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Goldberg Segalla’s Workers’ Compensation Quarterly newsletter provides a timely summary of decisions from across New York, Connecticut, New Jersey, and Pennsylvania concerning workers’ compensation matters. It explores the latest rulings and developments, changes in interpretive language used by the courts, permanency determinations, and more. We greatly appreciate your interest in our newsletter and welcome your feedback or questions. Please feel free to share this publication with your colleagues. If others in your organization are interested in receiving the publication, if you wish to receive it by regular mail, or if you would like to be removed from the distribution list, please contact Debra L. Doby at ddoby@goldbergsegalla.com.

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We have again expanded the reach of our Workers’ Compensation Practice Group — this time into Connecticut. We are equipped to defend clients before commissioners in all eight districts of the Connecticut Workers’ Compensation Commission at informal, pre-formal, and formal hearings, and to settle cases through full and final stipulation agreements. We also provide Connecticut employers with advice to proactively reduce the risk of worker injuries.

Michael D. Schweitzer joined our team as an associate in the Hartford office, bringing a deep understanding of the Connecticut process from his prior experience handling workers’ compensation matters on behalf of one of the 50 largest property and casualty insurers in the United States. In addition to having a wealth of experience defending respondents before the Connecticut Workers’ Compensation Commission, Mike is a proven trial lawyer with more than 10 first-chair jury and bench trial verdicts to his credit, along with the successful resolution of high-exposure cases through alternative dispute resolution and on appeal.

NEW YORK

ADA Classifies Obesity as a Disability: Possible Impact on NY Workers’ Compensation Law

In New York, even the smallest causation opinion from an attending physician can result in the establishment of an occupational disease or work-related condition against an employer. While it may be hard to argue that simple obesity would cause any actual disability or hindrance to gainful employment, if established on a claim, the treatment for obesity could include medications, therapy, and possible surgery. With this in mind, along with the recent classification of obesity as a standalone disability under the ADA and a growing American waistline — approximately one-third of U.S. adults are classified as obese — there is a question as to how the states’ workers compensation systems might handle claims for work-related or consequential obesity. (As a side note, at 25.2 percent, New York State has fewer obese adults as a percentage of the population than the national average.)

First, it would be important to define obesity. General screening for obesity is measured using Body Mass Index (BMI), a measurement of body fat based on height and weight that applies to adult men and women. According to this system, BMI under 18.5 percent is considered underweight; 18.5–24.9 percent is normal weight; and 25.0–29.9 percent is overweight. Higher BMI numbers denote classes of obesity: 30.0–34.9 percent is considered obese (class 1); 35.0–39.9 percent is obese (class 2); 40.0–49.9 percent is obese (class 3); and 50 percent and above denotes super obesity. A person’s BMI is not a direct measurement of body fat, however, so while BMI does provide a general guideline, it does not necessarily mean a person would truly classify as obese.

Fortunately, so far, the New York Workers’ Compensation Board has been reluctant to establish claims for causally related or consequential obesity. For example, in Auto Chem Corp., 2011 NY Work. Comp. Bd. G0160804, the carrier appealed a decision by the Law Judge amending the accident, notice, and causal relationship (ANCR) to include post-traumatic stress disorder (PTSD), anxiety, dermatitis, and consequential obesity. In relation to consequential obesity, the Board Panel reversed the decision, disallowing consequential obesity. In its decision, the Board Panel noted there was no affirmative finding of a connection to the work injury. Importantly, the Board noted that the claimant had, in fact, lost weight following the injury. This case highlights the importance of fact gathering following an injury or initiation of a claim in defending any potential obesity claim. Obtaining the claimant’s weight immediately after any injury in PCP or initial treatment records or (if possible) immediately before the injury can be a simple method of cutting the claim off with simple facts: the claimant’s weight before, and the claimant’s weight after. If medical records immediately following an injury or lost time are not available, a carrier should work to secure prior medical records from the claimant’s primary care physician in order to defend such claims.

Similarly, in Con Edison Co., 2006 NY Work. Comp. Bd. 08265271, the Board rescinded a finding of causally related morbid obesity (along with heart failure). In reversing the Law Judge’s decision, the Board Panel noted that even though one of the claimant’s doctors had opined that the obesity was casually related to the employment, the link was too tenuous and the opinion too speculative to support the establishment of obesity. Thus, it appears that the Board Panel will scrutinize medical opinions of doctors seeking to link an employment or accident to obesity. However, with the growing prevalence of the obesity problem in the United States, claimants’ attorneys may start looking at an obesity claim as a meal ticket. Employers should evaluate the benefits of promoting fitness in the workplace.

