STATEMENT OF DESIGNATION OF COUNSEL

Please use one form for each respondent.

MUR 5431

NAME OF COUNSEL: _____

FIRM: _____

ADDRESS: _____

_____

_____

TELEPHONE: (___) _____

FAX: (___) _____

The above-named individual is hereby designated as my counsel and is authorized to receive any notifications and other communications from the Commission and to act on my behalf before the Commission.

Joel Rosenwald
Print Name

4/15/04 _____ _____
Date Signature Title

RESPONDENT'S NAME: Comprehensive Health Care & Rehabilitation

ADDRESS: 148 Wilson Ave
Brooklyn NY

TELEPHONE: HOME( )

BUSINESS (718) 455-5500