

Â§ Acknowledgments and proofs without the state, but within the United States or any territory, possession, or dependency thereof. The acknowledgment or proof of a conveyance of real property situate in this state, if made (a) without the state but within the United States, (b) within any.

The new law amends Real Property Law, Section to establish statutory forms that must be used by corporations for acknowledgments. In addition, the new law enacts Real Property Law, Section a which sets out two new forms that must be used on conveyances and other instruments affecting real property located in New York. The new statutory forms are for use by any "person," which is defined to include "any corporation, joint stock company, estate, general partnership including any registered limited liability partnership or foreign limited liability partnership , limited liability company including a professional service limited liability company , foreign limited liability company including a foreign professional service limited liability company , joint venture, limited partnership, natural person, attorney in fact real estate investment trust, business trust or other trust, custodian, nominee or any other individual or entity in its own or any representative capacity. Beginning September 1, , the certificate of acknowledgment must conform substantially with one of two alternative forms in Section for the acknowledgment of a conveyance or other instrument by a corporation. See Corporate Acknowledgement Form These acknowledgment forms may be used immediately. However, these forms should not be used for the acknowledgment, within New York State, of conveyances or other instruments in respect to real property situate in this state that are executed on or after September 1, A certificate of such an acknowledgment must comply with Section a of the Real Property Law, which is discussed below. See Acknowledgement of Conveyance Form Beginning September 1, , acknowledgments must conform substantially with the new form, which may be used immediately. Section a also sets forth the certificate which must be used for a proof of execution by a subscribing witness, within New York State, of a conveyance or other instrument in respect to real property situate in this State. See Certificate of Subscribing Witness Form Beginning September 1, , certificates must conform substantially with the new form, which may be used immediately. A certificate or acknowledgment of proof by persons in or with the armed forces of the United States must include the additional information set forth in Section of the Real Property Law. In all other cases, use a form acknowledgment or proof that has been acceptable in the past. For example, the section forms for corporations or a traditional form of acknowledgment or proof for individuals, representatives and other entities may be used The following describes how the new law is to be implemented. Although the following focuses on acknowledgments, the rules for using the new form for proof by a subscribing witness are the same as those for use of the new acknowledgment: Acknowledgments taken within New York State: For all except corporations: Use either the new uniform acknowledgment or any form that has been acceptable in the past under New York law. Use either the new uniform acknowledgment or the Real Property Law, Section form. Use only the new uniform acknowledgment. Acknowledgments taken outside New York State: Use any form that has been acceptable in the past under New York law or a form that conforms to the law of the place where the acknowledgment is taken. Do not use the new uniform acknowledgment.

Chapter 2 : Office of General Counsel

Below is the uncorrected machine-read text of this chapter, intended to provide our own search engines and external engines with highly rich, chapter-representative searchable text of each book.

Advanced Search Every year, an influenza epidemic occurs that results in substantial global mortality and morbidity, as well as significant economic costs. The Centers for Disease Control and Prevention estimates that a mean of , excess hospitalizations occur and 36, Americans die every year because of influenza and its complications; therefore, influenza kills more Americans than does any other vaccine-preventable disease [1]. A mean of 1 in Americans will die of influenza and its complications by the end of the upcoming influenza season. This annual mortality continues despite the availability of influenza vaccines in the United States since the s. Nearly 70 years later, the public and some health care workers still have questions regarding influenza vaccine safety, efficacy, effectiveness, and cost-effectiveness of vaccination of adults, even though multiple studies and a review of the influenza vaccine data for healthy adults have convincingly revealed that vaccination is effective in preventing influenza virus infection [2].

What Were the Results of the Study? In this issue of *Clinical Infectious Diseases*, Nichol et al. The study assessed the burden of influenza-like illness (ILI) among University of Minnesota employees during the 2009 influenza season. Study data occurrence of ILI, symptoms, impact on work, and health care use were self-reported and collected by internet survey every month throughout the influenza season. Significant morbidity associated with ILI was evident among study participants. These improvements occurred despite findings that vaccinated persons were more likely to have functional impairments and chronic medical conditions and to take prescription drugs, which should have caused a bias against finding these results.

