IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

NAVY SEAL # 1, et al.**,** Plaintiffs, v. **JOSEPH R. BIDEN, JR.**, in his official capacity as President of the United States, et al., Defendants.	Case No. 8:21-cv-02429-SDM-TGW

DEFENDANTS' OPPOSITION TO PLAINTIFFS' RENEWED MOTION FOR A PRELIMINARY INJUNCTION

The Supreme Court has made clear: "Judges are not given the task of running the Army." *Orloff v. Willoughby*, 345 U.S. 83, 93 (1953). Nor are they given the task of running the Navy, Marine Corps, Air Force, Coast Guard, or National Guard. Yet by seeking to enjoin the military's COVID-19 vaccine directive, Plaintiffs ask this Court to substitute its judgment for that of the Secretary of Defense and senior military leaders across all branches of the military as to the acceptable level of risk to military operations and conclude that vaccination is not necessary for military readiness. Plaintiffs base their request on the false premise that hundreds of military officers are engaging in a "sham," by which they will grant medical exemptions but categorically deny all religious exemptions to vaccination. But the detailed declarations submitted by the Government make clear that the Military Services are conducting the individualized assessments required under the Religious Freedom Restoration Act

("RFRA"). Those declarations also make clear that granting temporary medical exemptions, which may expire in as little as a few weeks, is not comparable to permanently granting more than 20,000 religious exemption requests. The fact that the military has granted few religious exemptions does not mean that officers are not discharging their duties in good faith; instead, it reflects that the military has a compelling interest in ensuring that service members are medically ready to defend this Nation. Plaintiffs' motion for a preliminary injunction with respect to the military's policy should be denied, including with respect to the two officers as to whom the Court entered a temporary restraining order ("TRO") on February 2, 2022 (ECF No. 67). That TRO should be immediately vitiated for the reason set forth in Defendants' opposition to that motion, *see* ECF No. 66, and because of the harms to national security of enjoining the military from relieving Plaintiffs Special Warfare Officer and Lieutenant Colonel from their commands now that the military has lost confidence that they will follow orders.

Nor are Plaintiffs entitled to extraordinary injunctive relief on their challenge to the executive order requiring vaccination of the federal civilian workforce ("EO 14043"). Each of the three anonymous civilian employees listed in the amended complaint has submitted a request to be excepted from the vaccination requirement that remains pending at this time. Thus, these civilian employees' claims are not ripe and the Court lacks jurisdiction, as multiple courts across the country have concluded in similar circumstances. Even setting that aside, there is no basis for Plaintiffs' First Amendment or RFRA claims because EO 14043 acknowledges that individuals may

be entitled to religious accommodations, and the anonymous plaintiffs—who have all sought such accommodations—proffer only threadbare allegations that are insufficient to establish a likelihood of success on the merits. Plaintiffs' claim under the Administrative Procedure Act ("APA") likewise fails because it does not challenge any discrete, final agency action and because EO 14043 is within the President's broad constitutional and statutory authority to manage Executive Branch employees. Finally, the federal civilian employees face no prospect of irreparable harm for their employment-related injuries (which can be remedied at the conclusion of any successful challenge), and the public interest is best served by allowing the federal government to decide how best to protect the federal workforce from a deadly virus that has caused serious disruptions to government operations.

Plaintiffs are also unlikely to succeed in their challenge to EO 14042, which announced vaccine requirements for government contractors. This Court was clear in its November 11, 2021 Order that Plaintiffs' allegations regarding EO 14042 were not sufficient to show that any plaintiff had standing to challenge the order. ECF No. 40, at 4, *id.* n.1, *id.* n.2. Plaintiffs then filed an Amended Complaint but failed to remedy this basic pleading deficiency. And even if Plaintiffs could show standing to challenge EO 14042, their claims are unlikely to succeed on the merits.

