IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No.: _____

RON HENCEY, MARTIN BRAZELL,
GARY CAIN, MARTIN COTE,
PAUL DELL'AIRA, TOM FLOYD,
THAD KRUPA, CHRISTINE LOWRY,
COREY MAHJOUBIAN, STEVE MATACIA,
JOESEPH MILLER, GORDAN NIEBERGALL,
JOSEPH OKA, RHETT PANSANO, DERON REYNOLDS,
RICHARD SHERLOCK, GENO WASILEWSKI,
JEFF WISH, ROBERT ZERR, and MARIE GORHAM,

Plaintiffs,

v.

UNITED AIRLINES, INC., a Delaware Corporation;
UNITED STATES DEPARTMENT OF TRANSPORTION;
PETE BUTTIGIEG in his official capacity as
Secretary of the United States Department of Transportation;
UNITED STATES DEPARTMENT OF LABOR;
MARTIN J. WALSH in his official capacity as
Secretary of the United States Department of Labor;
FEDERAL AVIATION ADMINISTRATION;
and STEVE DICKSON in his official capacity
as Administrator of the Federal Aviation Administration;

Defendants,

_____/

PETITION FOR TEMPORARY RESTRAINING ORDER

COMES NOW, Plaintiffs, Ron Hencey, Martin Brazell, Gary Cain, Martin Cote, Paul Dell 'Aira, Tom Floyd, Thad Krupa, Christine Lowry, Corey Mahjoubian, Steve Matacia, Joseph Miller, Gordan Niebergall, Joseph Oka, Rhett Pansano, Deron Reynolds, Richard Sherlock, Geno Wasilewski, Jeff

Wish, Robert Zerr, and Marie Gorham, by and through undersigned counsel, hereby petitions[1] the Court for a Temporary Restraining Order seeking injunctive relief against Defendants, United Airlines Inc., a Delaware corporation ("United"); United States Department of Transportation ("DOT"); Pete Buttigieg, in his official capacity as Secretary of the United States Department of Transportation ("Buttigieg"); United States Department of Labor ("DOL"); Martin J. Walsh, in his official capacity as Secretary of the United States Department of Labor; Federal Aviation Administration ("Walsh"); and Steven Dickson, in his official capacity as Administrator of the Federal Aviation Administration ("Dickson") (collectively, "Federal Government Agencies") and states the following in support:

I. OVERVIEW

1. This matter is one of **national security** that warrants the Court's immediate attention, intervention, and the issuance of an emergency, temporary restraining order ("TRO") *for the immediate cessation of the unlawful, life-threatening, vaccine-mandate imposed by United*; as well as, any

[1] "The right to petition is cut from the same cloth as the other guarantees of [the First] Amendment, and is an assurance of a particular freedom of expression." *McDonald v. Smith*, 472 U.S. 479, 482 (1985). Further, the right to petition "extends to all departments of the Government," including administrative agencies. *Cal. Motor Transp. Co. v. Trucking Unlimited*, 404 U.S. 508, 611–12 (1972).

other airline companies contemplating same until the science/medicine is more fully developed and better understood[2].

2. Pursuant to Federal Rules of Civil Procedure 65 (b)(1)(A) & (B), attached for the Court's consideration are the affidavits of two (2) highly qualified, medical doctors, Dr. W. Ben Edwards and Dr. Steve McCullough, attached hereto as **Ex. A** and **Ex. B** respectively.

3. Under penalty of perjury, it is their expert, professional opinions as treating physicians and medical doctors that within a reasonable degree of medical certainty, **the COVID-19 vaccines[3] pose particularized, life-threatening dangers to pilots and those in the airline industry**.

4. Dr. Edwards and Dr. McCullough have no monetary incentive or proverbial 'dog in this fight'; indeed, they are "working on this case pro-bono; and have not been paid by Mr. Kenneth Ferguson Esq., Plaintiffs, or anyone else to provide this opinion." They have done so "because they have serious, grave concerns for these pilots and the public-at-large" (emphasis added).

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[2] Preferably until the legality of employer-mandated vaccines have been finally decided also.

[3] Plaintiffs and undersigned explicitly reject the term "vaccine" as a description of the injections approved under EUA for use in reducing the symptoms of COVID-19. The traditional definition of a vaccine as given by Cambridge Dictionary is "a substance containing a virus or bacterium in a form that is not harmful, given to a person or animal to prevent them from getting the disease that the virus or bacterium causes." This definition is the one relied upon by health care professionals and the lay public since vaccines first emerged, but recently has been altered in a number of places to allow for the synthetic and experimental material colloquially referred to as the "COVID-19 vaccines" to be included. Plaintiffs will refer to the injections of this material as the "vaccine" or "injection" for purposes of this filing but reject the categorization. *See* Compl. fn1, in 21-cv-702-CLM.

5. Excerpts from Dr. Edward's affidavit include:

In my expert medical opinion, **subjecting airline pilots to the emergency use authorized Covid-19 gene therapy injections would subject them to a greater risk of harm than any benefit**. The above opinion is based on the following:

i. Pilots are vigorously screened and monitored for health problems, and are generally regarded as extremely fit and healthy. So, they are at a very low risk for developing significant complications from an acquired infection with Covid-19.

ii. Multiple published studies as well as me and my colleagues' clinical experience shows that there are exceedingly effective early outpatient therapies for Covid-19 that can reduce hospitalization and mortality rates by 80-90%, even in an unhealthy, high-risk population.

iii. The full benefit of the vaccine is still not well established as we are still very, very early in the clinical trial phase and there are multiple early indicators that the current dominant Delta variant is not susceptible to being covered by the vaccine.

iv. A full understanding of the safety data and the probability of adverse reactions is still very difficult to estimate based off the fact the control group from the original study have now all received the vaccine, *the FDA and CDC have not held any briefings to update clinicians*, and we are relying on a self-reporting system that was relatively unknown to healthcare workers initially, is very cumbersome to use, is reportedly 2 months behind on data entry, and historically has been known to only report 1-10% of adverse reactions. ***But, despite all of that, there are still more deaths reported to VAERS, in excess of 12,000 now, than all other vaccines combined over the previous 2 decades***. ***Many of the adverse***

outcomes and deaths are related to blood clotting problems, including stroke, heart attack, and pulmonary embolism. It is well established that airline travel, due to altitude and prolonged sitting, is a risk factor for blood clotting problems.

v. ***Lastly, the fact that pilots are responsible for the lives of the crew and passengers onboard their aircraft, there is even more of burden of proof on the individual or entity who is attempting to mandate the pilots be subjected to take part in the is clinical trial of covid-19 vaccine to prove that the benefit clearly outweighs the risk and that there are no viable alternatives***. It is my very firm and sincere opinion that this standard has not been met by the mandating entities.

6. Excerpts from Dr. McCullough's affidavit include:

I believe within a reasonable degree of medical certainty that the COVID-19 vaccine(s) ***are not safe generally; and particularly dangerous for airline pilots***. ***It is my belief based on a reasonable degree of medical certainty that the vaccine could cause the death of airline pilots and that their lives are in danger should they be administered the vaccine and travel at high altitudes***. I believe within a reasonable degree of medical certainty that the data upon which United Airlines has based its mandate upon is flawed and/or inaccurate; ***and imposing this vaccine is not only dangerous and could cause harm to the pilots, but to their passengers and the public-at-large***.

I have seen and examined adolescent patients with post-COVID-19 myocarditis which typically occurs two days after the injection, most frequently after the second injection of mRNA products (Pfizer, Moderna).

The US FDA has given an update on the JNJ vaccine concerning the risk of cerebral venous sinus thrombosis and thrombosis with thrombocytopenia in women ages 18-48 associated with low platelet counts. ***This complication causes a variety of stroke-like syndromes that can involve the cranial nerves, vision, and coordination. Blood clots in the venous sinuses of the brain are difficult to remove surgically and require blood thinners sometimes with only partial recovery***. In some cases, special glasses are required to correct vision and these young adults can be expected to miss considerable time away from school undergoing neurological rehabilitation. ***Because this risk is not predictable no woman under age 48 under any set of circumstances should feel obliged to take this risk with the JNJ vaccine***. Such catastrophic neurologic thrombotic events could occur in pilots on duty during flight [citation omitted]

Additionally, the US FDA has an additional warning for Guillen-Barre Syndrome ***or ascending paralysis for the JNJ vaccine which is not predictable and when it occurs can result in ascending paralysis, respiratory failure, the need for critical care, and death***. Not all cases completely resolve, and some vaccine victims may require long term mechanical ventilation, or become quadra- or paraplegics.

To my knowledge, there are no studies that demonstrate the clinical benefit of COVID-19 vaccination in COVID-19 survivors or those with suspected COVID-19 illness or subclinical disease who have laboratory evidence of prior infection… Thus, it is my opinion that the COVID-19 vaccination is contraindicated in COVID-19 survivors many of whom may be in the student population.

It is my expert medical opinion that it is not good research or clinical practice to widely utilize novel biologic therapy (mRNA, adenoviral DNA COVID-19 vaccines) in populations where there

> is no information generated from the registrational trials with the FDA, specifically COVID-19 survivors, suspected COVID-19-recovered, pregnant or women who could become pregnant at any time after investigational vaccines; and especially pilots. In my expert medical opinion, the risks associated with the investigational COVID-19 vaccines far outweigh any theoretical benefits, are not minor or unserious, and many of those risks are unknown or have not been adequately quantified nor has the duration of their consequences been evaluated or is calculable. Therefore, in my expert medical opinion, the Emergency Use Authorization and administration of COVID-19 vaccines for pilots creates an unethical, unreasonable, clinically unjustified, unsafe, and poses an unnecessary risk to the pilots of the United States of America. Likewise, in my medical expert opinion, the mandatory, administration of COVID-19 vaccines in pilots creates unnecessary risk to pilots, flight crew, and the airline passengers of the United States of America.

II. PARTIES

7. Plaintiffs are employee-pilots of Defendant, United Airlines, Inc. (hereinafter collectively, "Plaintiffs", or incorporated by reference, collectively, as "Pilots", "Americans", or "We the People"). Plaintiffs have been subjected to United's unlawful, invasive, discriminatory, and unbridled mandate whereby the Pilots and other employees are forced to either be stripped of their livelihood and employment; or be injected with a novel vaccine which not only unlawfully infringes on their Constitutionally protected rights, but also places them at a particular and significant risk of harm with the enhanced possibility of heart failure and clotting working at high altitudes that transport numerous souls aboard their aircraft who entrust the Pilots to fly them safely to their

destinations on a daily basis. These twenty (20) Plaintiffs named below have a combined total of over 259 years of military aviation and 490 Years of commercial aviation.

a. RONALD E. HENCEY Captain B787, DENFTC, 42 years as a Commercial Pilot

b. MARTIN BRAZELL, F/O B756, DENFTC, 24 years as a Commercial Pilot / 27 years Military Pilot

c. GARY CAIN, Captain A320, DEN, 21 years as a Commercial Pilot / 21 years Military Pilot

d. MARTIN COTE, F/O B787, DENFTC, 24 years as a Commercial Pilot / 21 years Military Pilot

e. PAUL DELL'AIRA, F/O B777 EWR, 26 years as a Commercial Pilot / 10 years Military Pilot

f. TOM FLOYD, Captain 737, ORD, 20 years as a Commercial Pilot / 22 years Military Pilot

g. THAD KRUPA, F/O B756, DENFTC, 26 years as a Commercial Pilot

h. CHRISTINE LOWRY, F/O B787, EWR, 20 years as a Commercial Pilot / 10 years Military Pilot

i. COREY MAHJOUBIAN, F/O B777, EWR, 26 years as a Commercial Pilot

j. STEVE MATACIA, F/O B787, DCA, 27 years as a Commercial Pilot / 28 years Military Pilot

k. JOESEPH MILLER, F/O B777, EWR, 17 years as a Commercial Pilot

l. GORDAN NIEBERGALL, F/O B787, SFO, 23 years as a Commercial Pilot / 25 years Military Pilot

m. JOSEPH OKA, F/O B787, ORD, 27 years as a Commercial Pilot / 10 years Military Pilot

n. RHETT PANSANO, F/O B787, IAH, 31 years as a Commercial Pilot

o. DERON REYNOLDS, F/O B777, EWR, 24 years as a Commercial Pilot / 25 years Military Pilot

p. RICHARD SHERLOCK, F/O B787, DENFTC, 31 years as a Commercial Pilot

q. GENO WASILEWSKI, F/O B757, DENFTC, 24 years as a Commercial Pilot/21 years Military Pilot

r. JEFF WISH, Captain A320, DEN, 24 years as a Commercial Pilot / 28 years Military Pilot

s. ROBERT ZERR, F/O A320, DENFTC, 26 years as a Commercial Pilot / 11 years Military Pilot

t. MARIE GORHAM, F/O A320, DENFTC, 28 years as a Commercial Pilot

8. Defendant, United Airlines, Inc. ("United"), is a large, major American airline headquartered at Willis Tower in Chicago, Illinois. United operates a large domestic and international route network with a fleet of roughly 834 aircraft and 67,000 employees. United is the employer of the Plaintiff-employees.