What Was the Importance of This Study? The study by Nichol et al. An important topic that is rarely addressed in these types of studies and that is worth highlighting is presenteeism. In the study by Nichol et al. The impact of significantly reduced work effectiveness in the workplace and school are obvious. What may be less obvious are the consequences of presenteeism, such as safety concerns. The use of an internet-based survey to rapidly evaluate influenza vaccine effectiveness was also a novel method. Currently, influenza vaccine effectiveness studies are often reported years after the season in which the study occurred; thus, the studies have only retrospective informational value. Internet-based surveys such as the one used by Nichol et al. Similarly, such technology could prove to be invaluable as a real-time information source to public health officials and private practitioners during the chaos of an influenza pandemic. Many studies have demonstrated the safety, efficacy, and cost-effectiveness of influenza vaccine among the elderly population and healthy working adults [6–14]. Studies such as the one by Nichol et al. These findings must be shared among health care workers, patients, health care media, and health care professional societies, to influence public health policy in a manner that benefits the public health. According to current knowledge about influenza vaccine, every adult should be offered influenza vaccine annually and should be educated by their physician about influenza and the influenza vaccine. In particular, when applying these findings to a health care setting, where transmission of virus from infected health care workers to patients occurs, strong consideration should be given to requiring influenza vaccination for health care workers as a condition of employment and renewal of credentials, to prevent absenteeism, presenteeism, and transmission to patients and other staff—outcomes that result in suboptimal patient safety and low-quality patient care [16 , 17]. A recent article on the ethics of requiring influenza vaccination for health care workers determined that, from a biomedical ethics point of view, health care institutions have an obligation to insure high rates of influenza vaccination among their staff and should use mandates to do so [18]. Although the Advisory Committee on Immunization Practices has signaled its intent to make this public health recommendation, the timeframe for implementation is 2–4 years away. In addition, studies similar to the one by Nichol et al. Consideration of such annual studies should be performed to improve the database on influenza vaccine effectiveness in subpopulations and across influenza seasons and to allow for the acquisition of real-time public health data. Continued efforts to develop more-effective vaccines especially for the elderly population , such as universal influenza vaccines that might prevent the burden of yearly vaccination

campaigns, and to develop comprehensive funding programs for adult vaccination should not be only aspirational goals, but should be explicitly grounded in public health policy and funding. This latter point is critical; although the United States has a comprehensive childhood vaccination program, it does not have a comprehensive adult vaccination program or adequate funding mechanisms for such a program. In view of the tremendous economic and health impact of influenza and the benefits of preventing it with vaccine, a comprehensive adult vaccination program should be instituted, and adequate funding should be provided for such a program. Data demonstrating vaccine safety, effectiveness, and efficacy need to be shared with policy makers who are unaware of the true magnitude of the annual morbidity and mortality and the negative annual economic impact associated with influenza. Individual health care workers, health care systems, and employers should have renewed and vigorous advocacy for the implementation of a vaccination program against annual widespread epidemic illness, unnecessary health care costs and deaths, increased work and school absenteeism and presenteeism, and huge direct and indirect economic costs. Health care workers, professional societies, and policy makers should demand that comprehensive public health programs and funding for adult vaccination programs, particularly for influenza vaccine, be accomplished. At a minimum, a comprehensive vaccination program should be implemented before the next influenza pandemic.

Acknowledgments Potential conflicts of interest.

Chapter 3 : Henderick Milton () | WikiTree FREE Family Tree

Acknowledgments and proofs without the state, but within the United States or any territory, possession, or dependency thereof. The acknowledgment or proof of a conveyance of real property situate in this state, if made (a) without the state but within the United States, (b) within any territory, possession, or dependency of the United States, or.