PROCEDURAL BACKGROUND

Defendants have previously set forth the background for the Department of Defense vaccination directive and the Executive Orders requiring vaccination for federal employees and contractors in their opposition to Plaintiffs' motion for a

preliminary injunction and incorporate that background by reference. *See* ECF No. 23. Defendants also incorporate by reference and respectfully refer the Court to the legal standards and arguments in that opposition brief, as well as the declarations and exhibits filed in support of that opposition brief and in opposition to Plaintiffs' motion for class certification. *See* ECF Nos. 23, 23-1–23-25, 42, 42-1–42-5. Defendants also expressly incorporate herein in Defendants' Opposition to Plaintiffs' Emergency Motion for a Temporary Restraining Order with respect to two of the Plaintiffs, ECF No. 66, as well as the declarations and exhibits filed in support of that opposition, ECF Nos. 66-1–66-7. The Court should now consider and deny Plaintiffs' motion for a preliminary injunction with respect to those two officers, as well as their broader request as to all the other Plaintiffs, for the reasons set forth in prior submissions.

Defendants have limited this brief to responding to Plaintiffs' Supplemental Memorandum and Renewed Motion for Preliminary Injunction ("Pls.' Supp. Br."), ECF No. 51, and to addressing the Court's Order granting in part Plaintiffs' Emergency Motion for a Temporary Restraining Order, ECF No. 67.

ARGUMENT

I. The Service Member Plaintiffs Are Unlikely to Succeed on the Merits of Their Claims.

A. The Religious Exemption Process Is Not a "Ruse."

Plaintiffs claim that hundreds of military officials are acting in concert to issue indiscriminate and undifferentiated denials of each service member's request for a religious exemption to the COVID-19 vaccination requirement. *See* Pls.' Supp. Br. 2–

5, 7–13. Plaintiffs' claim is entirely unfounded and should be rejected.

The record reflects that the Military Services are making the required individualized assessment under RFRA for each service member who has requested an exemption from the COVID-19 vaccination requirement on religious grounds. Each of the Military Services has submitted detailed declarations concerning the process each Service undertakes to review and adjudicate religious exemption requests.[1] As reflected in these declarations, to evaluate each service member Plaintiff's religious accommodation request, military officials from their branch of Service engage in a careful, thorough, and case-by-case analysis of each request, evaluating whether a service member's objection to compliance is based upon a sincere religious belief, evaluating whether requiring compliance would substantially burden the member's religious exercise, identifying the government's compelling interest, and determining whether there are any lesser restrictive means of furthering that interest. And, after the approval authority conducts this rigorous analysis of each request, the appeal authority for each Service conducts their own separate analysis on each appeal. In sum, "[t]here is no blanket policy or practice of approving or disapproving all religious accommodation requests, including with respect to the COVID-19 vaccine."

[1] *See* Decl. of Colonel Michele Soltis (Army), ECF No. 23-17; Decl. of Major General Telita Crosland (Army), ECF No. 42-6; Decl. of Vice Admiral William Merz (Navy), ECF No. 23-18; Decl. of Captain Mery-Angela Sanabria Katson (Navy), ECF No. 42-4; Decl. of Lieutenant General David Furness (Marine Corps), ECF No. 23-19; Decl. of Colonel Adam Jeppe (Marine Corps), ECF No. 42-3; Decl. of Major Matthew Streett (Air Force), ECF No. 23-21; Decl. of Major General Sharon Bannister (Air Force), ECF No. 42-1; Decl. of Rear Admiral Shannon Gilreath (Coast Guard), ECF No. 23-25; Decl. of Commander Brooke Grant (Coast Guard), ECF No. 42-2; Decl. of Deputy Director Laurence Bazar (Army National Guard), ECF No. 42-5.

Crosland Decl. ¶ 4, ECF No. 42-6; Bannister Decl. ¶ 4, ECF No. 42-1.

Plaintiffs' supplemental brief makes no attempt to argue the individual merits of any Plaintiff service member's religious accommodation request but instead argues that "the vaccine mandate does not allow for individualized assessments" of their religious exemption requests writ large. Pls.' Supp. Br. 11. The military's adjudication of Plaintiffs' own religious accommodations would almost certainly disprove that allegation by reflecting individualized analyses of their requests, but because Plaintiffs still have not provided most of their names to Defendants, Defendants are unable to investigate their allegations. For the two Plaintiffs who sought a temporary restraining order (and thus the two names Plaintiffs divulged to Defendants), the record indeed shows that the military appeal authority conducted an individualized assessment of both Plaintiffs' religious accommodation request packages, taking into account, for example, each Plaintiff's military duties and considering whether there were any less restrictive means than vaccination that would further the military's compelling interest in readiness. *See* ECF Nos. 66-2, 66-3.