A Law Judge found WCL 25-a not to apply due to outstanding tentative rates, held in abeyance periods, and possible lost time. We appealed the decision and the Board Panel reversed the Law Judge’s determination that 25-a did not apply. The Board found that “direction of a tentative rate or the direction to hold a period in abeyance acts to preserve the rights of the parties … by producing additional evidence, absent the production of such evidence these direction cannot be found to bar a finding that the case was truly closed.”

Law Judge Found 0% SLU after BCTS Surgeries

The claimant underwent a carpal tunnel syndrome (CTS) release on each hand a year apart. Per the Workers’ Compensation Board’s permanency guidelines, bilateral carpal tunnel conditions with surgery often result in a 10–20 percent scheduled loss of use of the hand. Prior to the claimant’s permanency evaluation in summer 2014, her medical reports noted that the claimant had only subjective complaints of pain but had recovered a full range of motion. During her permanency evaluation, however, the claimant was found to have a restricted range of motion by both the treating physician and independent medical examiner.

The IME physician, despite the restricted range of motion, indicated his belief that the claimant had no permanency on the bases of the pre-permanency evaluation reports finding no loss of range of motion. Following litigation, in which the claimant’s treating physician conceded he had no medical reason as to why the claimant’s range of motion had decreased on his permanency review, the Workers’ Compensation Law Judge sided with our position and concluded that the claimant was not entitled to a permanency award.

Although this finding has been appealed by the claimant and the appeal is pending, the claim highlights the value of careful analysis of the pre-permanency and post-hearing permanency reports in order to review for the prospect of malingering and consideration of litigation in lieu of a compromise permanency award.

Appellate Division Disallowed WCL Case as Fungus Was Not “Condition Specific” to His Employment


The claim centers around a long-time employee and maintenance mechanic/planner at a Covanta Energy Corporation facility in Westbury, Nassau County, New York. Mr. Connolly’s work involved travel throughout all parts of the facility, including a cooling tower in which the claimant alleged he had seen “green plant life growing” and a boiler house that contained decomposing garbage. In 2011, he was diagnosed with allergic bronchopulmonary aspergillosis, which was the result of an exposure to aspergillus fungus. The claimant filed a claim for workers’ compensation alleging he had contracted the disease due to his work at Covanta. The carrier opposed, maintaining there was no sufficient evidence that the condition was causally related to his work activities.

Although the Workers’ Compensation Law Judge and Board Panel found there was substantial evidence supporting a finding of a causal relationship between the claimant’s work and his disease, the Third Department reversed that finding. Specifically, the court highlighted the medical testimony of the claimant’s treating physician, who conceded that the aspergillus fungus could be found nearly anywhere and that he could not pinpoint when or where the alleged exposure occurred at Covanta’s facility. The court also noted that the independent medical examiner testified that the aspergillus fungus could be found even in soil in the claimant’s own backyard and that the date and location of the claimant’s contracture could not be determined. Based on this medical testimony, the court concluded that the claimant “could have been exposed to [the fungus] anywhere at any time,” that even if the condition was present at the workplace, “it was not a condition specific to claimant’s job,” and that the medical evidence was simply insufficient to establish a causally related occupational disease. As such, the decisions of the Workers’ Compensation Board and Board Panel were reversed and the claim was dismissed.

Court of Appeals Upholds Medical Treatment Guidelines

On November 20, 2014, the Court of Appeals issued a long-awaited decision involving the Medical Treatment Guidelines. Under Matter of Kigin v. State of New York Workers’ Compensation Board, et al., 2014 NY Slip Op 08052, the primary issue on appeal was whether the Workers’ Compensation Board exceeded its statutory authority when it enacted certain portions of the Medical Treatment Guidelines. The Court of Appeals affirmed the Appellate Division’s holding that the Board did not exceed its statutory authority and a claimant’s due process rights were not violated by the enactment of the Medical Treatment Guidelines.

This decision is positive for employers and carriers because it means the Medical Treatment Guidelines are here to stay. The
Court held the Board did have the authority to create the Medical Treatment Guidelines in order to devise a preapproved list of medical treatments to be medically necessary for specific body sites. This includes treatment for the back, neck, shoulders, knees, and carpal tunnel syndrome. The court found the Board did so in a manner consistent with the Workers’ Compensation Law under Section 13 as well as the statutory framework in general.