Advanced Search Abstract To obtain data on the clinical manifestations of infection, the age distribution, and the underlying conditions of children with influenza severe enough to lead to hospital referral, we performed a retrospective study of children treated at Turku University Hospital Turku, Finland in 1997. Influenza A or B antigen was detected in the nasopharyngeal aspirates of 15 children studied. The median age of children with influenza A was 2. One-fourth of the children had an underlying medical condition. High fever, cough, and rhinorrhea were the most frequently recorded symptoms. The study shows that the majority of patient hospitalizations for pediatric influenza involve previously healthy infants and young children. Laboratory confirmation of influenza is particularly important for children because the clinical presentation of the infection is less characteristic than that seen in adults. Influenza in children ranges from subclinical illness to complicated disease that affects multiple organs. In addition to its typical manifestation as respiratory tract and systemic signs and symptoms, influenza can present as croup, bronchiolitis, pneumonia, febrile disease mimicking bacterial sepsis, or, on occasion, CNS, cardiac, muscle, or renal complications [1-6]. Influenza predisposes the infected patient to bacterial superinfections, of which otitis media [7, 8] and pneumonia [9, 10] are the most common. It is difficult to diagnose influenza in young children on the basis of clinical grounds, because no specific signs or symptoms exist, and because other viral respiratory infections that present with fever also occur frequently during an influenza season [11]. Therefore, the influenza-associated morbidity among infants and young children may have been underestimated. Recently developed vaccines and antiviral drugs offer new approaches to the prevention and treatment of influenza. Live, attenuated, intranasally administered vaccine is safe and effective for use in children [12]. The neuraminidase inhibitors zanamivir [13] and oseltamivir [14] have been shown to be effective in the treatment of influenza. Because the use of extensive vaccination against influenza among children is under discussion [15], more data are needed regarding the risk factors for severe disease and hospitalization for influenza. Awareness of the different clinical manifestations of influenza in children is particularly necessary when effective antiviral agents are available. We report the clinical presentation of laboratory-confirmed influenza A or B virus infection in children treated at a referral hospital. Patients and Methods Patients. This retrospective study involved children treated as inpatients or outpatients at the Department of Pediatrics, Turku University Hospital Turku, Finland, during the year period from 1997 through 1998. Most children are referred to the hospital by primary care givers. Children who had influenza A or B antigen detected in nasopharyngeal aspirates were identified by a review of the files of the Department of Virology, University of Turku Turku, Finland. The medical records of these children were reviewed to collect clinical data. The following underlying conditions were recorded: Only radiologically verified pneumonias were recorded. The influenza vaccination status of the study children could not be recognized, but, during the study period, influenza vaccines were rarely used for children in Finland. Detection of antigens in nasopharyngeal aspirates was used for rapid diagnosis of respiratory viral infections. Viral antigens were detected by indirect immunofluorescence in 1997, by indirect EIA in 1998, and by time-resolved fluoroimmunoassay from 1997 through 1998 [16]. In our laboratory, these methods of antigen detection have been found to have good sensitivity and specificity for the diagnosis of influenza, compared with serologic analysis [17] and immunoperoxidase staining of cell cultures [18]. A total of 15 nasopharyngeal aspirates were tested during the study period. Influenza A was detected in 10 children, and influenza B was detected in 5 children. Results Diagnosis and patient characteristics. Influenza A diagnoses were made during outbreaks of varying intensity that occurred in winter. The month of peak activity varied between December and May. Influenza B outbreaks occurred on a more irregular basis than did influenza A outbreaks. Figure 1 Distribution of influenza A diagnoses in relation to annual peak activity. Compiled data from 20 influenza seasons in 1997-1998. Figure 1 View large Download slide Distribution of influenza A diagnoses in

relation to annual peak activity. The median age of the children with influenza A was 2. Figure 2 shows the age distribution of the children. The frequency of influenza B also was high in infants. Boys were overrepresented in both groups of children those with influenza A and those with influenza B. One-fourth of the children had a chronic illness or another underlying condition table 1. Table 1 Demographic characteristics and history of children with pediatric influenza before referral to the Department of Pediatrics, Turku University Hospital Turku, Finland. Figure 2 Age distribution of children with influenza A infection top or influenza B infection bottom. Figure 2 View large Download slide Age distribution of children with influenza A infection top or influenza B infection bottom. Table 2 shows the signs and symptoms of influenza in the children at presentation. Table 2 Clinical findings, at presentation, for children with influenza. Table 2 View large Download slide Clinical findings, at presentation, for children with influenza. The rate of hospitalization was similar for children with influenza A or B infection. The median duration of hospitalization was 2. Encephalitis was diagnosed in 5 children, of whom 3 children with influenza A infection and 1 child with influenza B infection had an uneventful recovery. Influenza A possibly caused CNS infection in both a boy with a diagnosis of viral meningitis and a girl with seizures, confusion, and abnormal findings of electroencephalography. Four children with influenza A infection had status epilepticus. Of these 4 children, 2 had an uneventful recovery after undergoing short treatment with a ventilator, a 2-year-old previously healthy boy needed treatment with the ventilator for 7 days and then recovered with mild neurologic defects, and a 3-year-old girl with tuberous sclerosis died of status epilepticus without responding to treatment. Other severe or uncommon manifestations. A 3-year-old girl with Down syndrome and myeloid leukemia was given a diagnosis of myocarditis and cardiac failure associated with influenza A infection. Two other female infants with Down syndrome, who were aged 5 months and 1 year, needed ventilator treatment for severe influenza A pneumonia, as did a 2-week-old female infant born with multiple anomalies. A 6-year-old girl had *Staphylococcus aureus* laryngotracheitis as a complication of influenza A infection. Myositis was diagnosed in 3 boys with influenza B, who were 6, 8, and 11 years of age. A 3-year-old girl with acute lymphoblastic leukemia died of progressive pneumonia of polymicrobial etiology 5 weeks after influenza A virus was detected. A male infant who had a severe neurologic defect caused by birth asphyxia died of bronchiolitis due to concomitant influenza A and respiratory syncytial viral infections. Serum C-reactive protein CRP concentrations were normal or only slightly increased in most children table 3. Blood for culture was obtained from children. One culture yielded *Stenotrophomonas maltophilia* interpreted as a pathogen. The results of cultures of spinal fluid samples obtained from 45 children were negative.

