards and research; it does not assert that ordinary compliant cellular exposure has been shown to cause Havana Syndrome. [3, 17]

The FCC's rule at 47 C.F.R. § 1.1310(d)(4) permits higher exposure levels for shorter periods when the specified average remains within the applicable limit. A meaningful compliance conclusion must

identify the frequency, exposure category, averaging requirements, measurement method, and all applicable restrictions, including localized requirements where relevant. Compliance with one average is not equivalent to demonstrating compliance with the entire framework. [17]

Dagro and colleagues modeled brain mechanical stresses from high-peak-power microwave pulses. We cite that study as a mechanism hypothesis relevant to pulse-specific research. Its modeled power densities were orders of magnitude above most real-world exposures, and its computational results are not a clinical demonstration of injury from ordinary cellular infrastructure. The practical significance of a model depends on whether the exposure conditions can be established and whether its predictions are corroborated. [18]

ICNIRP 2020 includes additional restrictions for brief local exposures above 400 MHz. Our position does not depend on claiming that every existing framework ignores pulses. It is that a comparison of complete frameworks, health endpoints, and measurement practices is necessary to evaluate the concerns presented by Dr. Ber and the civilian reports. Average and peak measures, pulse duration and repetition, duty cycle, modulation, localized absorption, and cumulative exposure should be considered where relevant to the effect under study. [3, sections 5-7; 13]

We support standards that respond to reproducible adverse-health findings, including any such findings below existing limits. Findings of biological change, demonstrated harm, and a proposed mechanism should remain distinguishable. Studies with transparent methods, appropriate exposure characterization, and independent replication are essential to determining what protective changes are justified.

7 Consent WBANs implants and wireless interfaces

RFI questions 3, 5, 9, 10, 11(d), 13(f), 13(j), 16, 17, and 18

Targeted Justice's position is that bodily autonomy, valid consent, and device security must be part of the public-health framework for connected and implanted technologies. We oppose nonconsensual implantation, unauthorized device control, and harmful interference with a person's medical care or bodily function. Regulatory permission for a device or transmission does not substitute for a person's consent to a medical intervention.

These comments include concerns about reports alleging secretly placed implants, wireless body area networks (WBANs), or associated interfaces, and alleged unauthorized use of electromagnetic or wireless signals to cause harm through them. Here, WBAN refers to devices networked on, around, or within the body. The concerns are presented as allegations; the existence of WBAN technology does not establish that an undisclosed device is present in a particular person.

FDA identifies electromagnetic interference, wireless coexistence, and cybersecurity as real safety considerations for connected medical devices. Those recognized risks support attention to device integrity, access controls, and adverse-event reporting. They do not independently demonstrate secret implantation or remote manipulation in an individual case. [19, 20]

Our position is that assessment must separately establish device presence and identity, authorization and consent, and any causal connection between an adverse event and interference, malfunction, or unauthorized access. Clinical history, examination, medical records, and clinically indicated testing should guide evaluation. When a device is identified, qualified clinicians and authorized technical specialists can evaluate its function, available records, programming history, and relevant security evidence while protecting the patient.

We support accessible reporting of suspected device-related harm, protection of confidential records, and appropriate oversight referrals where evidence supports nonconsensual intervention or unlawful conduct. Symptoms should receive appropriate care whether or not a suspected device is found. Research on wireless interfaces and device security should use ethically approved methods and should protect participants' informed consent.

8 Measurement surveillance and public information

RFI questions 7, 8, 9, 10, 11, 13, and 15

Our position is that civilian health surveillance and technically adequate exposure measurement are necessary parts of a coherent public-health response. Reporting should distinguish the person's account, verified clinical findings, measured exposure, and any conclusion about causation. A report should not require identification of a transmitter or perpetrator before it can be recorded.

Measurements relevant to intermittent or directional exposures require instruments suited to the frequency range, temporal resolution, dynamic range, and field conditions. Calibrated equipment, documented uncertainty, background and comparison measurements, time and location records, and preserved raw data make results interpretable. Detection of an emission and attribution to a specific transmitter are separate findings.