In any event, the allegations in Plaintiffs' amended complaint disprove their arguments that adjudication is undifferentiated. Plaintiffs hold different positions and are in different phases of the religious exemption process with different decision-makers across different Services. *See generally* Am. Compl. ¶¶ 32–65, 137–69, ECF No. 49-1. They received individualized assessments from military chaplains. *See id*. Some commanders recommended in favor of some requests, and some commanders did not.

Compare id. ¶ 33, *with id.* ¶ 38.[2] The approval authorities and the appeal authorities across the Services conduct individualized assessments of all requests. All Plaintiffs have been able to submit religious accommodation requests pursuant to policy, and none has been subject to discipline or separation for refusing the vaccine in the interim. There is no indication that any particular decision-maker is applying the wrong standard, or that the decision-makers are acting in a vast scheme to apply the wrong standard. Plaintiffs simply do not like the results received thus far, but that is not a basis for finding that the process is a "sham."

Plaintiffs' assertion that military has a policy of an "across-the-board denial" of religious exemption requests is simply incorrect. Pls.' Supp. Br. 3; *see also* TRO 8. Either Plaintiffs misunderstand the applicable policies and how they relate to each other or have incorrectly implied that some of the most senior military officers and civilian officials across all the Military Services are all proceeding in bad faith. The authorities who must approve vaccination exemption requests for both the Navy and Marine Corps are flag officers, and the appeal authorities are the Chief of Naval Operations and the Commandant of the Marine Corps, respectively, who are the most senior officers of the Services. Merz Decl. ¶ 14, ECF No. 23-18; Furness Decl. ¶ 12, ECF No. 23-19. The final appeal authority for the Coast Guard is the Director of Military Personnel, who holds the senior rank of Captain. Grant Decl. ¶ 7, ECF No.

[2] One Plaintiff indicates that, as commanding officer, he recommended in favor of 16 of 17 requests on his ship. Am. Compl. ¶ 38. Although all were eventually denied, the Plaintiff's own assessment that at least one request failed to meet the standard disproves the concept that the Court can adjudicate these requests as a whole, without individualized assessment required by RFRA.

42-2. The "vast majority" of the approval authorities for the Air Force are "three- and four-star General Officers," and the appeal authority is the Air Force Surgeon General, who, as a Lieutenant General, is a three-star general officer. Bannister Decl. ¶¶ 3, 17, ECF No. 42-1. For the Army and the Army National Guard, the approval authority is the Army Surgeon General, who is also a Lieutenant General and thus a three-star general officer, and the appeal authority is the Assistant Secretary of the Army for Manpower and Reserve Affairs, who is one of the five Assistant Secretaries of the Army and is appointed by the President with the advice and consent of the Senate. Crossland Decl. ¶ 4, ECF No. 42-6; Bazer Decl. ¶ 9, ECF No. 42-5; *see* 10 U.S.C. § 7016(a). Defendants' declarations reflect that these senior officials, as well as myriad other military officials who assist in processing religious accommodations requests like chaplains, military health providers, and attorneys, are conducting thorough, individualized assessments of each request. There is no possible basis to find that they are acting in bad faith. *See Dodson v. Dep't of Army*, 988 F.2d 1199, 1204 (Fed. Cir. 1993) ("[M]ilitary administrators are presumed to act lawfully and in good faith like other public officers, and the military is entitled to substantial deference in the governance of its affairs."); *Patel v. McHugh*, 2014 WL 953493, at *2 (S.D. Ga. Mar. 11, 2014) (same), *aff'd*, 586 F. App'x 583 (11th Cir. 2014); *Perry v. Dep't of Army*, No. 2013 WL 4432175, at *4 (M.D. Ga. Aug. 15, 2013) (same); *Hicks v. Sec'y of Air Force*, 2009 WL 2151200, at *8 (M.D. Fla. July 14, 2009) (same). Indeed, both the D.C. Circuit and Ninth Circuit dismissed similar theories of bad faith when vacating (D.C. Circuit) and staying (Ninth Circuit) preliminary injunctions preventing the military

