EXHIBIT "F"

Jared F. Brandoff, MD
Spine & Orthopaedic Surgery
222 Westchester Ave. Suite 101
White Plains, NY 10604
(914) 946-1010
New York State License #: 244173

June 21, 2019

Pillinger, Miller & Tarallo, LLP
J. McGarry Costello, Esq.
555 Taxter Road, 5th Floor
Elmsford, NY 10523

RE: Manuel Martinez
DOB: June 15, 1971
CLAIM #: USC-00544 / PA61128MP/FO
DOL: 05/19/2014

Dear Mr. Costello:

At your request, I performed an independent orthopedic-spine medical examination on May 31, 2019 on the claimant, Manuel Martinez, at 122 East 42nd Street, 17th Floor, New York, New York, 10168. Mr. Martinez was accompanied throughout the examination by Angelica Marin from "IME" who was sent by his attorney's office as well as by a gentleman named Francisco Salas, a Spanish language interpreter. Mr. Martinez provided us with proof of identity in the form of a valid New York State Driver's License. Mr. Martinez was advised that no doctor-patient relationship exists between us as a consequence of this independent medical examination.

In preparing this report, I have reviewed the following medical records and documents:

1. Verified Bill of Particulars dated December 1, 2014.
2. Depositions of Plaintiff, Examination before Trial dated September 29, 2015 and subsequently, a second dated June 13, 2016.
3. Medical records from St. Luke's Hospital.
4. Medical records from Lutheran Medical Center.
5. Radiology reports from Kolb's Radiology.
6. Radiology reports from Precision Imaging of New York.

7. Radiology reports from Madison Avenue Radiology Center.
8. Medical records from Dr. Arden Kaisman, M.D.
9. Medical records from Dr. Kenneth McCulloch, M.D.
10. Medical records from the Doctor's Office /Urgent Medical Care.
11. IME report from Dr. Thomas Nipper.

HISTORY OF INJURY:

According to Mr. Martinez, while walking down the street of Manhattan, his right foot stepped into a hole and he fell to the ground. He states that he twisted as he fell and landed on his right shoulder. He said he lay on the ground until EMS arrived where he was placed on a backboard with a collar with complaints of back pain. According to the claimant, he was brought to Columbia Hospital where he was treated and released. According to Mr. Martinez, approximately one week later, he returned back to the hospital complaining of back pain, and once again, he was released. He was then referred to a doctor whose name he did not remember, and ultimately, he was referred to a Doctor Michael Gerling. Dr. Gerling performed pain management modalities on him and according to the claimant did three out of his four subsequent surgeries. He states he had one surgery to his neck and three surgeries to his low back. He was not sure about the names of his doctors. He did not remember the dates of any of his surgeries or the date of the accident specifically. He did not know what types of surgeries were performed on him. He states to me that he was told that the surgeries will make his pain better and prevent future pain. He states that the surgeries helped a little but not nearly as much as he had hoped, and the benefits did not last long. He explained to me that he was referred to the spine surgeon by his lawyers.

REVIEW OF MEDICAL RECORDS:

Reviewed first are the Verified Bill of Particulars dated December 1, 2014 with alleged injuries to right shoulder, cervical spine and lumbosacral spine. For purposes of this dictation and report, we will speak strictly of the spine. According to the Verified Bill of Particulars, there are alleged disc herniations at C6-7 and C5-6 as well as bulges at C3-4 and C4-5. Also, according to the Bill of Particulars, there are disc herniations at L5-S1, L4-5 and L3-4.

Reviewed next are the Depositions of the Plaintiff, Examinations before Trial dated September 29, 2015 and June 13, 2016. Essentially, it reiterates the mechanism of injury, which is a trip-and-fall in a small hole in the sidewalk while walking down the streets of New York City.