A civilian reporting framework should use transparent inclusion criteria, consent and privacy safeguards, and methods for identifying duplicate reports. Self-selected reports can identify concerns and support follow-up; prevalence and causal estimates require appropriate denominators and study design. Clinician reports, environmental measurements, occupational information, and voluntary longitudinal studies can supply complementary evidence.

Children, pregnant people, older adults, workers, people with implanted devices, and those with relevant preexisting conditions should be considered according to their exposure circumstances and clinical needs. Public reporting should explain methods, uncertainties, aggregate findings, and any protective measures. Identifiable medical records and sensitive location histories belong in appropriate confidential channels, not in this public docket. [1]

9 Recommendations implementing our position

RFI questions 16, 17, and 18

The following recommendations implement the positions set out above. They supplement the nine Recommended HHS Actions incorporated from Dr. Ber's submission. The electronic product radiation control program under 21 U.S.C. § 360ii(a), including its research, evaluation, exposure-

reduction, and coordination functions, provides a relevant statutory foundation for HHS's consideration of these issues. Our recommendations concern how HHS should exercise its applicable authorities; they do not assume that this provision commands a particular scientific conclusion or every proposed project. [3, 21]

1. Establish a civilian clinical and reporting pathway. Identify a responsible HHS point of contact and publish referral information, reporting procedures, and the respective roles of CDC, NIH, and FDA.

2. Develop clinical guidance and case definitions. Evaluate the civilian presentations and proposed AHI1 phenotype described by Dr. Ber, with clinical assessment separated from source attribution and access to care maintained during uncertainty.

3. Include civilians in research. Support appropriate observational and mechanistic studies, transparent eligibility criteria, relevant comparison groups, and prespecified analyses of clinically defined subgroups.

4. Address pulse characteristics and exposure assessment. Review complete exposure frameworks and measurement practices, assess the evidence concerning brief and repeated exposures, and provide the FCC with health-based recommendations supported by the findings.

5. Address device integrity and consent. Clarify reporting and referral routes for electromagnetic interference, device malfunction, cybersecurity incidents, and supported concerns about nonconsensual implantation or device use.

6. Coordinate technical and health assessments. Use the respective capabilities of HHS, the FCC, Commerce/NTIA, and other responsible authorities to evaluate supported exposure concerns, preserve relevant records lawfully, and correlate technical findings with clinical information.

7. Protect participants and research integrity. Provide consent-based evaluation, appropriate confidentiality, independent review, disclosure of conflicts, and publication of both positive and negative findings.

8. Publish responsibilities and milestones. Set out a coordinated work plan with responsible offices, referral procedures, and progress reporting so civilian reports are addressed through an identifiable process.

Targeted Justice submits these positions for inclusion in the HHS record: civilian clinical access, accurate exposure assessment, attention to pulsed and directional emissions, protection against intentional harmful use, and bodily autonomy in connected-device settings belong within federal public-health policy. Our recommendations give practical effect to those positions.

Respectfully submitted,
Ana L. Toledo, Esq.
Counsel for Targeted Justice, Inc.

References and incorporated submission

Attachment A: Len Ber, MD, Comment of Len Ber, MD, Medical Director, Civilian Registry for Diagnosed Havana Syndrome Patients, October 15, 2026, 30 pages, HHS-OASH-2026-0397.

Complete document: LenBerComments.pdf. Designated for submission with these comments.

[1] U.S. Department of Health and Human Services. Request for Information on Electromagnetic Fields (EMFs), Radiofrequency (RF) Radiation, and Wireless Radiation Exposure. 91 Fed. Reg. 59792-59794 (Sept. 21, 2026), FR Doc. 2026-19252. [Source](#)

[2] Targeted Justice, Inc. FCC public comment on tower and beamforming concerns. ET Docket No. 13-84, DA 26-997. Oct. 19, 2026. Seven-page FCC submission, FCC Comment on Tower Concerns.pdf.