from implementing its then-existing policy regarding military service by transgender individuals and individuals with gender dysphoria. *Doe 2 v. Shanahan*, 755 F. App'x 19, 25 (D.C. Cir. 2019); *Karnoski v. Trump*, 926 F.3d 1180, 1202-03 (9th Cir. 2019); *see also Doe 2 v. Shanahan*, 917 F.3d 694, 731 (D.C. Cir. 2019) (Williams, J., concurring) ("the plausibility of such a scheme tends to unravel as we try to imagine the dozens of participants," including "Cabinet members and other officials," "who would have been needed for its realization" (quotation marks omitted)). Plaintiffs' contentions should also be rejected here.

Plaintiffs refer to the data submitted by Defendants showing that only three religious accommodation requests have been granted at this point and on that basis argue that the military has a policy of an "across-the-board denial" of such requests. Pls.' Supp. Br. 3; *see also* TRO 8. But the data support no such conclusion. Only a small percentage of the accommodation requests have been fully adjudicated on appeal across the Services. *See, e.g.*, Katson Decl. Ex. 1, ECF No. 73-3 (showing that only 81 requests have been fully adjudicated, while 1,222 appeals remain pending in the Navy). Accordingly, drawing any conclusions from the available data—and certainly any conclusion that accommodation requests are not being considered in good faith—is unwarranted.

In any event, the denial of many religious exemption requests for the COVID-19 vaccination requirement does not show that the process is a "ruse" or a "sham," as Plaintiffs allege, Pls.' Supp. Br. 2, 24; rather, it is entirely consistent with a finding that the military has assessed its interests in vaccination of service members as extremely

compelling and not readily satisfied by less restrictive alternatives. The Court stated that "[o]ne struggles to imagine a wholesome and lawful explanation for the results evidenced in this record." TRO 8. To the contrary, when one considers the unique nature of military service, the explanation should be readily apparent. The purpose of the military is to fight and win our nation's wars and to protect the American public from foreign threats, and the military must have medically ready, "globally deployable forces" to do so. *See* Decl. of Admiral William Lescher ¶ 5 & Attach., ECF No. 66-4; Ex. 1 (DoDI 1332.45) at 4 ("To maximize the lethality and readiness of the joint force" it is DoD policy that "all Service members are expected to be deployable.").[3] The military has an indisputably compelling interest in ensuring that service members are healthy and ready to deploy at a moment's notice and that interest is vital to the national security of the United States. Lescher Decl. ¶ 11.

Vaccination requirements for the military are nothing new. To the contrary, the military's compelling interest in a fully vaccinated force is supported by generations of historical experience. *See* Congressional Research Report Defense Health Primer: Military Vaccinations, ECF No. 23-13; Stanley Lemon, et al., *Protecting Our Forces: Improving Vaccine Acquisition and Availability in the US Military*, National Academies Press, 2002, *available at* https://perma.cc/E545-TQ9G at 10, Table 1-1. For decades, the military has implemented a variety of enduring or situational inoculation measures

[3] This declaration was originally prepared in conjunction with other litigation and speaks directly to the military's interest in vaccination. It also speaks to the Navy's interest in having members of its special operations forces, such as Plaintiff Navy SEAL 1, vaccinated for COVID-19.