Chapter 4 : EK_'s Profile | Smule

Acknowledgments and proofs without the state, but within the United States or any territory, possession, or dependency thereof. The acknowledgment or proof of a conveyance of real property situate in this state, if made (a) without the state but within the United States, (b) within any territory, possession, or dependency of the United States, or (c) within any place over which the United.

Find articles by R. Sue Kirkman Find articles by M. Readers may use this article as long as the work is properly cited, the use is educational and not for profit, and the work is not altered. This article has been cited by other articles in PMC. Several approved or experimental treatments for type 1 and type 2 diabetes e. However, defining remission or cure of diabetes is not as straightforward as it may seem. The distinction between successful treatment and cure is blurred in the case of diabetes. Presumably improved or normalized glycemia must be part of the definition of remission or cure. Glycemic measures below diagnostic cut points for diabetes can occur with ongoing medications e. Do we use the terms remission or cure for all patients with normal glycemic measures, regardless of how this is achieved? The opinions and recommendations expressed herein are those of the authors and not the official position of the American Diabetes Association. Medically, cure may be defined as restoration to good health, while remission is defined as abatement or disappearance of the signs and symptoms of a disease 3. Implicit in the latter is the possibility of recurrence of the disease. Many clinicians consider true cure to be limited to acute diseases. Infectious diseases could be seen as a model: The consensus group considered the history of childhood acute lymphoblastic leukemia, which evolved from a uniformly fatal disease to one that could be put into remission to one that can now often be considered cured 4. Conversely, chronic myelocytic leukemia is now considered to be in prolonged remission, but not cured, with therapies such as imatinib. For a chronic illness such as diabetes, it may be more accurate to use the term remission than cure. Additionally, if cure means remission that lasts for a lifetime, then by definition a patient could never be considered cured while still alive. Hence, it may make sense operationally to consider prolonged remission of diabetes essentially equivalent to cure. This is analogous to certain cancers, where cure is defined as complete remission of sufficient duration that the future risk of recurrence is felt to be very low. Abnormal glucose metabolism leading to hyperglycemia defines the disease diabetes, yet hyperglycemia exists on a continuum and the diagnosis of the disease occurs at levels sufficiently high to be associated with the diabetes-specific complication retinopathy. The group modeled its consensus definitions somewhat on terminology that exists for certain malignancies, with hyperglycemia analogous to tumor load. Cancer may initially be put into remission, either partial substantial reduction in tumor load or complete no evidence of tumor. Eventually, the duration of a complete remission is felt to be sufficient such that the risk of recurrence is likely to be low, and such a prolonged remission might operationally be considered a cure. However, unlike tumor size in people with cancer, glucose levels in people with diabetes may fluctuate greatly from day to day. In a patient with type 2 diabetes, for example, improved or normal glycemia that occurs after only a few days of a stringent diet should certainly not be considered remission. Otherwise, patients could be in and out of remission constantly. The minimum duration of improved or normal glycemia that must occur before being labeled remission was the subject of great debate, and in the end the group consensus was to be conservative. Additionally, although glycemic measures just below the diabetic cut points could be defined as absence of the disease diabetes, the group considered impaired glucose homeostasis a sign of minimal residual disease and hence only a partial remission. The group was unable to reach a consensus on the incremental value of oral glucose tolerance testing, beyond the more convenient A1C and FPG tests, in defining remission. The authors agreed upon the following definitions, which are the same for type 1 and type 2 diabetes: Remission is defined as achieving glycemia below the diabetic range in the absence of active pharmacologic anti-hyperglycemic medications, immunosuppressive medications or surgical ongoing procedures such as repeated replacements of endoluminal devices therapy. A remission can be characterized as partial or complete. Nondiabetic glycemia resulting from ongoing medications or repeated procedures such as in the dynamic phase of band adjustment after laparoscopic gastric banding would not meet the definition of