9. Defendant, United States Department of Transportation ("DOT") was established by an act of Congress on October 15, 1966, whose mission is to "ensure America has the safest, most efficient and modern transportation

system in the world…and enhance the quality of life in communities both rural and urban."

10. Defendant, Pete Buttigieg, is serving as the United States Secretary of Transportation and will be sued in his official capacity as Secretary of the United States Department of Transportation ("Buttigieg").

11. Defendant, United States Dept of Labor ("DOL"), is a cabinet-level department of the U.S government responsible for among other things, occupational safety and health, wage and hour standards, and unemployment benefits.

12. Defendant, Martin J. Walsh, is serving as the United States Secretary of Labor and will be sued in his official capacity as Secretary of the United States Department of Labor ("Secretary Walsh").

13. Defendant, Federal Aviation Administration ("FAA"), is the largest transportation agency of the U.S. government and regulates all aspects of civil aviation in the country, as well as, over surrounding international waters.

14. Defendant, Stephen Dickson, currently serves as the Administrator of the Federal Aviation Administration ("Dickson") and will be sued in his official capacity.

III. BACKGROUND & FACTS

15. On or about May 5, 2020, United Airlines imposed a mask mandate for its passengers and flight crews, as well as, personnel working in United's offices and Training Center in Denver, Colorado. The effectiveness of masks in stopping the spread of COVID-19 is not backed by scientific data; and studies have shown that wearing a mask for extended periods of time can be injurious to overall health.

16. On or about May 24, 2021, the pilots at United Airlines, were presented an "incentive" to receive the Covid vaccine. This "incentive" was significant; and the amount of pay was based on when the first shot was obtained. On a sliding scale, the amount could be as much as $4,500. This "incentive" is unlawfully coercive and discriminatory; and potentially even criminal.

17. Plaintiffs believe the COVID cases and deaths presented to the pilot group to justify the push to vaccinate the pilots are inaccurate; and it is widely known the PCR tests oftentimes produce false positives. Furthermore, the deaths listed as "COVID deaths" include high-risk individuals with numerous co-morbidities which is not applicable to fit pilots who are checked annually and semi-annually for fitness. Plaintiffs will allege and ultimately prove that United Airlines has not been transparent as to the actual number of employee-covid cases and deaths; and has either manufactured these numbers or have not kept this information confidential according to law.

18. In the Spring of 2021, United Airlines informed Training Center employees, which includes numerous pilots, that vaccinated employees were no longer required to wear masks within the Training Center. However, unvaccinated employees must wear masks at all times (unless actively eating or drinking). Additionally, anyone not wearing a mask is to carry their vaccination card to prove mask exemption status as vaccinated to anyone who requests proof. Unvaccinated individuals not wearing a mask are subject to disciplinary action up to and including termination. This is facially discriminatory, violative of constitutional rights, and so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency and utterly intolerable in a civilized community.

19. On August 6, 2021, United then announced a vaccine mandate for employees. The mandate requires all employees to be vaccinated no later than five weeks after FDA vaccine approval, or five weeks after September 20, 2021, whichever comes first. Employees not vaccinated by October 25, 2021, will be terminated. Plaintiffs believe the vaccines to be unsafe in general and specifically unsafe for pilots. Blood clots, vison impairment, neurological issues, and heart issues, are among the many vaccine-related injuries; and the overall responsibility for passengers and crew, falls to the pilots. In short, Plaintiffs believe this mandate is a danger to themselves, as well as, the general flying public. *See also* Exhibits A, Exhibit B.

20. Pilots conduct their duties based on factual data. For example, aircraft airworthiness and pilot performance duties require rigorous testing and substantial verified safety data, before implementation – none of that is present here with the novel MRNA vaccines. In turn, the airline industry has experienced extreme strains and stressors since the onset of Covid which has impacted Pilots' flight as reflected in United Airlines' safety data. Flight Operations Quality Assurance or "FOQA", has shown that since the onset of Covid, there has been an increase in the pilot "error rate." Prior to flight, pilots are required to brief numerous items. Previously not included in these briefings but later added due to the now known error rate was the change to include "personal threats" which incorporates the novel, Covid-induced stress. The vaccine mandate is a safety concern that has severely impacted and increased their "personal threat" stress as many of the pilots do not want to take the vaccine but struggle with the idea they could lose their livelihoods if they don't and in turn, are unsure what to do. This is supported by objective evidence as reflected in the number of pilots who have taken sick leave after the "personal threat" was incorporated in to the briefing.

21. United Airlines' mandate and policies are discriminatory at best, predicated on misinformation or disinformation, and places the pilots and general public at dire risk. In fact, on August 12, 2021, the Master Executive Counsel of the Airline Pilots Association acknowledged "The new Company

COVID-19 vaccine requirement is an issue that has the potential to cause distractions on the flight deck. We must remain professional as we work to effectively manage this threat to ensure it does not lead to errors." The combination of increased potential for blood clots and other vaccine-related health issues constitute an emergency safety situation that necessitates the Court's immediate attention and intervention (emphasis added).

22. A TRO is necessary not only because the Plaintiffs themselves face the threat of irreparable harms, imminent bodily injury, or death absent a TRO, but the public-at-large is unknowingly being exposed to similar immanent harms, bodily injury, or death as well (i.e., passengers on-flight and civilians).

Attorney Certification

A. Notice

23. Pursuant to and in accordance with Fed. R. Civ. P. 65(b)(1)(B), Undersigned Counsel certifies that I attempted to call and speak with whom I had reason to believe to be the Vice President-Regulatory and/or the Policy Managing Director-International Affairs & Regulatory at United to provide notice but was unsuccessful in my efforts as no one answered.

24. Undersigned was, however, able to reach James F. Conneely, who I believe is an in-house attorney working at Untied with the title "Managing Counsel-Regulatory." Undersigned identified himself, who he was representing, and conveyed that the purpose of his call was to provide United

notice that he was representing the Plaintiffs, that he plans to file suit against them in the future, and was seeking preliminary injunctive relief or a temporary restraining order ("TRO") regarding the company's unlawful, discriminatory vaccine mandate and the specific dangers the vaccines pose to their employees being in the airline industry. Undersigned's intent and desire was to provide proper notice for the injunctive relief and later a courtesy copy of the complaint to an email address and was put on hold. After roughly 2 two minutes, Mr. Conneely stated that I would need to contact their registered agent in Florida, CT Corp, and serve them with the lawsuit. When attempting to explain the urgency of the situation regarding the injunction and/or a request for a TRO given the life-threatening, health concerns of their employees, Mr. Conneely responded with something to the effect of: "he wasn't going to help me sue them" which was shortly followed by Mr. Conneely hanging up on me. Candidly, I was taken back by my perceptions of Mr. Conneely's callous indifference and lack of concern toward the lives of the people who make the company function; which buttresses the argument below as to why notice is unnecessary – I believe United Airlines does not care.

B. Why Notice Should Not Be Required

25. Pursuant to and in accordance with Fed. R. Civ. P. 65(b)(1)(B), I believe such exigent circumstances exist that notice should not be required and the Court should have no reservations issuing the temporary restraining order as

requested. What is at stake is literally a matter of life and death; not only for the United employees but the public-at-large. Put in context, should a pilot and co-pilot both capitulate into taking the vaccine (or even taken it freely, knowingly, and voluntarily) and express or experience some of the symptoms or conditions that Dr. Edwards and Dr. McCullough are worried about as articulated in their affidavits at 36,000 ft., their passengers and the public can only pray and hope that at least 1 of the '300 souls on-board[4]' know how to fly and land an aircraft (emphasis added).

26. Plaintiffs have undoubtedly satisfied their four obligations for the Court to issue a TRO as evidenced throughout this filing. *See Long v. Sec'y, Dep't of Corrs.*, 924 F.3d 1171, 1176 (11th Cir. 2019) (listing factors to include: (1) a substantial likelihood of success on the merits, (2) that irreparable injury will be suffered if the relief is not granted, (3) that the threatened injury outweighs the harm the relief would inflict on the other litigant, and (4) if issued, the injunction would not be adverse to the public interest); *see also Studebaker Corp. v. Griffin*, 360 F.2d 692, 694 (2d Cir. 1966); *United States v. Lynd*, 301 F. 2d 818, 823 (5th Cir. 1962) ("The grant of a temporary restraining injunction need not await any procedural steps perfecting the pleadings"); *National Organization for Reform of Marijuana Laws v. Mullen*, 608 F.Supp.

[4] "Souls on board" is a term-of-art in the airline industry for the number of passengers on the aircraft which also serves as a reminder that people's lives are in their hands.

945, 950 n. 5 (N.D. Cal. 1985) ("[o]wing to the peculiar function of the preliminary injunction, it is not necessary that the pleadings be perfected, or even that a complaint be filed, before the order issues").

i. Substantial Likelihood of Success on the Merits

Parties "are not required to prove their claim, but only to show that they [are] likely to succeed on the merits." *Glossip v. Gross*, 135 S. Ct. 2726, 2792 (2015); *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008). Given the nature, number, and moreover, the substance and obvious egregiousness of the allegations set forth, there is a substantial likelihood Plaintiffs will prevail on the merits of its suit which is germane to the relief sought. *See Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 66 (2020) (finding a similar §1983 action was likely to prevail as to Governor's emergency Executive Order imposing occupancy restrictions on houses of worship during COVID-19 pandemic).

The Parties and the claims are properly before this Court. This Court has jurisdiction over the subject matter for reasons under 28 U.S.C §1332 as the matter in controversy exceeds the sum of seventy-five thousand dollars ($75,000) exclusive of interest and costs and between citizens of different states; 28 U.S.C. §1331 and 28 U.S.C. §1343 because the matters in the controversy arise under the Constitution and laws of the United States and since this action seeks redress for the deprivation, under color of state law, the

rights, privileges, and immunities secured by the Constitution of the United States, as well as, Federal and state law; 5 U.S.C. §§701, et sec., as Plaintiffs are persons who are suffering legal wrongs because of agency action or adversely affected due to same; 42 U.S. Code §2000e–5; the declaratory judgment act pursuant to 28 U.S.C. §§2201-02; and the Court's inherent equitable powers. Venue is proper in this district under 28 U.S.C. §1391(b), (c), and (d) as at least one of plaintiffs' claims arose in Florida, many of the acts complained of occurred in this judicial district, and an agency-office is located within this district.

United has given its employees an unconscionable ultimatum which among other things, grossly violates *numerous* provisions of the Constitution: choose between their jobs[5] which afford them the ability to feed, clothe, and house their families – or – take an experimental, life-threatening vaccine which evidence suggests not only does more harm than good; but poses greater risks to those in the airline industry (emphasis added). This is facially absurd considering *at minimum*, two highly qualified doctors have provided affidavits under penalty of perjury stating that in their professional medical opinions, the COVID-19 vaccines which United Airlines is imposing upon its employees can not only kill them, induce clots, or cause paralysis, but remarkably, Dr.