to maintain the readiness of the force. *See* ECF No. 23-13. Nine vaccines are required for all service members—now ten with the addition of the COVID-19 vaccine—while eight others are required in specialized circumstances, such as deployments to certain parts of the world. *See* Army Regulation ("AR") 40-562, Table D-1, ECF No. 23-6. Accordingly, "[t]he judgment of each of the Military Services is that vaccines," including the COVID-19 vaccine, "are the most effective tool the Armed Forces have to keep our personnel safe, fully mission capable and prepared to execute the Commander-in-Chief's orders to protect vital United States[] national interests." *See* Lescher Decl. ¶ 11, ECF No. 66-4; Mem. for all Defense Employees (Aug. 9, 2021), ECF No. 23-2; Ex. 3 (Decl. of Colonel Tanya Rans) ¶ 10; Ex. 4 (Decl. of Major Scott Stanley) ¶ 20; Decl. of Colonel James Poel ¶ 4, ECF No. 66-7.[4]

As the Vice Chief of Naval Operations explains, "[u]nvaccinated or partially vaccinated service members are at higher risk to contract COVID-19, and to develop severe symptoms requiring hospitalizations that remove them from their units and impact mission execution." Lescher Decl. ¶ 2, ECF No. 66-4; *see also* Ex. ¶ 18 ("Between July and November of 2021, non-fully-vaccinated active-duty service members had a 14.6-fold increased risk of being hospitalized when compared to fully vaccinated active-duty service members. In December 2021 unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults."); Ex. 3 ¶¶ 14–40 (explaining continued benefits of vaccination). This can lead to medical evacuations

[4] This declaration was originally prepared in conjunction with other litigation and speaks directly to the Air Force's interest in vaccination.

that "create additional risk . . . to the mission" and "place those service members executing medical evacuation at risk of harm," including by providing "transport from a hostile, remote or diplomatically sensitive area." Lescher Decl. ¶ 21; Ex. 11 (Decl. of Captain Frank Brandon) ¶ 12. For a force that requires every service member to be deployable, this means even vaccination against tetanus—which is not transferable from human to human—is required. *See* Ex. 1 at 4; AR 40-562, Table D-1, ECF No. 23-6. Moreover, because of the extremely transferable nature of COVID-19, the heightened risk that an unvaccinated service member will contract COVID-19 necessarily heightens the risk that others in his unit will contract COVID-19. Lescher Decl. ¶ 17 ("[U]nvaccinated personnel in a unit degrade the force health protection conditions in the unit, placing personnel in the unit at risk and degrading the unit's ability to safely conduct operations, regardless of the scope of the operation.").

Plaintiffs (and the Court) may disagree with these assessments, but disagreement with the military's compelling interests in vaccine requirements does not mean that military leaders are operating in bad faith. And the law governing the Court's review of military decisions is clear: the Supreme Court has long directed district courts to give deference to the professional judgment of military authorities concerning the relative importance of a particular military interest. *See Rostker v. Goldberg*, 453 U.S. 57, 71, 81–83 (1981); *Trump v. Hawaii*, 138 S. Ct. 2392, 2421–22 (2018); *Winter v. NRDC, Inc.*, 555 U.S. 7, 9 (2008); *cf. Doe 2*, 917 F.3d at 728 (Williams, J., concurring) (assessing plaintiffs' empirical attacks on the military's justifications with deference for military judgment). This is true even for claims under the First

Amendment and RFRA. *See Goldman v. Weinberger*, 475 U.S. 503, 507 (1986); S. Rep. 103-111, 12, *reprinted in* 1993 U.S.C.C.A.N. 1892, 1901 (expressing the committee's "inten[tion] and expect[ation]" that courts will apply deference principles under RFRA). The most senior military leaders have determined vaccination is essential for military readiness. The Court should defer to that assessment, and should not make determinations based its own intuition or reading of limited data to discount the military's compelling interest in protecting the health and safety of the force.

B. Aggregate Medical Exemption Data Do Not Undermine the Government's Compelling Interest in Vaccination.

Plaintiffs rely entirely on aggregate data pertaining to religious exemptions and temporary medical exemptions to the COVID-19 vaccine requirement to argue that the military is engaging in a sham process by granting exemptions for medical reasons, but not for religious reasons. But the number of medical exemptions from vaccination requirements does not determine whether any individual service member is entitled to a permanent religious exemption. And those data in no way lend credence to Plaintiffs' theory that the religious exemption process is a "ruse."