The variance process in general is also upheld with this recent decision. The claimant had alleged the variance process was a denial of a claimant’s due process rights as the guidelines fail to provide an opportunity to be heard in a meaningful time and manner. The Court of Appeals disagreed and found a claimant’s due process rights are not violated as the variance procedure specifically provides a process for reviewing a denial of a variance request.

The court also affirmed the findings of the Appellate Division, which held that medical treatment falling outside the guidelines are predetermined and presumed not to be medically necessary. See Matter of Kigin v. State of New York Workers’ Compensation Board, et al., 109.A.D.3d 299 (3rd Dept. 2013). The court stressed that the medical provider’s burden to prove medical necessity is a threshold determination that must be made whenever a carrier properly and timely articulates an objection to a variance request. It continues to place the burden of proof on the claimant’s treating physician, rather than the employer or carrier, to prove why treatment outside the Medical Treatment Guidelines is medically necessary.

**Carrier Obligated to Pay ATF When Directed**

A claimant was classified with PPD in 2009 and the carrier was directed to make an ATF deposit. The employer filed an unsuccessful administrative appeal decided on December 28, 2009; on the same date, the Workers’ Compensation Law Judge issued another decision setting the ATF deposit at $127,241.44. The carrier appealed both decisions. The Board Panel upheld the decision 2–1, which entitled the carrier to a Full Board appeal. The Full Board upheld the decisions and imposed a $500 penalty for a frivolous appeal.

However, before the appeals were decided, the claimant actually died and the carrier requested ATF direction be rescinded. The Appellate Division held that the obligation to pay the lump sum into the ATF is fixed once the carrier is directed to pay it. The obligation is stayed with an appeal pending so long as timely payments continue to be made to the claimant. If the appeal is lost, however, the ATF payment is due, with interest, as of the date of the original direction. WCL Sec. 27(4) even includes that the rule shall apply “regardless of whether the widow or widower or other parties in interest have died.”

The court further ruled that the Board is not required to recalculate the amount of the payment to be made. The Appellate Division did overturn the frivolous appeal finding as the carrier was entitled to the appeal by virtue of the 2-1 Board Panel ruling. See Matter of Monahan v. Founders Pavilion and ATF, decided December 4, 2014.

**CONNECTICUT**

**Claimants Lose Argument to Increase AWW at Time of Permanency**

Recently, in Czyrko v. State of Connecticut, S901 CRB-6-13-12 (December 4, 2014), the claimant argued the appropriate average weekly wage (AWW) for computing permanent partial disability (PPD) benefits is the AWW on the date of the disability, which was more than double the amount of her AWW on the date of injury. The Compensation Review Board (CRB) disagreed and reasoned that since PPD benefits are compensation for the loss of the use of specific body parts over a claimant’s life, and not compensation for the inability to work, the appropriate AWW for computing PPD benefits is the AWW ending on the date of injury. Following the Czyrko decision, when claimants demand payment of PPD benefits, carriers should make sure that the AWW used in the calculation of benefits is the claimant’s AWW on the date of the accident, and not the date of the PPD determination.

**NEW JERSEY**

**Independent Contractor Defense Is Still Alive**


The claimant, Perry, a licensed horse trainer, trained horses owner Horowitz at the Meadowlands Race Track. After slipping on a patch of ice and sustaining serious injuries, Perry filed a workers’ compensation claim against Horowitz. The court of compensation determined that Perry was an employee of Horowitz, and Horowitz appealed.

The Appellate Division reviewed the two tests used to determine whether a worker is an employee versus an independent contractor: (1) the control test and (2) the relative nature of the work test. The court clarified that under the control test it considers such factors as evidence of right to control, right of termination, furnishing of equipment, and method of payment. The
relative nature of the work test focuses on the employee’s substantial economic dependence upon the employer and functional integration of their respective operations.

Perry took the position that Horowitz did exercise control over the methods he used to train the horses, including specifying the number of miles the horses would run, the method used to care for the horses’ feet, and the amount of food the horses were fed.

In applying the control test, the Appellate Division noted that Perry did not receive wages from Horowitz; he was not in a servant role for Horowitz; he did not receive a W-2 or 1099 form from horse owners; there were no deductions or withholdings from his compensation; he was not told what type of food to feed the horses; he was not supplied with the equipment, stalls, or food used to care for the horses; and he rented the stalls directly from the Meadowlands Race Track. Even though Horowitz specified how much food Perry should feed the horses, Perry fed them less because he did not believe in giving horses too much food. Application of the control test pointed toward an independent contractor relationship.