[5] Or as described in *Truax*, "the right to earn a living by a calling for one's choice." *Truax v. Raich*, 239 U.S. 33, 41, (1915).

Edwards and Dr. McCullough were both very clear that these perils are more likely to manifest in pilots. And given the disproportionate, harmful impact this has on those in the airline industry, it begs the question where are the Federal Government Agencies whose mission statements or purpose for their existence like the Federal Aviation Administration's is to "ensure America has the safest, most efficient and modern transportation system in the world?[6]" To that end, as the vaccines have been rolling out since December 2020[7] and Plaintiff-Ron Hencey has sought agency intervention who responded stating that it was not within their jurisdiction, Plaintiffs will likely succeed on the merits and the Court will exercise its mandamus authority and compel these agencies to act and fulfill their obligations.

Plaintiffs will almost certainly prevail on the merits of their claims relating to the vaccine mandate as violative of Plaintiffs' religious beliefs and right to privacy/health concerns whether they are ultimately averred as a §1980, Title VII, or EEOC action[8]. Likewise, Plaintiffs will also likely prevail in their suit against United's patently discriminatory mask decree whereby only the "unvaxxed" must wear a mask for similar reasons as the vaccine

[6] https://www.faa.gov/about/plans_reports/media/FAA_Strategic_Plan_Final_FY2019-2022.pdf
[7] https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020
[8] "In expounding a statute, we must not be guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy." *United States v. Boisdore 's Heirs*, 8 How. 113, 122, 12 L.Ed. 1009 (1849) (Taney, C.J.,); *Mastro Plastics Corp. v. NLRB*, 350 U.S. 270, 285, 76 S.Ct. 349, 359, 100 L.Ed. 309 (1956); *Richards v. United States*, 369 U.S. 1, 11, 82 S.Ct. 585, 592, 7 L.Ed.2d 492 (1962); *Dandridge v. Williams*, 397 U.S. 471, 517 (1970).

mandate; as well as, more nuanced, esoteric causes of action like the Genetic Information Non-discrimination Act of 2008 ("GINA"). Upon examination of the legislative history and intent behind GINA, the irony, hypocrisy, and United's culpability *per-se* is on full display:

> In 2008, Congress enacted the Genetic Information Non-discrimination Act of 2008 (GINA), which prohibits discriminatory practices on the basis of genetic information in respect to employment. In enacting the statute, Congress made findings that while advances in medical technology provide many opportunities for early detection and prevention of illness, those advances also "give rise to the potential misuse of genetic information to discriminate in health insurance and employment." Congress also found that it has "a compelling public interest in relieving the fear of discrimination and in prohibiting its actual practice" and that "Federal legislation establishing a national and uniform basic standard is necessary to fully protect the public from discrimination and allay their concerns about the potential for discrimination, thereby allowing individuals to take advantage of genetic testing, technologies, research, and new therapies." 42 U.S.C.A. § 2000ff note. In the context of a motion for class action certification for a GINA claim, the United States District Court for the Eastern District of New York in *Hawkins v. Jamaica Hospital Medical Center* noted that GINA represents a congressional determination that "a request or requirement for genetic information in the employment context is itself harmful," because of the "risk and fear of invidious discrimination on the basis of such genetic information," such that a violation of the statute cannot be viewed as a mere technical violation. *Hawkins v. Jamaica Hospital Medical Center Diagnostic and Treatment Center Corp.*, 2018 2018 WL 3134415, *4 (E.D. N.Y. 2018).[9]

Put in context, if the purpose of the legislation was to "promote a national, uniform standard to fully protect the public from discrimination and allay their

[9] *See* L. Camille Hébert, Employee Privacy Law | June 2021 Update in §12:8. Genetic Information Non-discrimination Act of 2008, 2 Empl. Privacy Law § 12:8 and citations, references therein.

concerns about the potential for discrimination", then certainly having United employees ***literally wear their private, medical information on their face*** is violative of GINA as a matter of law (emphasis added).

Finally, the Court ought to grant the TRO/injunction because of the likelihood Plaintiffs will prevail on its declaratory judgment actions which are rooted in common sense stemming from our Country's origins. Indeed, "the road to hell is paved with good intentions" and Plaintiffs submit that decades of congressional legislation signed by Presidents that have seeped by the judiciary for *at least* the past six decades has slowly whittled away Americans' inherent constitutional rights; sacrificing them at the altar of attempting to remedy turbulent political climates that these same institutions seemingly created. For clarity, this is not something attributable solely to the present, Biden administration nor is one particular party to blame. For instance, just this week, on August 06, 2021, Democrat Rep. Ritchie Torres recently introduced legislation to ban passengers from travel for those who are not vaccinated[10]; meanwhile, on August 09, 2021, Republican Sen. Ted Cruz introduced legislation to ban all mask and vaccine mandates in their entirety[11]. The reasons why Torres' bill ought to be swiftly struck down as unconstitutional and Cruz's bill wholly unnecessary are applicable here. In the

[10] https://www.congress.gov/bill/117th-congress/house-bill/4980/titles
[11] https://www.cruz.senate.gov/?p=press_release&id=5999

main, Torres' bill is facially repugnant to the Constitution while Cruz's merely restates rights we already have as Americans. Should any behavior inconsistent with Constitutional rights ever be considered, such decisions ought to be made in accordance with and pursuant to the traditions our founders intended and the Constitution – they must be left for the States. *See Home Building & Loan Ass'n v. Blaisdell*, 290 U.S. 398, 54 S.Ct. 231, 235, 78 L.Ed. 413, 88 A.L.R. 1481 speaking through its Chief Justice:

> 'Emergency does not create power. Emergency does not increase granted power or remove or diminish the restrictions imposed upon power granted or reserved. The Constitution was adopted in a period of grave emergency. Its grants of power to the federal government and its limitations of the power of the states were determined in the light of emergency, and they are not altered by emergency. Wheat power was thus granted and what limitations were thus imposed are questions which have always been, and always will be, the subject of close examination under our constitutional system.

See also, U.S. Const. art. IV, § 4; U.S. Const. amend. IX; *Highland Farms Dairy v. Agnew*, 300 U.S. 608, 612 (1937) ("How power shall be distributed by a state among its governmental organs is commonly, if not always, a question for the state itself."); *Cohens v. State of Virginia*, 19 U.S. 264, 313, 5 L. Ed. 257 (1821) ("All the powers not granted are retained by the States"); *See also Marbury v. Madison,* 5 U.S. 137, 138, 2 L. Ed. 60 (1803) ("An act of congress repugnant to the constitution cannot become a law… The courts of the United States are bound to take notice of the constitution.").

Within strict and heavily guarded parameters, **all** Americans have certain, fundamental, inalienable rights and civil liberties that cannot be abridged ("Rights"). These Rights – like freedom of religion[12]; privacy or "the right to be let alone—the most comprehensive of rights and the right most valued by civilized man[13]"; meaningful access to courts[14]; people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures[15]; cruel and unusual punishment[16]; or the right to earn a living by a calling for one's choice[17] are not mutually exclusive and importantly, emanate from the same source: The United States Constitution.

While the preamble to the Constitution may not itself be a source of power[18], if nothing else it memorializes our Nation's objectives and serves as a constant reminder why "***WE THE PEOPLE of the United States***…" have consented to be governed by our chosen electorate (emphasis added). In other words, Americans have agreed to forgo absolute freedom in exchange "to form a more perfect Union, establish Justice, insure domestic Tranquility, provide for the common defence, promote the general Welfare, and secure the Blessings

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[12] U.S. Const. amend. I
[13] See *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (dissent).
[14] "It is beyond dispute that the right of access to the courts is a fundamental right protected by the Constitution." *Graham v. Nat'l Collegiate Athletic Ass'n*, 804 F.2d 953, 959 (6th Cir.1986).
[15] U.S. Const. amend. IV
[16] U.S. Const. amend. VIII
[17] *Truax v. Raich*, 239 U.S. 33, 41, (1915); *In re Griffiths*, 413 U.S. 717 (1973).
[18] *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 22, 25 (1905)

of Liberty to ourselves and our Posterity…[19]" This social contract is codified in the Constitution and is between We the People and our government which is comprised of *our chosen electorate*. This cannot be overstated – it is the pulse of this lawsuit and the source of Plaintiffs' (if not most Americans) grievance: the Constitution outlines the contours as to how the United States will operate; and expressly delineates certain Rights which the government promises to uphold and our armed forces swears to protect. This agreement is between Plaintiffs/Americans/We the People and our chosen electorate – not Big Tech, not Big Pharma, or any other corporation like United (collectively "Private Corporations"). *See e.g., Marsh v. State of Ala.*, 326 U.S. 501 (1946) (posing the question: "Can those people…be denied freedom of press and religion simply because a single company has legal title to all the town?).

It is axiomatic that Plaintiffs are protected from certain rights being infringed upon by the government which they have consented to be governed by; yet Congress and the judiciary have held that Private Corporations cannot be held liable for the same infringements[20] barring certain, rare exceptions[21]. Rhetorically, why would Americans be okay with having a legal vehicle to sue government "persons" who infringe their constitutional rights whose purpose

[19] Preamble, U.S. Const.
[20] *See e.g., Civil Rights Cases*, 109 U.S. 3, 11, 3 S.Ct. 18, 21, 27 L.Ed. 835 (1883); *Shelley v. Kraemer*, 334 U.S. 1, 13, 68 S.Ct. 836, 842, 92 L.Ed. 1161 (1948).
[21] *See e.g., Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 926 (1982); or alternatively involved in a conspiracy *United States v. Price*, 383 U.S. 787, 794 (1966).

is to serve and protect them, but be deprived a legal remedy from Private Corporations who violate the same rights but whose sole purpose is to profit off their backs?

Put another way, both federal and state government, along with their respective laws, rules, and regulations, are only able to exist because We the People allow them to. Americans relinquish absolute freedom and *with their consent*, have agreed to be governed by those they elect so long as it is within the letter and spirit of the Constitution. Notwithstanding the Pandemic, United made **14.593 billion dollars** up through June 2021; which was only made possible **because of the hard work of its employees**[22]. Now, this same entity is forcing Plaintiffs, the life-blood of United's existence, to make a choice of either taking a shot that can kill them or face termination? Consider also that over 50% of the named-plaintiffs (many more to follow) served in the armed forces – people who have literally put their lives on the line – so that We the People have an opportunity to succeed and advanced which is the only reason why United is able to prosper (emphasis added). Suffice to say it does not take the anecdotal 'sophisticated astuteness of a Philadelphia lawyer[23]' to appreciate why Plaintiffs have been harmed, will likely prevail on the merits of the constitutional and discriminatory practices, and why Plaintiffs and

[22] https://www.macrotrends.net/stocks/charts/UAL/united-airlines-holdings-inc/revenue
[23] *See Russell v. Equifax A.R.S.*, 74 F.3d 30, 34 (2d Cir. 1996)

frankly most Americans are angry with such private mandates and proposed, government legislation.

In sum, Plaintiffs will likely prevail because United cannot abridge certain fundamental unalienable rights simply because they have "Inc." behind their name. The mandate and unlawful, discriminatory practices like paying employees more money who are vaccinated than those who are not; and requiring employees to wear a mask who are not vaccinated and those who are do not, are clear violations of Constitutional rights including freedom of religion, privacy, the right for people to be secure in their persons, houses, papers, and effects, against unreasonable searches and seizures, and cruel and unusual punishment. Plaintiffs will likely prevail because United's actions are repugnant to the Constitution, and simply because United is a corporation is not an excuse and cannot be used as an instrument for circumventing federally protected rights.

ii. Irreparable Injury Will be Suffered and iii. Threatened Injury Outweighs Harm Relief Would Inflict on United

Absent the requested relief, each of the pilots' and airline attendants' lives stand to be inexorably and irreparably altered forever; if not ended. The same holds true for those passengers the pilots are flying. The pilots are under immediate threat of concrete harm; and as the Plaintiffs will attest, it has and will continue to have an adverse impact on their flight-performance if the

threat is not neutralized. This is unsafe and reckless at best; and the pilots and public need the Court's help (emphasis added). The relief sought would not harm United anymore than the risks, costs, and harms they have already realized, appreciated, and accounted for prior to the imposition of the mandate.