Reviewed next are records from St. Luke's Hospital from the date of the accident May 19, 2014. It is notable that the claimant states that he was brought to Columbia Hospital, but in fact, he was brought to St. Luke's. Beginning with the prehospital ambulance report, it states that while walking, he tripped and fell and now his back hurts. He denies loss of consciousness. He did complain of neck and back pain and pain to his right leg. It is notable that during transportation to the hospital, the claimant removed the tape securing his neck, and he removed the C-spine collar, and then he refused to sign the paperwork for removing the tape and cervical collar. Moving on to evaluation of the emergency room records, it states the patient presents with the chief complaint of neck pain. The patient tripped and fell in a hole that was about 1.5 feet deep, hit his elbow on the ground with an abrasion, complains of midback pain as well as neck pain. No head trauma. No loss of consciousness. Mild right leg pain. Physical examination revealed mild paracervical tenderness on examination. The assessment and plan was fall from standing height with mid-back and neck pain and no head trauma or LOC. With the attending impression that there was "very low concern for cervical spine injury" given that the pain was paracervical with a very low energy mechanism of impact. While in the emergency room, he underwent a CT scan of the cervical spine. The report of this scan speaks of prevertebral soft tissues within normal limits. No CT evidence of large disc herniations on the soft tissue images. Small disc bulges at C2-3, C3-4 and C4-5 without significant spinal stenosis. Straightening of the normal cervical lordosis likely due to muscle spasm. Vertebral body and facet alignment is otherwise normal. There is significant cervical spondylosis most pronounced at C6-7. There is left paracentral disc herniation at C5-6 with broad posterior endplate spondylitic ridge/disc complex identified at C6-7. He was offered Ibuprofen and Vicodin and discharged home in good condition.

Reviewed next are the records of Dr. Michael Gerling including ambulatory surgery records from Lutheran Medical Center for date of surgery 12/15/2014. During this time, it appears that he underwent an uncomplicated anterior cervical discectomy with fusion and instrumentation at C5-6 and C6-7. According to the indications, the patient had a traumatic injury to the cervical spine with severe neck pain. Nothing more specific than that is stated and certainly no specifics about his particular accident. It goes on to state that the patient was found to have weakness and numbness on examination, with demonstrated disc herniations on MRI. It is interesting

that the preop and postop diagnoses are herniated cervical discs with myelopathy, but the patient exhibits no long tract signs and no evidence of myelopathy. It is also notable that in the technique that the posterior longitudinal ligament was left intact. Typically for surgeries where there is cord compressions and questions of myelopathy, the posterior longitudinal ligament is removed in its entirety. Nevertheless, the procedure appears to have been performed uneventfully, and the patient did go home in good condition.

Reviewed next are records from Kolb Radiology including an MRI of the lumbar spine March 12, 2016. Findings on this study include at L5-S1, there is a focal central posterior disc herniation impinging upon the thecal sac and minimally narrowing the inferior aspect of the neural foramina after the L5 nerve roots have exited. At L4-5, there is a central posterior disc herniation impinging upon the thecal sac, narrowing the neural foramina bilaterally and abutting the exiting bilateral L4 nerve roots for which clinical correlation is in order. At L3-4, there is central posterior disc herniation impinging upon the thecal sac and narrowing the inferior aspect of the neural foramina bilaterally. The herniation abuts the exiting right L3 nerve root. The remainder of the disc levels shows no evidence of bulge or herniation.

Reviewed next is a CT scan of the cervical spine without contrast dated January 26, 2016. The conclusion states 3 mm central posterior disc herniation C2-3. Disc bulge C3-4. Status post anterior fusion C5-6 and C6-7.

Next reviewed are radiology reports from Precision Imaging of New York starting with MRI of the cervical spine June 1, 2014. Impression states that the entire study is limited to sagittal views only due to patient discomfort. Frankly, that would render this to be an inadequate examination according to typical medical practices. Nevertheless, the report goes on to state that there is a large posterior disc herniation at C6-7, which impinges directly upon the spinal cord displacing it posteriorly. There is a second smaller disc herniation at C5-6 also impinging upon the spinal cord. Axial views would be necessary for additional evaluation of the neural foramina. In the body of the report, it states that the remainder of the disc levels shows no evidence of bulge or herniation. The discs are of normal height. The marrow signal and cord signal are normal. There is no evidence of instability.

