



The above-named petitioner requests compensation under the National Vaccine Injury Compensation Program, 42 U.S.C. sec 300aa-10 et seq. (Sup. 2000), for the injury of xxxxxxxxxxxx (date of birth: xxxxxxxx), the Petitioner herein, who received a Tetanus vaccination (dT 0.5 IM) on xxxxxxxx, (See Exhibit 3 pages 1 and 3) and who thereafter suffered the “Table Injury” known as Brachial Neuritis which was “caused in fact” by the above stated vaccination or in the alternative thereafter suffered some form of neurological syndrome or physical injury, either or all of which was “caused in fact” by the above stated vaccination. (See Exhibit 1 page 1; Exhibit 2 pages 1 and 2; Exhibit 4 page 1)

(1) Immediately after the Vaccination, on xxxxxxxxxxxx at approximately XXXXX p.m. at the medical care facility known as xxxxxxxxxxxx located in the City of xxxxxxxxxxxx, State of xxxxxxxxxxxxxxxxx, the Petitioner felt pain at the injection site, in his left shoulder/arm, which was not unexpected by him. The pain at the injection site did not subside over the following days and xxxxxxxx noted that the pain increased over that period of time and he began noticing numbness, tingling and pain spreading down through his left shoulder down his left arm and into his left hand. The pain, numbness and tingling did become progressively worse and petitioner noted, on approximately xxxxxxxxxxxxxxx, that he was having some very real difficulties in the use of his left arm, while driving his automobile, due to the pain in his left upper extremity. These problems included a decrease in sensation in his left arm and hand as well as pain which ran from his left shoulder traveling down into his left hand. Within XXXXXXXXXXXXXXXX after the tetanus injection xxxxxxxxxxxxxxx noticed weakness and decreased Range of Motion in his left upper extremity in addition to numbness, tingling and pain spreading down through his left shoulder down his left arm and into his left hand and he was having trouble sleeping due to the left arm pain. (See Exhibit 1 page 1; Exhibit 3 pages 1 and 3; Exhibit 9 pages 6 and 9.)

(2) Prior to the date and time of the above referenced vaccination Petitioner did not suffer from the injury or symptoms as described in paragraph (1) above. Further xxxxxxx was in overall good physical condition. (See Exhibit 1 page 1; Exhibit 3 pages 2 and 3.)

(3) On xxxxxxxxxxxx went to his treating physician, Dr. xxxxxxxxxxx, for treatment for those physical injuries he sustained on xxxxxxxxxxxx which caused him to receive the Tetanus

vaccination, and advised Dr. xxxxxxxxx that he had pain in the left deltoid area where he received the Tetanus shot and that it hurt him to move his left arm upward. Objectively, Dr. xxxxxxxxx found tenderness and soft tissue swelling of the deltoid muscle of the left arm at the area where xxxxxx received his Tetanus shot. Dr. xxxxxxxxx found normal range of motion of the left shoulder but with pain caused in such motion. (See Exhibit 9 page 6.)

(4) On xxxxxxxxxxxxx again went to his treating physician, Dr. xxxxxxxxx, in regard to this matter. Dr. xxxxxxxxx reports that xxxxxxxxx stated “xxxxxxxxxxxxxxxxxxxxxxxxxxxx. (See Exhibit 9 page 9.) On xxxxxxxxxxxxxxxxxxxxx had an X-ray of his left shoulder which noted xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx. (See Exhibit 16 page 1.)

(5) On xxxxxxxxxxxxx again went to his treating physician reporting his injuries healed except that “he feels the xxx.” Objectively Dr. xxxxxxxxx noted “xx” (See Exhibit 9 pages 12 and 13.)

(6) The Chart notes of xxxxxxxxxxxxx, the treating physician, reflect continuity in complaints related to the left upper extremity associated with the injection site through the present. The other injuries sustained in the work related injury appear to have resolved by xxxxxxxxxxxxx. Dr. xxxxxxxxx sought allowance of “adverse reaction to tetanus shot” under the xxxxxxxxx Worker’s Compensation system which condition was allowed on or about xxxxxxxxxxxxx. The xxxxxxxxx Bureau of Worker’s Compensation has assigned the description “Complication of medical care” to Dr. xxxxxxxxxxxxx of “adverse reaction to Tetanus shot” under Claim number xxxxxxxxxxxxx. (See Exhibit 9 page 23; Exhibit 10 page 1.) Physical Therapy Progress notes are provided for the period of xxxxxxxxx to xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx. (See Exhibit 15 pages 1 to 19.)