Furthermore, objective, lay-facts demonstrate why this is facially absurd, without justification, and why Plaintiffs and those similarly situated should not be forced to barter with or into picking-and-choosing between which of their fundamental, Constitutional rights they have to sacrifice "to earn a living by a calling of their choice.[24]" First, according to the Center of Disease Control and Prevention ("CDC")[25], if you are under the age of seventy (70) years old (encompasses all Plaintiffs), the chances of surviving COVID-19 is roughly ninety-nine percent (99%) or almost the same as influenza ("the flu")[26]. Second, as conveyed in the affidavits attached, studies have shown the vaccine's effectiveness against COVID and the latest "delta-variant" is de minimis[27] or does more harm than good. Finally, there is no risk or harm in keeping the status quo as it was pre-mandate (emphasis added). This is buttressed by the fact that neither the Department of Labor, Department of Transpiration, ***nor the Federal Aviation Administration*** have sanctioned such

[24] *Truax* at 41 (1915) (alteration added)
[25] https://tallahasseereports.com/2020/09/26/cdc-releases-updated-covid-19-fatality-rate-data/
[26] https://www.cdc.gov/nchs/fastats/flu.htm
[27]https://www.wsj.com/articles/pfizer-covid-19-vaccine-is-less-effective-against-delta-infections-but-still-prevents-serious-illness-israel-study-shows-11627059395

recommendations or required the vaccine be administered to Plaintiffs. To the contrary and in part why these agencies are named-defendants, in light of the data/evidence that is known, that what is unknown, and that which Plaintiffs believe to be hidden from public disclosure, their failure to act or intervene is a problem in itself and a wholesale dereliction of their congressionally prescribed duties of the respective offices. Plaintiffs pleading with the Court to merely maintain the status-quo prior to the inception of the mandate so that no harms can be done to the employees or the public-at-large by its enforcement.

iv. The Injunction would not be Adverse to the Public Interest

As this filing articulates and as supported by the affidavits attached, the relief sought would not be averse to the public interest; to the contrary, Plaintiffs are asking the Court to prevent the imposition of the mandate in large because the public is safer without it.

WHEREFORE, based on the foregoing, Plaintiffs respectfully request that the Court grant the relief requested and preserve the status quo by (a) enjoining United and preferably the airline industry from imposing vaccination mandates at least until the science and medicine is more concrete and fully developed; (b) enjoining United from discriminating how they enforce their mask policy differently for the unvaccinated than those who are not vaccinated; (c) enjoin United from any retaliatory conduct against the named-

plaintiffs and those who refuse to get the vaccine; and any further relief the Court deems just and proper.

Respectfully submitted this 13th day of August, 2021.

FERGUSON LAW, P.A.
Attorney for Plaintiffs
1323 Southeast 3rd Avenue
Fort Lauderdale, Florida 33316
T – (954) 256 – 5646
F – (954) 256 – 5655
Service: Service@FergusonLawPA.com
E-Mail: Wayne@FergusonLawPA.com

/s/ Kenneth W. Ferguson
Kenneth W. Ferguson, Esq.
FBN: 98950

EXHIBIT A

AFFIDAVIT OF DR. W. BEN EDWARDS

BEFORE ME, the undersigned person, duly authorized to administer oaths, personally appeared, Dr. W. Ben Edwards, MD, to me well known, who, after being first duly cautioned and sworn, deposed and stated as follows:

1. My name is Dr. Ben Edwards, I am over eighteen years of age, and I am not suffering under any mental disability and am competent to give this sworn affidavit. I am able to read and write and to give this affidavit voluntarily and on my own free will and accord. No one has used any threats, force, pressure, or intimidation to make me sign this affidavit. I understand that I am swearing or affirming under oath to the truthfulness of the claims made in this affidavit under penalties of perjury; that I have read these statements in this affidavit; and these statements are my understanding of the facts and that my opinion provided is based on a reasonable degree of medical certainty. I am working on this case Pro Bono; and have not been paid by Mr. Kenneth Ferguson Esq., Plaintiffs, or anyone else to provide this opinion. I am providing this affidavit as I have serious, grave concerns for these pilots and the public-at-large.

2. I have personal knowledge and understanding of these matters and I make this affidavit in support of the truth of the contents contained herein. In short: I believe within a reasonable degree of medical certainty that the COVID-19 vaccine(s) are not safe generally; and particularly dangerous for airline pilots. It is my belief based on a reasonable degree of medical certainty that the vaccine could cause the death of airline pilots and that their lives are in danger should they be administered the vaccine and travel at high altitudes.

I believe within a reasonable degree of medical certainty that the data upon which United Airlines has based its mandate upon is flawed and/or inaccurate; and imposing this vaccine is not only dangerous and could cause harm to the pilots, but to their passengers and the public-at-large. In support, I submit the following for the Court's consideration.

3. As for my qualifications, I received a bachelor's degree from Baylor University, I completed my medical degree from the University of Texas Houston Medical School. I went on to complete my family medicine residency at McLennan County Medical Education and Research Foundation in Waco, TX, including service as Chief Resident. I have furthered my education with a Fellowship in Integrative Medicine from the Academy of Comprehensive Integrative Medicine.

4. Regarding my clinical experience, I spent my first 7 years of practice as the only physician in the county at the Garza County Health Clinic in Post, Texas practicing family medicine and urgent care. In 2012, I established an integrative medical clinic, Veritas Medical, in Lubbock, Texas and have expanded to 3 clinic locations in Abilene, San Angelo and Lubbock. Veritas Medical is an integrative medical practice that focuses on complex, medical symptoms of unknown etiology. Our typical patients have exhausted all conventional medical options without relief of symptoms. Integrative practitioners have extra training in immune system dysregulation and inflammatory processes in the body.

5. Since the outset of the pandemic, we have been treating patients successfully in our clinic with protocols that have been developed in collaboration with colleagues from around the country and world. As I'm sure the Court can appreciate, this unprecedented challenge has required physicians on the front lines to not only consider the opinions of

public health officials and agencies but also our clinical experience and judgment at the bedside. I have formed my opinions in close communications with many clinicians around the world as well as closely following the published literature on the outbreak.

As to my Expert Opinion

6. In my expert medical opinion, subjecting airline pilots to the emergency use authorized Covid-19 gene therapy injections would subject them to a greater risk of harm than any benefit. The above opinion is based on the following as well:

i. Pilots are vigorously screened and monitored for health problems, and are generally regarded as extremely fit and healthy. So, they are at a very low risk for developing significant complications from an acquired infection with Covid-19.

ii. Multiple published studies as well as my and my colleagues' clinical experience shows that there are exceedingly effective early outpatient therapies for Covid-19 that can reduce hospitalization and mortality rates by 80-90%, even in an unhealthy, high-risk population.

iii. The full benefit of the vaccine is still not well established as we are still very, very early in the clinical trial phase and there are multiple early indicators that the current dominant Delta variant is not susceptible to being covered by the vaccine.

iv. A full understanding of the safety data and the probability of adverse reactions is still very difficult to estimate based off the fact the control group from the original study have now all received the vaccine, the FDA

and CDC have not held any briefings to update clinicians, and we are relying on a self-reporting system that was relatively unknown to healthcare workers initially, is very cumbersome to use, is reportedly 2 months behind on data entry, and historically has been known to only report 1-10% of adverse reactions. But, despite all of that, there are still more deaths reported to VAERS, in excess of 12,000 now, than all other vaccines combined over the previous 2 decades. Many of the adverse outcomes and deaths are related to blood clotting problems, including stroke, heart attack, and pulmonary embolism. It is well established that airline travel, due to altitude and prolonged sitting, is a risk factor for blood clotting problems.

v. Lastly, the fact that pilots are responsible for the lives of the crew and passengers onboard their aircraft, there is even more of burden of proof on the individual or entity who is attempting to mandate the pilots be subjected to take part in the is clinical trial of covid-19 vaccine to prove that the benefit clearly outweighs the risk and that there are no viable alternatives. It is my very firm and sincere opinion that this standard has not been met by the mandating entities.

I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE UNITED STATES OF AMERICA THAT THE FOREGOING IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND UNDERSTANDING.

Dr. W. Ben Edwards, M.D.

JURAT AND VERIFICATION

STATE OF TEXAS

COUNTY OF LUBBOCK

The foregoing instrument was acknowledged before me by means of ☒ physical presence or ☐ online notarization, this August 11th, ~~2020~~ 2021 by W. Ben Edwards, who is personally known to me:

Paula J. Hines

[Notary Seal] Notary Public

PAULA J. HINES
Notary Public, State of Texas
Notary ID# 635032-5
My Commission Expires 07-05-2024

PAULA J. HINES

Name typed, printed or stamped

My Commission Expires: 7-5-2024

EXHIBIT B

AFFIDAVIT OF DR. PETER MCCULLOUGH, MD, MPH

BEFORE ME, the undersigned person, duly authorized to administer oaths, personally appeared, Dr. Peter McCullough, MD, MPH, to me well known, who, after being first duly cautioned and sworn, deposed and stated as follows:

1. My name is Dr. Peter McCullough, MD, MPH, I am over eighteen years of age, and I am not suffering under any mental disability and am competent to give this sworn affidavit. I am able to read and write and to give this affidavit voluntarily and on my own free will and accord. No one has used any threats, force, pressure, or intimidation to make me sign this affidavit. I understand that I am swearing or affirming under oath to the truthfulness of the claims made in this affidavit under penalties of perjury; that I have read these statements in this affidavit; and these statements are my understanding of the facts and that my opinion provided is based on a reasonable degree of medical certainty. I am working on this case Pro Bono; and have not been paid by Mr. Kenneth Ferguson Esq., Plaintiffs, or anyone else to provide this opinion. I am providing this affidavit as I have serious, grave concerns for these pilots and the public-at-large.

2. I have personal knowledge and understanding of these matters and I make this affidavit in support of the truth of the contents contained herein. In short: I believe within a reasonable degree of medical certainty that the COVID-19 vaccine(s) are not safe generally; and particularly dangerous for airline pilots. It is my belief based on a reasonable degree of medical certainty that the vaccine could cause the death of airline pilots and that their lives are in danger should they be administered the vaccine and travel at high altitudes. I believe within a reasonable degree of medical certainty that the data upon which United Airlines has based its mandate upon is flawed and/or inaccurate; and imposing this vaccine is not only dangerous and could cause harm to the pilots, but to their passengers and the public-at-large. In support, I submit the following for the Court's consideration:

3. After receiving a bachelor's degree from Baylor University, I completed my medical degree as an Alpha Omega Alpha graduate from the University of Texas Southwestern Medical School in Dallas. I went on to complete my internal medicine residency at the University of Washington in Seattle, a cardiology fellowship including service as Chief Fellow at William Beaumont Hospital, and a master's degree in public health in the field of epidemiology at The University of Michigan. I am board certified in internal medicine and cardiovascular disease and hold an additional certification in clinical lipidology, and previously echocardiography. I participate in the maintenance of

certification programs by the American Board of Internal Medicine for both Internal Medicine and Cardiovascular Diseases. I am on the active medical staff at Baylor University Medical Center and Baylor Jack and Jane Hamilton Heart and Vascular Hospital, in Dallas, Texas. I practice internal medicine and clinical cardiology as well as teach, conduct research, and I am an active scholar in medicine with roles as an author, editor-in-chief of two peer-reviewed journals, editorialist, and reviewer at dozens of major medical journals and textbooks. I am a Professor of Medicine, Texas Christian University and the University of North Texas Health Sciences Center School of Medicine.