Reviewed next is magnetic resonance imaging of the lumbar spine dated June 1, 2014. Impression states disc herniations L3-4, L4-5 and L5-S1 with central and foraminal narrowing as detailed above. Specifically, at L5-S1, there is central posterior disc herniation impinging upon

the thecal sac mildly narrowing the inferior aspect of the neural foramina bilaterally, left greater than right. At L4-5, there is large posterior disc herniation impinging upon the thecal sac narrowing the inferior aspect of the neural foramina bilaterally. At L3-4, there is a central posterior disc herniation impinging upon the thecal sac narrowing the inferior aspect of the neural foramina bilaterally. There is also mild loss of disc height of the L3-4 and L4-5 discs. The remainder of the discs is of normal height and hydration.

Reviewed next are radiology reports from Madison Avenue Radiology Center starting with a CT of the cervical spine November 2, 2018 with impression evidence of previous discectomy and anterior fusion at C5-6. No evidence of recurrent disc bulge, herniation or stenosis. The study is limited by metallic artifact from the previous surgery.

Reviewed next is CT of the lumbar spine dated November 2, 2018, which states there is evidence of previous laminectomy and posterior fusion from L3 through L5. No evidence of recurrent disc bulge, herniation or spinal stenosis within L3 and L5. There is a moderate spinal stenosis at L2-3 secondary to disc bulge, facet hypertrophy and ligamentum flavum thickening. Mild disc bulge is also seen at L1-2. There is straightening of the lumbar spine, which could be due to muscle spasm.

Reviewed next are medical records from Dr. Arden Kaisman, M.D. starting with an initial consultation June 24, 2014 where it states that the claimant was injured in a fall on May 9, 2014 when in fact the injury was May 19, 2014. As a consequence of this fall, it states that he sustained injuries to his neck, low back and right shoulder. In the course of the examination, he reviews the MRI findings from June 1, 2014 and reiterates that there are disc herniations notable in the lumbar spine. His assessment is herniated discs L3-4, L4-5 and L5-S1 with lumbar radiculopathy and myofascial pain syndrome. He then dictates a plan, which includes continue physical therapy. Continue antiinflammatory medications. Recommend percutaneous lumbar discectomy at L4-5 and L3-4 levels. The claimant then goes on to have a percutaneous lumbar discectomy procedure performed by Dr. Kaisman on July 2, 2014 just a few days after Dr. Kaisman's initial consultation. There are no documented attempts at conservative therapy prior to recommending this procedure. Furthermore, percutaneous discectomy is not a mainstream procedure and in fact is considered to be an experimental procedure by many insurance carriers. Accordingly, it is not considered standard of care for treatment of lumbar disc herniation with nerve compression and radiculopathy.

Reviewed next are records from Dr. Kenneth McCulloch, who is an orthopedic surgeon. During his initial examination on May 28, 2014, he describes pain and moderately limited ranges of motion in the cervical spine, lumbar spine and shoulder. He appropriately orders MRIs of each of these body parts. During follow up examination on June 18, 2014, the findings of the various MRIs are reiterated, and the claimant appropriately is referred to specialists for the shoulder and for his spine.

Reviewed next are the records from the Doctor's Office /Urgent Medical Care starting with urine tox screen from July 14, 2014, August 29, 2014 and October 24, 2014 all of which are positive for active heroine use within 24 hours of the test. There is another test performed on November 25, 2014, which is positive for active use of heroine and cocaine, and another positive test on December 22, 2014 for heroine having been used within 24 hours of the test. There is also a report from an EMG/nerve conduction velocity test performed on July 31, 2014. This report conclusively states that there is evidence of a subacute right C5 and C6 radiculopathy. Subacute here defined as long-standing or chronic and certainly not recent. The claimant then goes for 12 follow up visits to this Urgent Care facility from July 31, 2014 to August 4, 2016 each time complaining of various different upper back, lower back, neck, and shoulder pain. He was referred for physical therapy and prescribed various different medications.