(7) On xxxxxxxxxxxxx had a nerve conduction study of his Left Upper Extremity which “xx. (See Exhibit 12 pages 1, 2 and 3.)

(8) On xxxxxxxxx xxxxxx sought the opinion of Dr. xxxxxxxxxxxxx (this is xxxxxxxxxxxxxxxxxxxxx own family doctor) who opined the condition could be related to a left



extremity symptoms are not typical of cervical radiculopathy but rather are the result of a reaction to a tetanus shot”. (See Exhibit 4 page 1; Exhibit 5 page 5.)

(12) xxxxxxxxxxxx suffers from chronic pain in his left shoulder and left upper extremity with weakness, atrophy and some neurological deficit present. These symptoms arose in close proximity to the actual date of the injection and remain present through the filing date of this Petition. (See Exhibit 1 page 1; Exhibit 2 pages 1 and 2; Exhibit 4 pages 1 and 2; Exhibit 5 pages 3 to 5; Exhibit 6 pages 1, 3 and 4; Exhibit 9 pages 6 to 40; Exhibit 13 pages 1 to 4.)

(13) It is the opinion of xxxxxxxxxxxxxxxxxxxx Treating Physician, xxxxxxxxxxxx, MD, as well as Dr. xxxxxxxx, a neurosurgeon consulted due to the left upper extremity pain, that xxxxxxxxxxxx left upper extremity symptoms and debility are the result of the Tetanus injection administered on xxxxxxxxxxxx. (See Exhibit 1 page 1; Exhibit 2 pages 1 and 2; Exhibit 4 page 1; Exhibit 5 page 5; Exhibit 9 pages 23, 34, 37, 39 and 40; Exhibit 10 page 1.) Dr. xxxxxxxxxxxx specifically states “It is my opinion, based on my education, training and experience and to a reasonable degree of medical certainty, that xxxxxxxxxxxxxxxxxxxx suffered an adverse reaction to the Tetanus shot he was administered on xxxxxxxxxxxxxxxxxxxx which manifested itself as a left-sided Brachial Neuritis.” (See Exhibit 2 page 1.)

(14) xxxxxxxx still bears some objective evidence of injury at the injection site most recently noted in Dr. xxxxxxxxxxxx Chart Note dated xxxxxxxx in which he noted “There is a dimple xxxxxxxxxxxxxxxxxxxxxxxx.” (See Exhibit 9 page 39.)

(15) The Petitioner xxxxxxxx has not received compensation in the form of an award or settlement for his Vaccine related injuries nor has he filed a civil action for his injuries prior to filing this petition. xxxxxxxx has filed a claim for this injury with the xxxxxxxx Bureau of Workers Compensation under Claim Number xxxxxxxxxxxx under which some of the Medical Expenses have been paid. xxxxxxxx has a policy of Health Insurance through xxxxxxxxxxxxxxxxxxxx Insurance Company which has also paid part of his medical treatment and testing expenses. (See Exhibit 1 page 1; Exhibit 11 pages 1 to 3.)

(13) The petitioner requests that the compensation demand (including attorney's fees and costs) be deferred at this time pursuant to 42 U.S.C. sec 300aa-11(e) until such time as the entitlement issue has been resolved.

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

by: \_\_\_\_\_ XXXXXXXX  
XXXXXXXXXXXXXXXXXXXX. Dated  
Attorney at Law  
Counsel of Record for the Petitioner  
XXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXX  
XXXXXXXXXXXXXXXXXXXX  
Ph: XXXXXXXXXXXXXXX  
Fax: (XXXXXXXXXXXXXXXXXXXX)  
Email: [XXXXXXXXXXXXXXXXXXXX](mailto:XXXXXXXXXXXXXXXXXXXX)