4. I have led clinical, education, research, and program operations at major academic centers (Henry Ford Hospital, Oakland University William Beaumont School of Medicine) as well as academically oriented community health systems. I spearheaded the clinical development of in vitro natriuretic peptide and neutrophil gelatinase associated lipocalin assays in diagnosis, prognosis, and management of heart and kidney disease now used worldwide. I also led the first clinical study demonstrating the relationship between severity of acute kidney injury and mortality after myocardial infarction. I have contributed to the understanding of the epidemiology of chronic heart and kidney disease through many manuscripts from the Kidney Early Evaluation Program Annual Data Report published in the American Journal of Kidney Disease and participated in clinical trial design and execution in cardiorenal applications of acute kidney injury, hypertension, acute coronary syndromes, heart failure, and chronic cardiorenal syndromes. I participated in event adjudication (involved attribution of cause of death) in trials of acute coronary syndromes, chronic kidney disease, heart failure, and data safety and monitoring of antidiabetic agents, renal therapeutics, hematology products, and gastrointestinal treatments. I have served as the chairman or as a member of over 20 randomized trials of drugs, devices, and clinical strategies. Sponsors have included pharmaceutical manufacturers, biotechnology companies, and the National Institutes of Health.

5. I frequently lecture and advise on internal medicine, nephrology, and cardiology to leading institutions worldwide. I am recognized by my peers for my work on the role of chronic kidney disease as a cardiovascular risk state. I have over 1,000 related scientific publications, including the “Interface between Renal Disease and Cardiovascular Illness” in Braunwald’s Heart Disease Textbook. My works have appeared in the New England Journal of Medicine, Journal of the American Medical Association, and other top-tier journals worldwide. I am a senior associate editor of the American Journal of Cardiology. I have testified before the U.S. Senate Committee on Homeland Security and Governmental Affairs, the U.S. Food and Drug Administration Cardiorenal Advisory Panel

and its U.S. Congressional Oversight Committee, The New Hampshire Senate, the Colorado House of Commons, and the Texas Senate Committee on Health and Human Services. I am a Fellow of the American College of Cardiology, the American Heart Association, the American College of Physicians, the American College of Chest Physicians, the National Lipid Association, the Cardiorenal Society of America, and the National Kidney Foundation; and I am also a Diplomate of the American Board of Clinical Lipidology. In 2013, I was honored with the International Vicenza Award for Critical Care Nephrology for my contribution and dedication to the emerging problem of cardiorenal syndromes. I am a founding member of Cardiorenal Society of America, an organization dedicated to bringing together cardiologists and nephrologists and engage in research, improved quality of care, and community outreach to patients with both heart and kidney disease. I am the current President of the Cardiorenal Society of America, an expert organization dedicated to advancing research and clinical care for patients who have combined heart and kidney disease. I am the Editor-in-Chief of Cardiorenal Medicine, a primary research journal listed by the National Library of Medicine which is the only publication with a primary focus on research concerning patients with combined heart and kidney disease. Finally, I am the Editor-in-Chief of Reviews in Cardiovascular Medicine, a widely read journal that publishes reviews on contemporary topics in cardiology and is also listed by the National Library of Medicine.

6. Since the outset of the pandemic, I have been a leader in the medical response to the COVID-19 disaster and have published "Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection," the first synthesis of sequenced multidrug treatment of ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine and updated in Reviews in Cardiovascular Medicine. I have 45 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine. Through a window to public policymakers, I have contributed extensively on issues surrounding the COVID-19 crisis in a series of OPED's for The Hill in 2020. I testified on the SARS-CoV-2 outbreak in the U.S. Senate Committee on Homeland Security and Governmental Affairs on November 19, 2020. I testified on lessons learned from the pandemic response in the Texas Senate Committee on Health and Human Services on March 10, 2021, and on early treatment of COVID-19 at the Colorado General Assembly on March 31, 2021. Additionally, I testified in the New Hampshire Senate on legislation concerning the investigational COVID-19 vaccine on April 14, 2020. My expertise on the SARS-CoV-2 infection and COVID-19 syndrome, like that of infectious disease specialists, is approximately 18 months old with the review of hundreds of manuscripts and with the care of many patients with acute COVID-19, post-COVID-19

long-hauler syndromes, and COVID-19 vaccine injury syndromes including neurologic damage, myocarditis, and a variety of other internal medicine problems that have occurred after the mRNA and adenoviral DNA COVID-19 vaccines. I have formed my opinions in close communications with many clinicians around the world based on in part our collective clinical experience with acute and convalescent COVID-19 cases as well as closely following the preprint and published literature on the outbreak. I have specifically reviewed key published rare cases and reports concerning the possible recurrence of SARS-CoV-2 in patients who have survived an initial episode of COVID-19 illness.

As to my Expert Opinion

7. The CDC recently reported the lowest number of cases since March of 2020 (the beginning of the COVID-19 pandemic). Sam Baker & Andrew Witherspoon, COVID-19 cases hit lowest point in U.S. since pandemic began, AXIOS (June 3, 2021), https://www.axios.com/coronavirus-cases-infections-vaccines-success-fa7673a1-0582-4e69-aefb-3b5170268048.html

8. Further, according to my research, herd immunity is calculated by a specific formula, as follows: ((CC*6) + V + (.15*P)) ÷ P = HIN.

CC= COVID-19 cases in the state
6= the current CDC multiplier
V= number of vaccinated in the state
15% = the number of people in a given state that will not get COVID-19
P=Population of a state
HIN=Herd Immunity Totals

By this method of calculation, the United States has achieved herd immunity meaning that the total of this calculation exceeds 100%. As vaccines continue to fail, we can expect cases of COVID-19 and the meaning of herd immunity applies to spread. Despite expected incidents and prevalent cases, my opinion is that spread will be minimized and there will be no more large outbreak curves as the country experienced in November through early January before the advent of widely deployed early treatment protocols. Because the randomized trials of all COVID-19 vaccines revealed < 1% absolute risk reductions, and the recent observation of widespread failure of COVID-19 vaccines in countries such as Israel which has a substantial population vaccinated early the pandemic, we can expect

more vaccine failures in the United States and no fundamental impact of mass vaccination on the epidemic curves.

Table 1: COVID-19 Deaths by Age Group in the U.S. as of June 27, 2021: Source: https://COVID-19.cdc.gov/COVID-19-data-tracker/#demographics

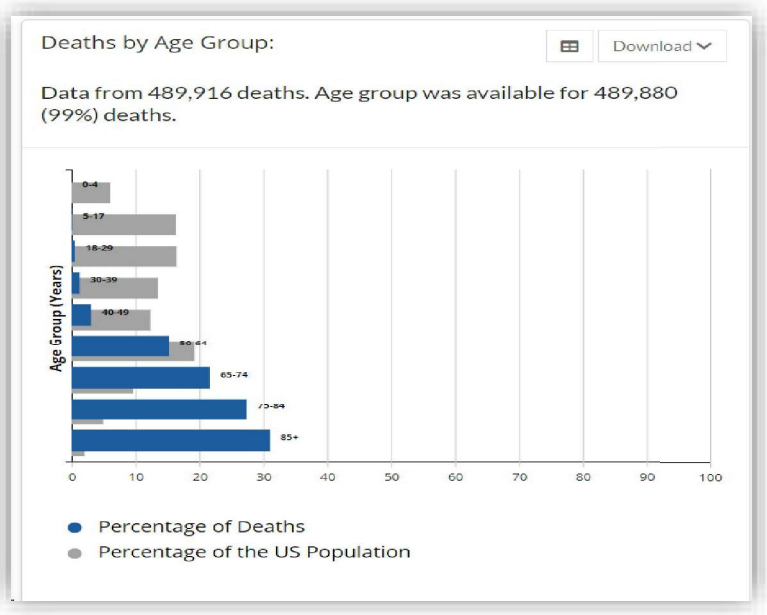


Table 2: COVID-19 Rate Ratios by Age. Source https://www.cdc.gov/coronavirus/2019-ncov/COVID-19-data/investigations-discovery/hospitalizationdeath-by-age.html

Risk for COVID-19 Infection, Hospitalization, and Death By Age Group

Updated June 24, 2021 Print

Rate ratios compared to 18- to 29-year-olds[1]

	0-4 years old	5-17 years old	18-29 years old	30-39 years old	40-49 years old	50-64 years old	65-74 years old	75-84 years old	85+ years old
Cases[2]	<1x	1x	Reference group	1x	1x	1x	1x	1x	1x
Hospitalization[3]	<1x	<1x	Reference group	2x	2x	4x	6x	9x	15x
Death[4]	<1x	<1x	Reference group	4x	10x	35x	95x	230x	610x

All rates are relative to the 18- to 29-year-old age category. This group was selected as the reference group because it has accounted for the largest cumulative number of COVID-19 cases compared to other age groups. Sample interpretation: Compared with 18- to 29-year-olds, the rate of death is four times higher in 30- to 39-year-olds, and 610 times higher in those who are 85 years and older. (In the table, a rate of 1x indicates no difference compared to the 18- to 29-year-old age category.)

9. There is negligible risk for adults younger than the age of 60. For example, for each 18-29-year-old that dies from COVID-19, four 30-39year olds die, ten 40-49-year-olds die, thirty-five 50-64-year-olds die, ninety-five 65-74-year-olds die, 230 75-84-year-olds die, and 610 over 85 years of age die. See Table 2.

10. In my expert medical opinion, the epidemic spread of COVID-19, like all other respiratory viruses, notably influenza, is driven by symptomatic persons; asymptomatic spread is trivial and inconsequential.

11. A meta-analysis of contact tracing studies published in The Journal of the American Medical Association showed asymptomatic COVID-19 spread was negligible at 0.7%. Zachary J. Madewell, Ph.D.; Yang Yang, Ph.D.; Ira M. Longini Jr, Ph.D.; M. Elizabeth Halloran, MD, DSc; Natalie E. Dean, Ph.D., Household Transmission of SARS-CoV-2: A Systematic Review and Meta-analysis, JAMA Network Open, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102 (last visited June 20, 2021).

12. Accordingly, a rational and ethical prevention measure to reduce the spread of COVID-19 is a simple requirement, as part of formal policies, that persons with active symptomatic, febrile (feverish) respiratory illnesses, like COVID-19, should isolate themselves. Indeed, during the H1N1 influenza A pandemic, fully open, unmasked college campuses were advised by federal health officials, "Flu-stricken college students should stay out of circulation" and "if they can't avoid contact they need to wear surgical masks." Great Falls Tribune, Advice: Flu-stricken college students should stay out of circulation, August 21, 2009, page 5, section A, available at https://www.newspapers.com/image/243611045

Advances in COVID-19 Treatments

13. Even if the virus is contracted, the treatment of the infection has improved tremendously since the advent of COVID-19. Studies have shown several different treatment methods, which have proven effective. A combination of medications, supported by the Association of American Physicians and Surgeons, for a minimum of five days and acutely administered supplements used for the initial ambulatory patient with suspected and or confirmed COVID-19 (moderate or greater probability) has proven effective. Brian C Procter, Casey Ross, Vanessa Pickard, Erica Smith, Cortney Hanson, Peter A McCullough, Clinical outcomes after early ambulatory multidrug therapy for high-risk SARS-CoV-2 (COVID-19) infection, Reviews in Cardiovascular Medicine (December 30, 2021), available at https://rcm.imrpress.com/EN/10.31083/j.rcm.2020.04.260 (last visited June 26, 2021), summarized in Table 3 below. This approach has resulted in an ~85% reduction in hospitalization and death in high-risk individuals presenting with COVID-19 (https://ijirms.in/index.php/ijirms/article/view/1100):

Table 3: COVID-19 Treatments

Agent (drug)	Rationale
Zinc	Inhibits SARS-CoV-2 RNA synthesis
Hydroxychloroquine 200 mg po bid	Inhibits endosomal transfer of virions, anti-inflammatory
Ivermectin (200 mcg/kg) usual dose nuclear12 mg po qd x 3 days nucleus	Attenuates importin á/â-mediated transport of SARS-CoV-2 into
Azithromycin 250 mg po bid	Covers respiratory bacterial pathogens insecondary infection
Doxycycline 100 mg po bid	Covers respiratory bacterial pathogens in secondary infection

Inhaled budesonide, Dexamethasone 8 mg IM	Treats cytokine storm
Folate, thiamine, vitamin B-12	Reduce tissue oxidative stress
Intravenous fluid	Intravascular volume expansion

14. I, along with my colleagues, conducted the study referenced in paragraph 23, which evaluated patients between the ages of 12 and 89 years. The average age was 50.5 and 61.6% were women. The study found that primary care physicians can treat COVID-19 patients resulting in rates of hospitalization and death. The study showed that administration of the medicines and supplements shown in Table 3 produces a less than 2% chance of facing hospitalization or death among high-risk adults (age over 50 with medical problems). As this study was done with mainly higher-risk patients at the peak of the pandemic, this is a highly successful treatment plan and just one of the many new treatments that have been used in the last year including those admitted for COVID-19 which are covered in the NIH COVID-19 Guidelines. Id.; see also National Institutes of Health, Therapeutic Management of Adults With COVID-19 (Updated May 24, 2021), https://www.COVID-1919treatmentguidelines.nih.gov/management/therapeutic-management/ (last visited June 21, 2021).