Finally reviewed is an independent medical examination report of Dr. Thomas Nipper, M.D. dated January 12, 2016. In his report, he states that the claimant does have evidence of an orthopedic disability, but he also states that prognosis for recovery is good. There is no mention anywhere of causality of his symptoms or disability to the trip-and-fall accident from May 19, 2014. Physical examination is notable for no evidence of muscle spasm in the cervical or lumbar spine and no tenderness to palpation. He does have mild restricted range of motion of the cervical spine with no neurological or motor deficits. He demonstrates mild decreased range of motion of the lumbar spine also with no neurological deficits and preserved strength.

MEDICAL HISTORY:

According to the claimant, he has no significant past medical history.

SOCIAL HISTORY:

The claimant continues to smoke cigarettes on a daily basis and has done so throughout the course of his treatments. He denies the use of ethanol. Urine testing would suggest that he does partake in the use of elicit recreational narcotics and cocaine.

WORK HISTORY:

When asked the type of work that he performs, the claimant states that he is not working and would not get into specifics about what work he has done.

CURRENT MEDICATIONS:

Current medications include Gabapentin, Meloxicam, Ibuprofen and Ambien. He denies any drug allergies.

CURRENT COMPLAINTS:

Current complaints include low back pain, which he states envelops his waist. Left leg pain and numbness, which is notable because throughout the medical records, his radiculopathy was on the right. He also states that he has had pain since the accident, but he is not sure when the accident was. He states to me that his pain on a daily basis is 8/10 and stable. He claims his pain is aggravated by walking and standing and relieved when he sleeps. He states that he can sit comfortably for up to 30 minutes but can only stand or walk for up to 15 minutes or less. He denies any bowel or bladder dysfunction. He states that he has had one surgery on his neck and three surgeries to his lumbar spine. He denies any prior treatment to his back or back problems.

PHYSICAL EXAMINATION:

Physical examination reveals a 5' 10" gentleman weighing approximately 210 pounds in no acute distress. His gait is steady with the use of a cane; however, the hand in which he holds his cane is inconsistent. When he walked down the hall to the examination room, he held the cane in his left hand, but when asked to walk during the examination, he held the cane in his right hand. When asked to remove his shoes, he refused to do so. When asked to walk on his

tippy toes or on his heels, he refused to do so. Range of motion testing of the cervical spine with the use of a goniometer revealed 30 degrees of flexion, normal is 50 degrees; 10 degrees of extension, normal is 60 degrees; 40 degrees of right and left rotation each, normal is 80 degrees. Range of motion testing of the lumbar spine revealed full flexion to 60 degrees, extension to 10 degrees, normal is 30 degrees; and lateral bending of 25 degrees each, which is normal. With regard to muscle strength testing, the patient exhibited breakaway strength to all motor groups tested upper and lower extremities in that he was able to exert 5/5 strength but only for a brief period and then he would allow his muscle to go limp. Nevertheless, he did exhibit 5/5 motor strength bilateral upper and lower extremities albeit for brief moments. He had negative clonus, negative Hoffmann's, negative Babinski and negative passive straight leg raise bilaterally. His deep tendon reflexes were 2+ and symmetric bilateral upper extremities and lower extremities in all tested areas. He had a well-healed left-sided anterior cervical surgery scar as well as well-healed bilateral paramedian lumbar incisions approximately 3 inches in length around the area of L5. He was well muscled and fit, but in general, exhibited poor efforts throughout the entire examination.