[3] Ber L. Comment of Len Ber, MD. Oct. 15, 2026. HHS-OASH-2026-0397. Thirty-page submission, incorporated in full as Attachment A. Specific references to his sections and pages identify his statements and proposed actions.

[4] Targeted Justice, Inc. Does V2K Induce Brain Tissue Damage? Jan. 29, 2025. Newsletter discussion and advocacy. [Source](#)

[5] Targeted Justice, Inc. More Microwave Burns... May 24, 2025. Newsletter containing participant reports and photographs. [Source](#)

[6] Targeted Justice, Inc. Microwave attacks to the Head. Oct. 25, 2024. Newsletter containing participant diagrams and source allegations. [Source](#)

[7] Targeted Justice, Inc. More "Punching Bag" Attacks. Apr. 25, 2026. Newsletter report and source attribution. [Source](#)

[8] Targeted Justice, Inc. Can a Directed Energy Weapon (DEW) attack look like the flu? Mar. 22, 2026. Newsletter describing reported measurements and a hypothesis. [Source](#)

[9] Frey AH. Human auditory system response to modulated electromagnetic energy. Journal of Applied Physiology. 1962;17(4):689-692. doi:10.1152/jappl.1962.17.4.689. [Source](#)

[10] National Academies of Sciences, Engineering, and Medicine. An Assessment of Illness in U.S. Government Employees and Their Families at Overseas Embassies. 2020. Summary and assessment of plausible mechanisms. doi:10.17226/25889. [Source](#)

[11] Intelligence Community Experts Panel on Anomalous Health Incidents. Executive Summary. Declassified Feb. 1, 2022. Core characteristics, findings, and research recommendations. [Source](#)

[12] Chan L et al. Clinical, Biomarker, and Research Tests Among US Government Personnel and Their Family Members Involved in Anomalous Health Incidents. JAMA. 2024;331:1109-1121. doi:10.1001/jama.2024.2413. Pierpaoli C et al. Neuroimaging Findings in US Government Personnel and Their Family Members Involved in Anomalous Health Incidents. JAMA. 2024;331:1122-1134. doi:10.1001/jama.2024.2424. [Source](#)

[13] ICNIRP. Guidelines for Limiting Exposure to Electromagnetic Fields (100 kHz to 300 GHz). Health Physics. 2020;118(5):483-524. doi:10.1097/HP.0000000000001210. See also the organization's explanation of differences, sections 3.5 and 3.6. [Source](#)

[14] Targeted Justice, Inc. The Cell Tower Movement. Oct. 11, 2023. Newsletter identifying the configuration and concerns raised in the FCC submission. [Source](#)

[15] Girnyk M, Jidhage H, Faxér S. Broad beamforming technology in 5G Massive MIMO. Ericsson Technology Review. Oct. 10, 2023. Manufacturer technical description. [Source](#)

- [16] U.S. Food and Drug Administration. Benefits and Risks: MRI. Discussion of heating, burns, implants, and device malfunction in the MRI environment. [Source](#)
- [17] 47 C.F.R. § 1.1310. Radiofrequency radiation exposure limits. Particularly paragraphs (a)-(d), paragraph (d)(4), and the exposure table in paragraph (e). [Source](#)
- [18] Dagro AM et al. Computational modeling investigation of pulsed high peak power microwaves and the potential for traumatic brain injury. Science Advances. 2021;7(44):eabd8405. doi:10.1126/sciadv.abd8405. Computational study. [Source](#)
- [19] U.S. Food and Drug Administration. Wireless Medical Devices. Guidance on wireless coexistence, electromagnetic compatibility, security, and adverse-event reporting. [Source](#)
- [20] U.S. Food and Drug Administration. Medical Device Cybersecurity: What You Need to Know. [Source](#)
- [21] 21 U.S.C. § 360ii. Program of control. Electronic product radiation control, research, evaluation, exposure reduction, and interagency coordination. [Source](#)