15. Treatment has improved so drastically for COVID-19 that according to the CDC AH Provisional COVID-19 Death Counts by Age, there were no deaths in Colorado for the 0-17 age group in 2020 or 2021. This is evidence of less virulent strains of SARS-CoV-2 and better treatment and less risk for students and a generally lowered virulence for the SARS-CoV-2 strains as the pandemic progresses over time.

16. In my expert medical opinion, the combination of lowering COVID-19 rates, achievement of herd immunity, and the drastically improved treatment options make the Emergency Use Authorization for the investigational COVID-19 vaccine sponsored by the US FDA and CDC, unreasonable from a scientific and medical perspective.

COVID-19 Vaccine Research and Development

17. The COVID-19 genetic vaccines (Pfizer, Moderna, J&J) skipped testing for genotoxicity, mutagenicity, teratogenicity, and oncogenicity. In other words, it is unknown

whether or not these products will change human genetic material, cause birth defects, reduce fertility, or cause cancer.

18. The Pfizer, Moderna, and JNJ vaccines are considered "genetic vaccines", or vaccines produced from gene therapy molecular platforms which according to US FDA regulatory guidance are classified as gene delivery therapies and should be under a 15-year regulatory cycle with annual visits for safety evaluation by the research sponsors. FDA. Food and Drug Administration. (Long Term Follow-up After Administration of Human Gene Therapy Products. Guidance for Industry. FDA-2018-D-2173. 2020. Accessed July 13, 2021, at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/long-term-follow-after-administration-human-gene-therapy-products.

19. The FDA has "advised sponsors to observe subjects for delayed adverse events for as long as 15 years following exposure to the investigational gene therapy product, specifying that the long-term follow-up observation should include a minimum of five years of annual examinations, followed by ten years of annual queries of study subjects, either in person or by questionnaire." (emphasis added) Thus, the administration of the Moderna, Pfizer, and JNJ vaccines should not be undertaken without the proper consent and arrangements for long-term follow-up which are currently not offered in the US. (See, EUA briefing documents for commitments as to follow up: Moderna , Pfizer , J&J). They have a dangerous mechanism of action in that they all cause the body to make an uncontrolled quantity of the pathogenic wild-type spike protein from the SARS-CoV-2 virus for at least two weeks probably a longer period based on the late emergence of vaccine injury reports. This is unlike all other vaccines where there is a set amount of antigen or live-attenuated virus. This means for Pfizer, Moderna, and J&J vaccines it is not predictable among patients who will produce more or less of the spike protein. The Pfizer, Moderna, and JNJ vaccines because they are different, are expected to produce different libraries of limited antibodies to the now extinct wild-type spike protein. We know the spike protein produced by the vaccines is obsolete because the 17th UK Technical Report on SARS-CoV-2 Variants issued June 25, 2021, and the CDC June 19, 2021, Variant Report both indicate the SARS-CoV-2 wild type virus to which all the vaccines were developed is now extinct.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001354/Variants_of_Concern_VOC_Technical_Briefing_17.pdf;
https://COVID-19.cdc.gov/COVID-19-data

tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019ncov%2Fcases-updates%2Fvariant-proportions.html#variant-proportions

The spike protein itself has been demonstrated to injure vital organs such as the brain, heart, lungs, as well as damage blood vessels and directly cause blood clots. Additionally, because these vaccines infect cells within these organs, the generation of spike protein within heart and brain cells, in particular, causes the body's own immune system to attach to these organs. This is abundantly apparent with the burgeoning number of cases of myocarditis or heart inflammation among individuals below age 30 years. See, infra ¶ 48 - 54.

Because the US FDA and CDC have offered no interpretation of overall safey of the COVID-19 vaccines according to the manufacturer or as a group, nor have they offered methods of risk mitigation for these serious adverse effects which can lead to permanent disability or death, no one should be pressured, coerced, receive the threat or reprisal, or be mandated to receive one of these investigational products against their will. Because the vaccine centers, CDC, FDA, and the vaccine manufacturers ask for the vaccine recipient to grant indemnification on the consent form before injection, all injuries incurred by the person are at their own cost which can be prohibitive depending on the needed procedures, hospitalizations, rehabilitation, and medications.

20. In general, it is never good clinical practice to widely utilize novel biological products in populations that have not been tested in registrational trials. For COVID-19 vaccines, this includes COVID-19 survivors, those with prior suspected COVID-19 infection, those with positive SARS-CoV-2 serologies, pregnant women, and women of childbearing potential who cannot assure contraception.

21. It is never good research practice to perform a large-scale clinical investigation without the necessary structure to ensure the safety and protection of human subjects. These structures include a critical event committee, data safety monitoring board, and human ethics committee. These groups in large studies work to objectively assess the safety of the investigational product and research integrity. The goal is mitigating risk and protecting human subjects. It is my understanding that the COVID-19 vaccine program is sponsored by the CDC and FDA and has none of these safety structures in place. It is my assessment, that the COVID-19 clinical investigation has provided no meaningful risk mitigation for subjects (restricting groups, a special assessment of side effects, follow-up visits, or changes in the protocol to ensure or improve the safety of the program).

COVID-19 Vaccine Risks

22. The COVID-19 public vaccination program operated by the CDC and the FDA is a clinical investigation and under no circumstance can any person receive pressure, coercion, or threat of reprisal on their free choice of participation. Violation of this principle of autonomy by any entity constitutes reckless endangerment with a reasonable expectation of causing personal injury resulting in damages.

23. The current COVID-19 vaccines are not sufficiently protective against contracting COVID-19 to support its use beyond the current voluntary participation in the CDC-sponsored program. A total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021. Among these cases, 6,446 (63%) occurred in females, and the median patient age was 58 years (interquartile range = 40–74 years). Based on preliminary data, 2,725 (27%) vaccine breakthrough infections were asymptomatic, 995 (10%) patients were known to be hospitalized, and 160 (2%) patients died. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalized for a reason unrelated to COVID-19. The median age of patients who died was 82 years (interquartile range = 71–89 years); 28 (18%) decedents were asymptomatic or died from a cause unrelated to COVID-19. Sequence data were available from 555 (5%) reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern, including B.1.1.7 (199; 56%), B.1.429 (88; 25%), B.1.427 (28; 8%), P.1 (28; 8%), and B.1.351 (13; 4%). None of these variants are encoded in the RNA or DNA of the current COVID-19 vaccines. In response to these numerous reports, the CDC announced on May 1, 2021, that community breakthrough cases would no longer be reported to the public and only those vaccine failure cases requiring hospitalization will be reported, presumably on the CDC website (https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm). This overt asymmetric reporting will create the false picture of only unvaccinated individuals developing COVID-19 when in reality patients who are fully vaccinated will be contracting breakthrough infections except for those vaccinated individuals who were previously immune from prior COVID-19 infection.

24. The Delta variant of SARS-CoV-2 accounts for the majority of cases in the United Kingdom, Israel, and the United States. Because of progressive mutation of the spike protein, the virus has achieved an immune escape from the COVID-19 vaccines with the most obvious example being Israel where indiscriminate vaccination achieved 80% immunization rates. *See* Table 4.

This has promoted the emergence of the Delta variant as the dominant strain and because it is not adequately covered by the Pfizer COVID-19 vaccine, >80% of COVID-19 cases have occurred in persons fully vaccinated. This confirms the failure of the vaccines against COVID-19.

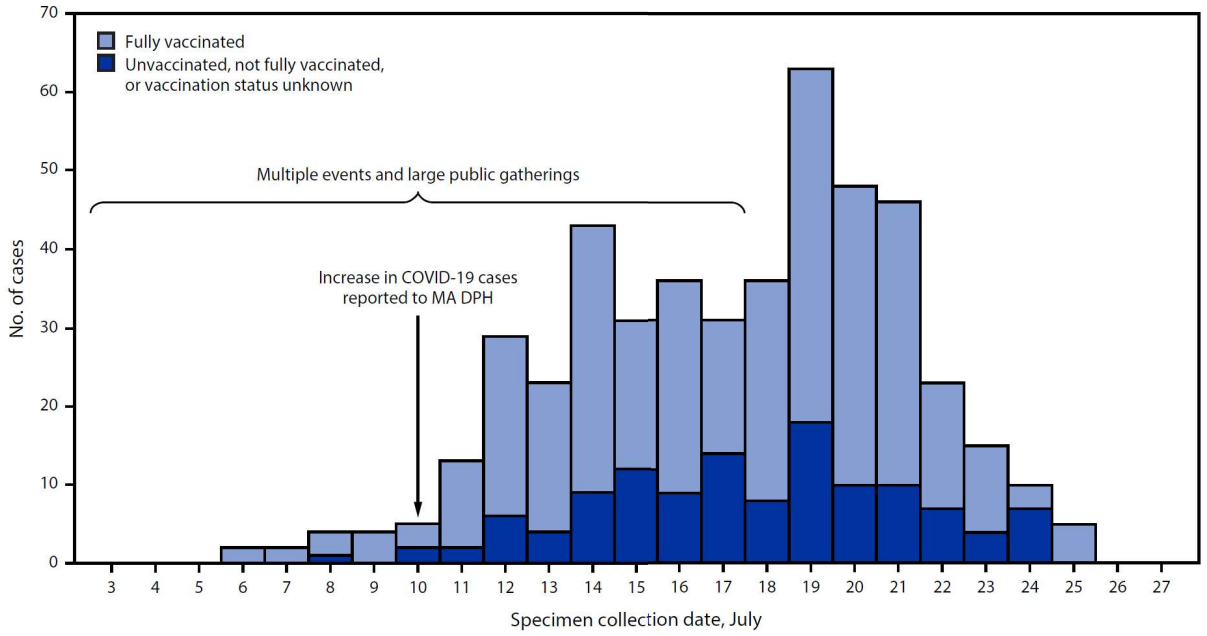
Table 4: Israel Confirmed Cases, Vaccinated vs. Unvaccinated

Source: https://datadashboard.health.gov.il/COVID-19019/general

25. In the SARS-CoV-2 variants of concern and variants under investigation in England Technical briefing 17 25 June 2021, 92,056 cases had the Delta variant and 50/7235 fully vaccinated and 44/53,822 of the unvaccinated died. This indicates that the fully vaccinated who contract the Delta variant have an 8.6-fold increased risk for death, (95% CI 5.73-12.91), $p < 0.0001$, as compared to those who chose to remain unvaccinated, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001354/Variants_of_Concern_VOC_Technical_Briefing_17.pdf

26. The CDC has published a report titled: "Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings — Barnstable County, Massachusetts, July 2021" demonstrating complete failure of the COVID-19 in controlled spread of SARS-CoV-2 in congregate settings. My interpretation of this report is that the vaccines are not sufficiently effective to make the elective, investigation vaccine recommended for use beyond individual preference. https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf

FIGURE 1. SARS-CoV-2 infections (N = 469) associated with large public gatherings, by date of specimen collection and vaccination status* — Barnstable County, Massachusetts, July 2021



Abbreviation: MA DPH = Massachusetts Department of Public Health.
* Fully vaccinated was defined as ≥14 days after completion of state immunization registry–documented COVID-19 vaccination as recommended by the Advisory Committee on Immunization Practices.