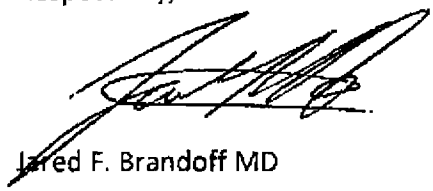
CONCLUSION AND SUMMARY:

In conclusion, this claimant, Manuel Martinez allegedly tripped and fell in a small hole on the sidewalk while walking in New York City on May 19, 2014. He was not compliant with treatment in the ambulance and he removed his cervical collar. The impression of the treating physician in the emergency room was that he had some muscle spasms of his neck and back with no significant injury based on their benign physical examination and the low-energy mechanism of the fall. In the course of treatment, he was referred by his attorney to a Pain Management specialist, who performed an experimental discectomy procedure on his lumbar spine, which derived no benefit. Further in the course of treatment, he had a CT scan and MRI of the cervical spine, which revealed evidence of chronic disc herniation with an element of spinal stenosis, the age of which was indeterminate but certainly not acute. Nevertheless, his physical examination did not demonstrate any evidence of myelopathy, nor did he have significant neurological deficits. In the course of treatment, he went on to have anterior cervical discectomy and fusion as well as several different lumbar operations. I do not have the benefit of seeing the records from his most recent lumbar surgeries; however, I suspect that they were performed because of persistent lumbar pain subsequent to his Pain Management discectomy procedure. When we consider the low-energy mechanism of injury, it is extremely unlikely that a trip-and-fall from standing height with landing on one's shoulder would cause

disc herniations in the cervical spine severe enough to cause cervical stenosis, nor would it cause isolated herniation of discs in the lumbar spine without evidence of acute traumatic injury in the adjacent soft tissues. In fact, had the disc herniations in the cervical or lumbar spine actually been caused at the time of the accident, in all likelihood, there would be evidence of soft tissue injury in the CT scans and MRI. In his studies there was no evidence of any acute injury whatsoever. I believe that there is no causal relationship between this claimant's disc herniations in the cervical and lumbar spine and his alleged trip-and-fall accident on May 19, 2014. Furthermore, I believe he has significant secondary gain from litigation and is an entirely unreliable historian and illegal drug user. Lastly, I believe that his residual deficits are mild at worst and require no further treatment.

I am a physician duly licensed to practice medicine and surgery in the state of New York and affirm the truth of the foregoing under the penalties of perjury pursuant to CPLR 2106. This report was prepared by me and is based upon my observations of the patient and contains my opinions, which are made within a reasonable degree of medical certainty.

Respectfully,



Jared F. Brandoff MD
JB/lw

Jared F. Brandoff, MD
Spine & Orthopaedic Surgery
222 Westchester Ave. Suite 101
White Plains, NY 10604
(914) 946-1010
New York State License #: 244173

October 13, 2019

Pillinger, Miller & Tarallo, LLP
J. McGarry Costello, Esq.
555 Taxter Road, 5th Floor
Elmsford, NY 10523

RE: Manuel Martinez
DOB: June 15, 1971
CLAIM #: USC-00544 / PA61128MP/FO
DOA: May 19, 2014

Dear Mr. Costello:

At your request, I have reviewed additional medical records regarding injuries to and treatment of Manuel Martinez for claimed injuries presumably sustained after an alleged trip and fall on May 19, 2014. Reviewed for this addendum are the following documents:

1. Plaintiff's Deposition, Examination Before Trial dated June 14, 2019.
2. Photographs of the sidewalk where plaintiff allegedly tripped.
3. Medical records and treatment records from Lutheran Medical Center for dates of service April 4, 2016 through April 5, 2016.
4. Office notes from Spine Care NYC Orthopedics/Dr. Michael Gerling, M.D.

REVIEW OF MEDICAL RECORDS:

Reviewed first is the plaintiff's additional deposition records, Examination Before Trial from June 14, 2019 where he more or less outlines his treatments with Dr. Gerling and his need for subsequent surgeries. There are no new revelations or discoveries which I have made as a consequence of reading this testimony.

Reviewed next are photographs of the sidewalk where the claimant allegedly tripped and fell. It appears that there is a small crack and depression on one sidewalk square of approximately one inch deep. Quite frankly, cracks and depressions like this are universally evident on nearly every sidewalk upon which I have ever traveled. At worst, the claimant may have caught his toe on the one inch depression causing him to trip and possibly even fall, but certainly, there was no large hole that he would have fallen into.