remission, as these interventions are considered treatment. Remission can be considered an outcome of devices e. For type 1 diabetes, remission could potentially be attained after immune modulating or islet-replacement therapies that do not require ongoing immunosuppression but not with transplants that require ongoing immunosuppression or future therapies such as an implanted artificial pancreas. Prolonged remission is complete remission that lasts for more than 5 years and might operationally be considered a cure. The 5-year period was chosen arbitrarily, since there are no actuarial data indicating the likelihood of relapse over various periods of time from the onset of normoglycemia. It is recognized that the risk of relapse likely remains higher for people with diabetes in remission than for age-, sex-, BMI-, and ethnicity-matched individuals who have never had diabetes. In addition to hyperglycemia, diabetes is characterized by specific microvascular or nonspecific cardiovascular complications. Diabetes management includes treating cardiovascular risk factors, such as hypertension and dyslipidemia, often to more stringent goals than those for patients who do not have diabetes. People with diabetes also need regular screenings for the microvascular complications of the disease, such as retinopathy and nephropathy. If a patient is in remission from diabetes, do they still require diabetes-specific treatment goals and screening protocols, and if so, for how long? The consensus group considered both issues to be a function of risk over time. For cardiovascular disease, the very high risk that diabetes imparts is unlikely to be modified quickly, if ever, by amelioration of hyperglycemia, particularly if the usual coexisting risk factors are still present. For diabetes-specific complications such as retinopathy, risk for incident complications is likely to decline significantly with prolonged normoglycemia, while established complications would likely need ongoing monitoring indefinitely. When complete remission exceeds 5 years, goals appropriate for a patient without diabetes could be considered, as long as the patient remained without recurrence of diabetes and without cardiovascular events. Once a complete remission exceeds 5 years, complication screening might occur at a reduced frequency depending on the status of each complication. Completely stopping screening for a particular complication should be considered only if there is no history of that complication. These definitions and consensus recommendations, summarized in Table 1 , are based on what the consensus group felt to be reasonable given the therapies of today. The authors hope that this article will engender active discussion in the field. As new therapies of curative intent emerge for type 1 and type 2 diabetes and actuarial and scientific evidence regarding prognosis builds, these issues will surely require further deliberation. The group acknowledges the presence of inevitable potential intellectual conflicts of interest related to their scientific and medical interests. No other potential conflicts of interest relevant to this article were reported. Adjustable gastric banding and conventional therapy for type 2 diabetes: Can diabetes be cured? Potential biological and mechanical approaches. Between remission and cure: Chronic Illness ; 3:

Chapter 5 : How Do We Define Cure of Diabetes?

Acknowledgments Index What People are Saying About This. Descartes' Error: Emotion, Reason, and the Human Brain out of 5 based on 0 ratings.

Chapter 6 : Stormwater Management

Contributor Up to \$ Acknowledgments We extend our gratitude to the Mercy ~ Chafty Memorial Golf Outing Committee: Tom Goldenbogen, Chair Sharon Adams.

Chapter 7 : Table of Contents | Social Media Mining

Acknowledgments Acknowledgments Landscape Ecol Eng () DOI /sy International Consortium of Landscape and Ecological Engineering and Springer We appreciate the invaluable contributions of the following reviewers during the editing of Vol. 7 Nos.

Chapter 8 : Education at War

Acknowledgments List of Contributors Index Details. ISBN Published: Contributors. Edited: Arshad Imtiaz Ali. Arshad.

Chapter 9 : Acknowledgments : La Villa

These materials were designed for grades but may be adapted for other grade levels. For more information contact the Monterey Bay National Marine Sanctuary, Foam Street, Monterey, California