27. In 1990, the Vaccine Adverse Event Reporting System ("VAERS") was established as a national early warning system to detect possible safety problems in U.S. licensed vaccines. VAERS is a passive reporting system, meaning it relies on individuals to voluntarily send in reports of their experiences to the CDC and FDA. VAERS is useful in detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine.

28. The total safety reports in VAERS for all vaccines per year up to 2019 was 16,320. The total safety reports in VAERS for COVID-19 Vaccines alone through June 18, 2021, is 387,288. Based on VAERS as of July 16, 2021, there were 11,405 COVID-19 vaccine deaths reported and 36,117 hospitalizations reported for the COVID-19 vaccines (Pfizer, Moderna, JNJ). By comparison, from 1999, until December 31, 2019, VAERS received 3167 death reports (158 per year) adult death reports for all vaccines combined. Thus, the COVID-19 mass vaccination is associated with at least a 39-fold increase in annualized vaccine deaths reported to VAERS.

29. COVID-19 vaccine adverse events account for 98% of all vaccine-related AEs from December 2020 through the present in VAERS.

30. The COVID-19 vaccines are not safe for general use and cannot be deployed indiscriminately or supported, recommended, or mandated among any group – this is particularly dangerous for pilots flying at high altitudes.

31. There are emerging trends showing that the vaccine is especially risky for those 12-29 in my expert medical opinion with complications in the cardiovascular, neurological, hematologic, and immune systems. (See, Rose J, et al). Increasingly the medical community is acknowledging the possible risks and side effects including myocarditis, Bell's Palsy, Pulmonary Embolus, Pulmonary Immunopathology, and severe allergic reaction causing anaphylactic shock. See Chien-Te Tseng, Elena Sbrana, Naoko Iwata-Yoshikawa, Patrick C Newman, Tania Garron, Robert L Atmar, Clarence J Peters, Robert B Couch, Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus, https://pubmed.ncbi.nlm.nih.gov/22536382/ (last visited June 21, 2021); Centers for Disease Control and Prevention, Allergic Reactions Including Anaphylaxis After Receipt of the First Dose of Pfizer-BioNTech COVID-19 Vaccine—United States, December 14–23, 2020 (Jan 15, 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7002e1.htm (last visited June 26, 2021).

32. The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis. It is known that myocarditis causes injury to heart muscle cells and may result in permanent heart damage resulting in heart failure, arrhythmias, and cardiac death. These conditions could call for a lifetime need for multiple medications, implantable cardio defibrillators, and heart transplantation. Heart failure has a five-year 50% survival and would markedly reduce the lifespan of a child or young adult who develops this complication after vaccine-induced myocarditis (ref McCullough PA Reach Study).

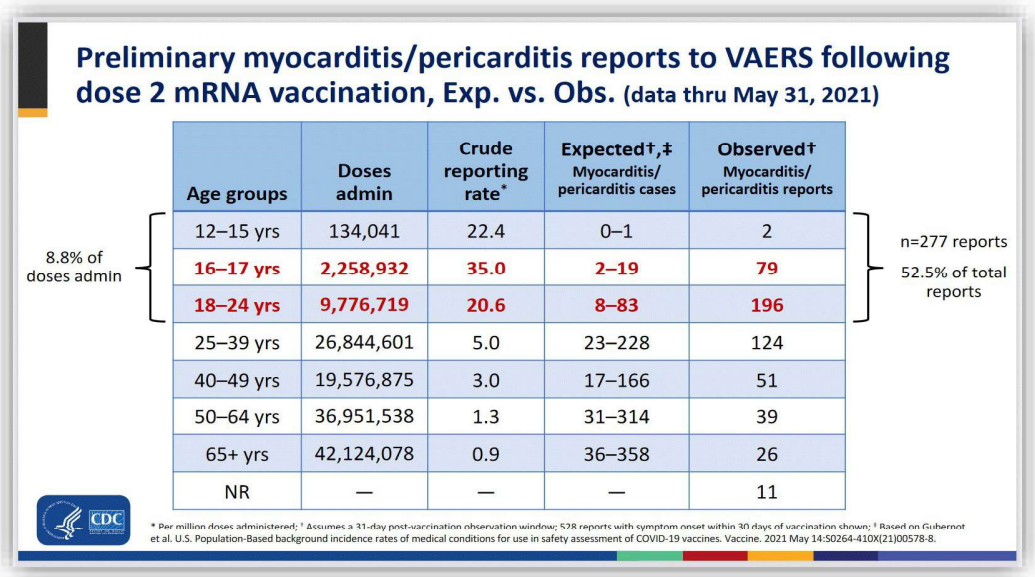
33. COVID-19 vaccine-induced myocarditis has a predilection for young males below age 30 years. The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis and the US FDA has issued a warning on the Pfizer and Moderna vaccines for myocarditis. In the cases reviewed by the CDC and FDA, 90% of children with COVID-19 induced myocarditis developed symptoms and clinical findings sufficiently severe to warrant hospitalization. Because

this risk is not predictable and the early reports may represent just the tip of the iceberg, no individual under age 30 under any set of circumstances should feel obliged to take this risk with the current genetic vaccines particularly the Pfizer and Moderna products. https://www.fda.gov/news-events/press-announcements/coronavirus-COVID-19-update-june-25-2021.

Multiple recent studies and news reports detail people 18-29 dying from myocarditis after receiving the COVID-19 vaccine. According to the CDC, 475 cases of pericarditis and myocarditis have been identified in vaccinated citizens aged 30 and younger. See FDA, Vaccines and Related Biological Products Advisory Committee June 10, 2021, Meeting Presentation, https://www.fda.gov/media/150054/download#page=17 (last visited June 21, 2021).

34. The FDA found that people 12-24 account for 8.8% of the vaccines administrated, but 52% of the cases of myocarditis and pericarditis were reported. Id.

Table 5: VAERS Report



Preliminary myocarditis/pericarditis reports to VAERS following dose 2 mRNA vaccination, Exp. vs. Obs. (data thru May 31, 2021)

Age groups	Doses admin	Crude reporting rate*	Expected†,‡ Myocarditis/ pericarditis cases	Observed† Myocarditis/ pericarditis reports
12–15 yrs	134,041	22.4	0–1	2
16–17 yrs	**2,258,932**	**35.0**	**2–19**	**79**
18–24 yrs	**9,776,719**	**20.6**	**8–83**	**196**
25–39 yrs	26,844,601	5.0	23–228	124
40–49 yrs	19,576,875	3.0	17–166	51
50–64 yrs	36,951,538	1.3	31–314	39
65+ yrs	42,124,078	0.9	36–358	26
NR	—	—	—	11

8.8% of doses admin

n=277 reports

52.5% of total reports

* Per million doses administered; † Assumes a 31-day post-vaccination observation window; 528 reports with symptom onset within 30 days of vaccination shown; ‡ Based on Gubernot et al. U.S. Population-Based background incidence rates of medical conditions for use in safety assessment of COVID-19 vaccines. Vaccine. 2021 May 14:S0264-410X(21)00578-8.

35. Further, the CDC just announced that the vaccine is "likely linked" to myocarditis. Advisory Board, CDC panel reports 'likely association' of heart inflammation and mRNA COVID-19 vaccines in young people, (June 24, 2021) https://www.advisory.com/daily-briefing/2021/06/24/heart-inflammation.

36. The CDC recently released data stating that there have been 267 cases of myocarditis or pericarditis reported after receiving one dose of the COVID-19 vaccines and 827 reported cases after two doses through June 11. There are 132 additional cases where the number of doses received is unknown. Id. There have been 2466 reported cases of myocarditis that have occurred, and the median age is thirty. Id. https://www.openvaers.com/COVID-19-data (accessed July 17, 2021)

37. I have seen and examined adolescent patients with post-COVID-19 myocarditis which typically occurs two days after the injection, most frequently after the second injection of mRNA products (Pfizer, Moderna). The clinical manifestations can be chest pain, signs and symptoms of heart failure, and arrhythmias. The diagnosis usually requires a clinical or hospital encounter, 12- lead electrocardiogram, blood tests including cardiac troponin (test for heart muscle damage), ECG monitoring, and cardiac imaging with echocardiography or cardiac magnetic resonance imaging. Given the risks for either manifest or future left ventricular dysfunction, patients are commonly prescribed heart failure medications (beta-blockers, renin-angiotensin system, inhibitors), and aspirin. More complicated patients require diuretics and anticoagulants. For post- COVID-19 vaccine myocarditis, I follow current position papers on the topic and restrict physical activity and continue medications for approximately three months before blood biomarkers and cardiac imaging are reassessed. If there is concurrent pericarditis, non-steroidal anti-inflammatory agents and colchicine may additionally be prescribed. Multiple medical studies are starting to come out detailing this problem[1]. Acute myocarditis could lead to sudden death in pilots on duty during flight.

38. The US FDA has given an update on the JNJ vaccine concerning the risk of cerebral venous sinus thrombosis and thrombosis with thrombocytopenia in women ages 18-48 associated with low platelet counts. This complication causes a variety of stroke-like

[1] See, e.g., Tommaso D'Angelo MD, Antonino Cattafi MD, Maria Ludovica Carerj MD, Christian Booz MD, Giorgio Ascenti MD, Giuseppe Cicero MD, Alfredo Blandino MD. Silvio Mazziotti MD, Myocarditis after SARS-CoV-2 Vaccination: A Vaccine-induced Reaction?, Pre-proof, Canadian Journal of Cardiology, https://www.onlinecjc.ca/article/S0828-282X(21)00286-5/fulltext (last visited June 26, 2021); Jeffrey Heller, Israel sees probable link between Pfizer vaccine and myocarditis cases (June 2, 2021), https://www.reuters.com/world/middle-east/israel-sees-probable-link-between-pfizer-vaccine-small-number-myocarditis-cases-2021-06-01/(last visited June 26, 2021); Tschöpe C, Cooper LT, Torre-Amione G, Van Linthout S. Management of Myocarditis-Related Cardiomyopathy in Adults. Circ Res. 2019 May 24;124(11):1568-1583. doi: 10.1161/CIRCRESAHA.118.313578. PMID: 31120823. Caforio AL, Pankuweit S, Arbustini E, Basso C, Gimeno-Blanes J, Felix SB, Fu M, Heliö T, Heymans S, Jahns R, Klingel K, Linhart A, Maisch B, McKenna W, Mogensen J, Pinto YM, Ristic A, Schultheiss HP, Seggewiss H, Tavazzi L, Thiene G, Yilmaz A, Charron P, Elliott PM; European Society of Cardiology Working Group on Myocardial and Pericardial Diseases. Current state of knowledge on aetiology, diagnosis, management, and therapy of myocarditis: a position statement of the European Society of Cardiology Working Group on Myocardial and Pericardial Diseases. Eur Heart J. 2013 Sep;34(33):2636-48, 2648a-2648d. doi: 10.1093/eurheartj/eht210. Epub 2013 Jul 3. PMID: 23824828.

syndromes that can involve the cranial nerves, vision, and coordination. Blood clots in the venous sinuses of the brain are difficult to remove surgically and require blood thinners sometimes with only partial recovery. In some cases, special glasses are required to correct vision and these young adults can be expected to miss considerable time away from school undergoing neurological rehabilitation. Because this risk is not predictable no woman under age 48 under any set of circumstances should feel obliged to take this risk with the JNJ vaccine. Such catastrophic neurologic thrombotic events could occur in pilots on duty during flight. https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda-statement-johnson-johnson-COVID-19-vaccine

39. Additionally, the US FDA has an additional warning for Guillen-Barre Syndrome or ascending paralysis for the JNJ vaccine which is not predictable and when it occurs can result in ascending paralysis, respiratory failure, the need for critical care, and death. Not all cases completely resolve, and some vaccine victims may require long term mechanical ventilation, or become quadra- or paraplegics. Prolonged neurological rehabilitation is commonly required, and this will call for time away from school and studies for those children injured from the JNJ vaccine with Guillen-Barre Syndrome. This syndrome is unpredictable and could occur in a pilot on duty during flight. https://www.fda.gov/media/150723/download

40. The vaccine is also far less safe than previous vaccines like the meningococcal meningitis vaccine that is typically required on college campuses which in 2019 recorded zero deaths. The COVID-19 vaccines since their EUA approval on May 10, 2021, have already claimed the lives of 15 children and 79 young individuals under age 30 (VAERS).