Reviewed next are the records from Lutheran Medical Center where Dr. Gerling performed spine surgery on April 4, 2016. In the operative report, Dr. Gerling describes a preoperative diagnosis of herniated lumbar discs L3-4 and L4-5 and a postoperative diagnosis of herniated lumbar discs L3-4 and L4-5. He then performs discectomies with facetectomies through paramedian or Wiltse approaches at the L3-4 and L4-5 levels bilaterally. By definition, this means he did not perform a laminectomy and had no intention of performing a full decompression. He then goes on to perform arthrodesis and fusion at L3-4 and L4-5. The indications state that this is a 44-year-old gentleman who presents with lumbar disc herniations. It also states that he had a traumatic injury to the lumbar spine with severe back pain radiating to the lower extremities predominantly on the left with numbness and weakness in his legs. He goes on to state that MRI demonstrates disc herniations. It goes on to state that intraoperatively, they elected to perform reconstructive fusion in order to circumvent further destabilization and exacerbation of symptoms. I can tell you that prophylactic prevention of further destabilization and further symptoms are not an adequate indication to perform lumbar spinal fusion surgery. Nevertheless, the procedure appears to have been done uneventfully, and the claimant did go home in good condition.

Reviewed next are the records from Dr. Gerling's office Spine Care New York City Orthopedics beginning with a consultation note on March 25, 2015 where Dr. Gerling recognizes that prior to treating with Dr. Gerling, the claimant went on to have a percutaneous discectomy procedure with Dr. Kaisman in July of 2014 for disc herniations L3-4 and L4-5. The claimant treats in Dr. Gerling's office several times between March 25, 2015 and March 17, 2016. Ultimately, having failed conservative treatments and after documenting weakness and long tract signs, which are consistent with cervical disease and NOT lumbar disease, Dr. Gerling indicates the claimant for lumbar discectomy and fusion. He very clearly states his intention to perform fusion from his office notes; however, in his operative report, he states that the decision to perform fusion was made intraoperatively as prophylactic measure to prevent further decompensation. Indications to perform fusion include instability from either

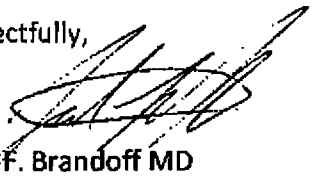
ligamentous deficiency or advanced deformity. This claimant exhibited none of that. Nevertheless, the claimant did have a fusion and subsequent additional procedure after this one.

CONCLUSION AND SUMMARY:

In conclusion, having read the plaintiff's further deposition, Examination before Trial, seen photographs of the mechanism of injury, read operative reports and records from Lutheran Medical Center and observed the records of Dr. Michael Gerling, I can tell you that my original opinion is unchanged. The claimant sustained a low energy mechanism of injury tripping and falling on a routine sidewalk crack. Any claims that a fall of this nature could have caused traumatic disc herniations to multiple levels of the cervical spine and multiple levels of his lumbar spine are unsubstantiated. The claimant went on to have a cervical fusion operation and three lumbar surgeries. While it is debatable as to whether or not these procedures were indicated based on his symptoms and radiology, what is not debatable is that these surgeries and symptoms do not result as a consequence of his alleged trip and fall on May 19, 2014. I see no causal relationship between his accident of May 19, 2014 and his pathology, and therefore, his need for surgery. Accordingly, I see no causal relationship between the alleged accident of May 19, 2014 and his current physical condition having had four spine surgeries.

I am a physician duly licensed to practice medicine and surgery in the state of New York and affirm the truth of the foregoing under the penalties of perjury pursuant to CPLR 2106. This report was prepared by me and is based upon my observations of the medical records and the claimant, and contains my opinions, which are made within a reasonable degree of medical certainty.

Respectfully,



Jared F. Brandoff MD
JB/lw