As to the relative nature of the of the work test, the Appellate Division noted that Perry’s work arrangement did not create a substantial economic dependence upon Horowitz. Perry relied on multiple owners for income over a 40-year career. He charged different rates for the horse owners depending on his financial situation at any given time.

Finding that Perry was running his own business as an independent contractor, the Appellate Division reversed. This decision highlights that an independent contractor defense will come down to the facts of each case. The independent contractor defense will undoubtedly remain difficult to prove, but it is still a viable defense.

**Non-Traditional Medical Benefits in Catastrophic Claims**


The claimant, Loeber, sustained a catastrophic injury that left him partially paralyzed and limited to a wheelchair. While the employer had previously agreed to certain types of modification to the first floor of Loeber’s home, he wanted other parts of the house renovated. The Judge of Compensation granted all of his requests. On appeal, the Appellate Division only partially affirmed some modifications such as: lifting the floor of the claimant’s family room to provide better access to the kitchen; modifying the kitchen to permit safe use; and reimbursement for installing a platform at the end of a wheelchair ramp leading to the rear entrance of Loeber’s house.

The Appellate Division reversed the Judge of Compensation’s decision to granting a home elevator for Loeber. He had requested the elevator to have access to the second floor of his home where his son’s bedroom was located, and to the basement where he wanted to perform woodworking. The Appellate Division found nothing in the record to demonstrate that the elevator was necessary or its costs reasonable. There was also no medical testimony to support the Judge of Compensation’s consideration of the psychological impact of the injury and need for the elevator.

If the requested renovation involves quality-of-life issues, such as an elevator, a respondent should insist on testimony from a medical expert, and also present an expert to address costs. Renovations that have to do with routine daily living and safety will not require a medical expert’s testimony.

**Claimants May Have More Than a Year to Reinflate Claims Dismissed for Lack of Prosecution if Medical Treatment Is Authorized by Carrier**

Employers should be cautious about authorizing additional treatment on a dismissed case. There is now wiggle room for restoring a case dismissed without prejudice, past the one year permitted in N.J.S.A. 34:15-54, as shown in *Planes v. Village Townhouse*, A-6026-12T3 (App. Div. November 25, 2014).

Planes’ case was initially dismissed on March 26, 2009, for lack of prosecution. The dismissal was vacated on October 22, 2009. There were delays in the case due to unrelated medical injuries that held up treatment for the compensable injury. In October 2010, the employer again requested a dismissal for lack of prosecution. Planes’ counsel requested an adjournment of hearing scheduled for December 16, 2010, due to a scheduling conflict. The Judge of Compensation denied the adjournment request and entered an order dismissing the case for lack of prosecution pursuant to N.J.S.A. 34:15-54, normally subject to reinstatement for good cause shown within a year of dismissal. The dismissal order included a note that the case could not be restored until claimant’s attorney was ready to settle or try the case. Following unrelated health roadblocks, Planes underwent authorized treatment on September 15, 2011. On May 17, 2012, his attorney moved to vacate the December 2010 dismissal order. The Judge of Compensation denied the motion.
The Appellate Division highlighted the fact that Planes had surgery within the one-year statutory period and his attorney did not have the doctor’s report until May 2, 2012. The motion to restore the case was filed two weeks later. The Appellate Division held that the Judge of Compensation could grant relief absent specific authority under N.J.S.A. 34:15-54. The matter could be restored if there was evidence to warrant equitable relief under Rule 4:50-1(f), especially if the respondent could not show prejudice due to restoring the case after the one-year statutory period. The Appellate Division remanded the case for further hearing.

Employers should be cautious about authorizing additional treatment on a dismissed case.

Court Says No to Fish and Chips

While either the claimant or the employer can make an application to commutation of workers’ compensation benefits, N.J.S.A. 34:15-25 requires the applicant to show that such a commutation is for the best interest of the claimant, such as: it will help the claimant avoid undue expenses or hardship, the claimant is on the verge of being removed from the United States, or the claimant has sold the “greater part of his business or assets.” Awards are structured to be paid incrementally, similar to ordinary wages, and the statute only allows commutation when unusual circumstances exist.