As an initial matter, unlike religious exemptions, medical exemptions serve the government's interest in military readiness. Giving a vaccine to a service member who is, for example, allergic to a component of the vaccine, would harm the member's health, and thus would be contrary to the military's interest in ensuring readiness and the health and safety of service members. Ex. 6 (Decl. of Major General Telita Crosland) ¶ 10; Ex. 7 (Decl. of Rear Admiral Gayle Shaffer) ¶ 11; Ex. 5 (Decl. of

Artemio Chapa) ¶ 13; Ex. 8 (Decl. of Rear Admiral Dana Thomas) ¶ 5; *see also Doe v. Mills*, 16 F.4th 20, 34 (1st Cir. 2021) (providing medical exemptions for contraindicated vaccines supports the State's goal of keeping healthcare works healthy and able to provide care); *Doe v. San Diego Unified Sch. Dist.*, 19 F.4th 1173, 1178 (9th Cir. 2021) (having a medical exemption to those with contraindications to the vaccines "serves the primary interest for imposing the mandate—protecting student 'health and safety'"). The inability of some members to receive the vaccine for a period of time due to contraindications or health issues increases the military's compelling interest in maximizing the vaccination of other service members to prevent the spread of the disease. Ex. 5 ¶ 15. Therefore, the fact that the Services have granted medical exemptions where the health of the member would have been compromised by vaccination does not diminish the military's assessment that vaccination is necessary to achieve its interest in military readiness.

In addition, the vast majority of medical exemptions are temporary in nature. All temporary medical exemptions last only up to 365 days, AR 40-562 ¶ 2.6, ECF No. 23-6, and many last as little as a few days or weeks depending on a change in the medical condition, *see* Ex. 5 ¶ 12; Ex. 8 ¶ 6. Once the exemption expires, the member must get vaccinated. Indeed, in the four weeks between Defendants' first and third data submissions, many temporary medical exemptions have already expired, and the service members will now be required to receive the COVID-19 vaccination.[5] Thus,

[5] *Compare* Mahoney Decl. ¶ 15, ECF No. 47-2, *with* Mahoney Decl. ¶ 11, ECF No. 73-2 (number of

the impact on the military mission and deployablity of a service member with a temporary medical exemption is decidedly different than a service member receiving a permanent religious exemption to the COVID-19 vaccination requirement.

Common reasons to grant temporary medical exemptions are pregnancy or acute infection (e.g., a current infection of COVID-19). *See* AR 40-562 ¶ 2.6, ECF No. 23-6. Indeed, the Navy's data shows that over 75% of the temporary medical exemptions for active-duty marines and nearly 70% of the temporary medical exemptions for active-duty sailors are related to pregnancy or current infection. Ex. 7 ¶ 6. Both of these conditions are time-limited, and once the condition is resolved, the member's temporary medical exemption expires and the member is expected to get vaccinated. *Id.* ¶ 7; Ex. 6 ¶¶ 8–9. Other reasons for a temporary medical exemption include, for example, cancer treatments, Ex. 6 ¶ 7, and members undergoing assessments for medical contraindications for vaccination, Ex. 7 ¶ 6. But, again, these exemptions are all temporary in nature and members are expected to get vaccinated once their condition resolves. There would be no such expectation for a religious exemption, which again is presumably permanent.

Moreover, many of the common reasons that a service member may receive a medical exemption from an immunization requirement may also make the service

temporary medical exemptions in the Army dropped from 1,354 to 1,105); *compare* Kaston Decl. Ex. 1, ECF No. 47-3, *with* Katson Decl. Ex. 1, ECF No. 73-3 (number of temporary medical exemptions in the Navy dropped from 303 to 252); *compare* Reid Decl. Ex. 1, ECF No. 47-4, *with* Reid Decl. Ex. 1, ECF No. 73-4 (number of temporary medical exemptions in the Marine Corps dropped from 419 to 232); *compare* Holbrook Decl. Ex. 1, ECF No. 47-5, *with* Holbrook Decl. ECF No. 73-5 (number of temporary medical exemptions in the Air Force dropped from 1,723 to 1,513).

member nondeployable, such that the member is already not medically ready to deploy, regardless of vaccination status. Ex. 9 (Decl. of Captain Joon Yun) ¶ 8. A pregnant service member is generally not worldwide deployable or deployable on ships or aircraft during pregnancy—and that is true whether or not that service member is vaccinated. Ex. 1 at 11. However, the member is expected to return to a worldwide deployable status following pregnancy, including getting vaccinated to be fully medically ready for deployment.[6] In contrast, a member with a religious exemption would not be expected to get the vaccine, as the member's religious convictions are presumably permanent.