41. For example, the VAERS (Vaccine Adverse Event Reporting System) data from the CDC shows, for 18-29-year-olds, there have been no deaths from the meningococcal vaccine from 1999 - 2019. See, United States Department of Health and Human Services (DHHS), Public Health Service (PHS), Centers for Disease Control (CDC)/Food and Drug Administration (FDA), Vaccine Adverse Reporting System (VAERS) 1990 - 06/11/2021, CDC WONDER On-line Database. Accessed at https://wonder.cdc.gov/vaers.html on June 23, 2021, 1:43:33 PM, ("Query Criteria"), Attached as Exhibit C.

42. The main side effects people reported from the meningitis vaccine are headache, injection site pain, nausea, chills, and a fever, and even these were limited as no more than fifteen of each were reported. Id. The student population and their parents, in general, accept the requirements for meningococcal vaccination because the vaccines are safe, effective, and do not pose a risk of death, unlike the COVID-19 vaccines.

43. In the brief time the COVID-19 vaccines have been available, there have been many more serious symptoms and even a death of a healthy 13-year-old boy . (See Nationwide VAERS COVID-19 Vaccine Data through June 18, 2021, attached as Exhibit B). Further, milder side effects from the vaccine include changes in hormone and menstrual cycles in women, fever, swelling at the injection site, etc. Jill Seladi-Schulman, Ph.D., Can COVID-19 or the COVID-19 Vaccine Affect Your Period? (May 25, 2021), https://www.healthline.com/health/menstruation/can-COVID-19-affect-your-period#COVID-19-and-men%20strual-cycles (last visited June 26, 2021); Rachael K. Raw, Clive Kelly, Jon Rees, Caroline Wroe, David R. Chadwick, Previous COVID-19 infection but not Long-COVID-19 is associated with increased adverse events following BNT162b2/Pfizer vaccination, (pre-print) https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1 (last visited June 26, 2021).

44. Recent studies from Tess Lawrie, MBBS, PhD, a highly respected evidence-based professional, on the UK's equivalent of the VAERS systems concluded that the vaccines were unsafe for use in humans due to the extensive side effects they are causing. Tess Lawrie, Re. Urgent preliminary report of Yellow Card data up to 26th May 2021, (June 9, 2021), http://www.skirsch.com/COVID-19/TessLawrieYellowCardAnalysis.pdf

Risks of COVID-19 Vaccines for Those Recovered from COVID-19

45. There is recent research on the fact that the COVID-19 vaccine is dangerous for those who have already had COVID-19 and have recovered with inferred robust, complete, and durable immunity. These patients were excluded from the FDA-approved clinical trials performed by Pfizer, Moderna, and J&J. From these trials the safety profile was unknown when the products for approved for Emergency Use Authorization in 2020. There has been no study demonstrating clinical benefit with COVID-19 vaccination in those who have well documented or even suspected prior COVID-19 illness.

46. A medical study of United Kingdom healthcare workers who had already had COVID-19 and then received the vaccine found that they suffered higher rates of side effects than the average population. Rachel K. Raw, et al., Previous COVID-19 infection but not Long-COVID-19 is associated with increased adverse events following BNT162b2/Pfizer vaccination, medRxiv (preprint), https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1 (last visited June 21, 2021).

47. The test group experienced more moderate to severe symptoms than the study group that did not previously have COVID-19. Id. The symptoms included fever, fatigue, myalgia-arthralgia, and lymphadenopathy. Id. Raw found that in 974 individuals who received the BNT162b2/Pfizer vaccine, those with a prior history of SARS-CoV-2 or those who had positive antibodies at baseline had a higher rate of vaccine reactions than those who were COVID-19 naive. Id.

48. Mathioudakis et al. reported that in 2020 patients who underwent vaccination with either mRNA-based or vector-based COVID-19 vaccines, COVID-19-recovered patients who were needlessly vaccinated had higher rates of vaccine reactions.

49. Krammer et al. reported on 231 volunteers for COVID-19 vaccination, 83 of whom had positive SARS-CoV-2 antibodies at the time of immunization. The authors found: "Vaccine recipients with preexisting immunity experience systemic side effects with a significantly higher frequency than antibody naïve vaccines (e.g., fatigue, headache, chills, fever, muscle or joint pains, in order of decreasing frequency, $P < 0.001$ for all listed symptoms, Fisher's exact test, two-sided)." (https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1).

Natural Immunity to COVID-19

50. To my knowledge, there are no studies that demonstrate the clinical benefit of COVID-19 vaccination in COVID-19 survivors or those with suspected COVID-19 illness or subclinical disease who have laboratory evidence of prior infection.

51. It is my opinion that SARS-CoV-2 causes an infection in humans that results in robust, complete, and durable immunity, and is superior to vaccine immunity which by comparison has demonstrated massive failure including over 10,000 well-documented vaccine failure cases as reported by the CDC before tracking was stopped on May 31, 2021. There are no studies demonstrating the clinical benefit of COVID-19 vaccination in COVID-19 survivors and there are three studies demonstrating harm in such individuals. Thus, it is my opinion that the COVID-19 vaccination is contraindicated in COVID-19 survivors many of whom may be in the student population.

52. Multiple laboratory studies conducted by highly respected U.S. and European academic research groups have reported that convalescent mildly or severely infected COVID-19 patients who are unvaccinated can have greater virus-neutralizing immunity—especially more versatile, long-enduring T- cell immunity—relative to vaccinated individuals who were never infected. See Athina Kilpeläinen, et al., Highly functional

Cellular Immunity in SARS-CoV-2 Non- Seroconvertors is associated with immune protection, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.05.04.438781v1 (last visited June 26, 2021); Tongcui Ma, et al., Protracted yet coordinated differentiation of long-lived SARS-CoV-2-specific CD8+ T cells during COVID-19 convalescence, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.04.28.441880v1 (last visited June 26, 2021); Claudia Gonzalez, et al., Live virus neutralisation testing in convalescent patients and subjects vaccinated against 19A, 20B, 20I/501Y.V1 and 20H/501Y.V2 isolates of SARS-CoV-2, medRxiv (pre-print), https://www.medrxiv.org/ content/10.1101/2021.05.11.21256578vl (last visited June 21, 2021); Carmen Camara, et al. Differential effects of the second SARS-CoV-2 mRNA vaccine dose on T cell immunity in naïve and COVID-19 recovered individuals, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.03.22.436441v1 (last visited June 26, 2021); Ellie N. Ivanova, et al., Discrete immune response signature to SARS-CoV-2 mRNA vaccination versus infection, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255677v1 (last visited June 26, 2021); Catherine J. Reynolds, et al, Prior SARS-CoV-2 infection rescues B and T cell responses to variants after first vaccine dose, (pre-print), https://pubmed.ncbi.nlm.nih.gov/33931567/ (last visited June 21, 2021); Yair Goldberg, et al., Protection of previous SARS-CoV-2 infection is similar to that of BNT162b2 vaccine protection: A three-month nationwide experience from Israel, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.04.20.21255670vl (last visited 06/26 21).

53. Cleveland Clinic studied their employees for the effects of natural immunity in unvaccinated people. Nabin K. Shrestha, Patrick C. Burke, Amy S. Nowacki, Paul Terpeluk, Steven M. Gordon, Necessity of COVID-19 vaccination in previously infected individuals, medRxiv (pre-print), https://www.medrxiv.org/content/10.1101/2021.06.01.21258176v2 (last visited June 21, 2021). They found zero SARS-CoV-2 reinfections during a 5-month follow-up among n=1359 infected employees who were naturally immune remained unvaccinated and concluded such persons are "unlikely to benefit from COVID-19 vaccination." Among those who were vaccinated, unlike the naturally immune, there were vaccine failure or breakthrough cases of COVID-19. Id.

54. An analysis by Murchu et al demonstrated in 615,777 individuals which included well-documented COVID-19 as well as subclinical infections with positive serologies, there was a negligible incidence (<1%) of COVID-19 over the long term. Murchu found

no evidence of waning immunity over time suggesting no possibility that future vaccination would be indicated for any reason. https://onlinelibrary.wiley.com/doi/10.1002/rmv.2260

55. A recently published article in Nature reported that prior infection induces long-lived bone marrow plasma cells which means the antibodies to prevent reinfection of COVID-19 are long-lasting. Jackson S. Turner et. al. SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans, (May 24, 2021) https://www.nature.com/articles/s41586-021-03647-4

CONCLUSION

In my expert medical opinion which is and is within a reasonable degree of medical certainty, despite the current Delta variant outbreak, the increasing likelihood of herd immunity to COVID-19, the low risk to children and adolescents of serious complications or death due to COVID-19, the negligible risk of asymptomatic spread of COVID-19, the vastly improved COVID-19 treatments currently available all make the risks inherent in COVID-19 significantly lower than they were in 2020.

It is my expert medical opinion that the COVID-19 vaccines are progressively losing efficacy over the prevention of COVID-19 and in widely vaccinated countries (Israel, Iceland, Singapore) up to 80% of COVID-19 cases have been previously vaccinated implying the vaccines have become obsolete with antigenic escape or resistance to variants (e.g. Delta) that have evolved to infect persons who were vaccinated against the now extinct wild-type SARS-CoV-2 strain.

It is my expert medical opinion that it is not good research or clinical practice to widely utilize novel biologic therapy (mRNA, adenoviral DNA COVID-19 vaccines) in populations where there is no information generated from the registrational trials with the FDA, specifically COVID-19 survivors, suspected COVID-19-recovered, pregnant or women who could become pregnant at any time after investigational vaccines; and especially pilots. In my expert medical opinion, the risks associated with the investigational COVID-19 vaccines far outweigh any theoretical benefits, are not minor or unserious, and many of those risks are unknown or have not been adequately quantified nor has the duration of their consequences been evaluated or is calculable. Therefore, in my expert medical opinion, the Emergency Use Authorization and administration of COVID-19 vaccines for pilots creates an unethical, unreasonable, clinically unjustified, unsafe, and

poses an unnecessary risk to the pilots of the United States of America. Likewise, in my medical expert opinion, the mandatory, administration of COVID-19 vaccines in pilots creates unnecessary risk to pilots, flight crew, and the airline passengers of the United States of America.

Dr. Peter A. McCullough, M.D., M.P.H.

JURAT AND VERIFICATION

STATE OF Texas

COUNTY OF Dallas

The foregoing instrument was acknowledged before me by means of ☒ physical presence or ☐ online notarization, this August 13, 2020 by Dixie Frazier, who is personally known to me:

Peter A. McCall, my mom

[Notary Seal] Notary Public

Dixie Lee Frazier

Name typed, printed or stamped

My Commission Expires: May 10, 2022

DIXIE LEE FRAZIER
Notary ID #131563137
My Commission Expires
May 10, 2022