While a life-saving operation will rise to the level of unusual circumstances for commutating an award, paying debts, doctors, lawyers, or others will not. The Appellate Division examined whether starting up a business is a good basis for seeking commutation of an award in Jenkins v. L.A. Fitness, A-3570-12T2 (February 4, 2015). The claimant, Jenkins, asked the court of compensation to commutate $16,000 out of a remaining award of $28,000 so he could open a business selling fish and chips. He intended to build on his mother’s catering business, which currently had just a few customers and was in debt. Jenkins would need to purchase equipment and supplies, pay overdue rent, and pay off his mother’s debts. The Judge of Compensation found that Jenkins did not have a reasonable business plan and he was already financially overextended. She denied the request for the commutation. The Appellate Division agreed and affirmed the decision.

The Appellate Division did not rule out all business when commutation is being considered for a claimant. However, a less than sound business idea will not yield a commutated award.

Motion to Restore: Just Show Any Cause?

The following case demonstrates the difficulty in fighting a Motion to Restore a case within the permitted year. N.J.S.A. 34:15-54 permits a claim dismissed for lack of prosecution to be reinstated for “good cause shown” within a year of the dismissal. The Appellate Division examined the meaning of “good cause shown” in Williams v. Ready Pack, A-1689-13T2 (App. Div. January 23, 2015). The claimant, Williams, re-opened her claim and requested additional treatment. She was murdered before she could attend the employer’s independent medical examination. The Judge of Compensation subsequently dismissed the case when it was not moved. Williams’ attorney filed a motion to restore after 11 months. He could only show that he had written two letters in an attempt to find William’s representatives during that time. That was not good enough “cause show” according to the Judge of Compensation, who refused to reinstate the case. The Appellate Division disagreed and decided that Williams’ death was enough to get over the “good cause shown” requirement to restore the case. Such cases are inevitably restored.

PENNSYLVANIA

Employer Required to Create and Notify Employees of Medical Panels in Pennsylvania

An employer is responsible for the payment for reasonable surgical and medical services, including services rendered by physicians or other health care providers, when an employee is injured in the course and scope of employment. If an employer establishes a list of panel providers, the injured employee is required to treat with one of the designated panel providers for a period of 90 days from the date of the first visit. If the injured employee does not receive treatment from a panel provider, the employer is relieved from liability for the payment for services rendered during the applicable period.

The panel should consist of at least six designated health care providers. There can be no more than four coordinated care organizations on the panel. Additionally, there must be at least three physicians. If there is not a chiropractor on the list, the employer will be liable for the payment of the chiropractic treatment even with a list of panel providers if chiropractic treatment is proper for the injury sustained. See Martin v. WCAB (Emmaus Bakery), 652 A.2d 1301 (Pa. 1995).

Simply creating a panel is not enough. The employer must provide to the employee clearly written notification of the employee’s rights and duties concerning medical treatment. To establish that an employee has received the required notice, there must be a written acknowledgement signed by the employee. Failure to provide the notification and without proof that the notification was
received by the employee will result in the employee being able to treat outside of the panel provider list. Without the notification and proof of the notification, the employer will be liable for payment of all treatment provided to the employee.

All employees should sign the notification of the employee’s rights and duties concerning medical treatment (1) when hired, (2) when an injury is alleged, and (3) when there is a change to the list of panel providers. The signed notification should be maintained in the employee’s personnel file.

In addition to providing the employee with a list of panel providers, the employer should allow the employee to decide which of the listed panel providers they seek treatment with. The 2013 Workers’ Compensation Medical Access Study prepared by TLG Research Associates for the Bureau of Workers’ Compensation found that employees who had their right to choose respected reported better outcomes and higher satisfaction.

The list of panel physicians should be reviewed regularly, and changes to the list should be made when necessary. Employers should make certain that the panel providers have access to job descriptions in order to determine whether an injured worker is able to perform his or her time-of-injury job. Employers should also communicate with the panel physicians if there is a modified duty program and whether job duty modifications can be made. By working with the panel physicians and allowing injured employees to decide which panel provider to see, a better outcome should be achieved.

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Goldberg Segalla’s Workers’ Compensation Practice Group was founded on the premise that the prevailing model of defending employers in workers’ compensation claims was inefficient and inadequate. We developed our own unique practice model, one that involves handling each claim from beginning to end, staying abreast of even the most minor changes in interpretive language used by the courts, and developing strategies tailor-made for each unique situation.

For more information on Goldberg Segalla’s Workers’ Compensation Practice Group, please contact Damon M. Gruber at dgruber@goldbergsegalla.com.
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