Previous adverse response to immunization may be grounds for a permanent medical exemption, *see* AR 40-562 ¶ 2.6, ECF No. 23-6, but such exemptions have rarely been necessary for the COVID-19 vaccine. For example, the Army has granted only six permanent medical exemptions for the COVID-19 vaccine, and all were a result of an adverse reaction to the first shot. Ex. 6 ¶ 10. For this same reason, the Navy has granted ten permanent medical exemptions,[7] Ex. 7 ¶ 10, and the Coast Guard has granted five, Ex. 8 ¶ 5.[8] These service members "have at least some

[6] Because "all Service members are expected to be deployable," a service member who is non-deployable for more than 12 consecutive months is evaluated for continued retention or possible referral to the Disability Evaluation System for a possible medical separation. Ex. 1 at 4.

[7] The Navy granted an additional permanent medical exemption because the service member "had medical conditions that precluded vaccination due to family history of vaccine reaction and severe cardiac disease, with a recommendation for medical board separation processing due to these underlying conditions." Ex. 7 ¶ 10.

[8] The Air Force is giving only temporary medical exemptions to ensure that members with temporary medical conditions get vaccinated once their condition is resolved and to allow the Air Force to reassess members with contraindications for the vaccine to determine whether a vaccine has been approved with constituents the member can safely take. Ex. 5 ¶ 11.

modicum of protection from having received the initial dose, which will increase the effectiveness of mitigation measures." Ex. 6 ¶ 10. More importantly, there is a decidedly different impact on the military force between granting 21,243 religious exemptions, *see* Pls.' Supp. Br. 3, from the COVID-19 vaccine and permanently excusing 21 individuals from a second COVID-19 vaccine dose when there is evidence that it may actually cause them physical harm.

Finally, Plaintiffs' argument that the military is "treating religious exemption requests less favorably than nonreligious exemption requests," Pls.' Supp. Br. 9; *see also* TRO 8, is wrong. Because they are unvaccinated, service members with a medical exemption are still subject to myriad limitations and restrictions, such as restrictions on deployment eligibility, foreign country entry restrictions, frequent COVID-19 testing or extended quarantine requirements, and travel restrictions. Ex. 9 ¶ 6; Ex. 11 ¶ 12. In addition, members who are unvaccinated for any reason may have to seek a separate medical clearance to perform certain duties or a waiver from a Combatant Commander to deploy within that commander's geographic area of responsibility. Ex. 9 ¶ 7. Accordingly, it is simply not the case that members who are medically exempt are permitted to serve without any consequences.[9]

[9] Plaintiffs further rely on the district court's misinterpretation of Navy instructions in *Navy Seals 1–26*, 2022 WL 34443 (N.D. Tex. Jan. 3, 2022), *appeal filed*, No. 22-10077 (5th Cir. 2022). There the court found that Navy treats vaccine medical exemptions and vaccine religious exemptions for members of the Navy Special Warfare community differently for deployability purposes. *Id.* at *9. But, as explained by the Force Medical Officer for Navy Special Warfare Command, the Navy requires any special operations service member who is not vaccinated, either by reason of a medical exemption or based on a religious request, to obtain a separate waiver in order to become deployable and continue in that career field. *See* Ex. 2 (Decl. of Captain Lanny Littlejohn) ¶ 6. "[A] service member who

C. Plaintiffs Have Failed to Exhaust Administrative Remedies.

Plaintiffs also are unlikely to succeed on the merits of their claims, and therefore are not entitled to any preliminary injunctive relief, because they have failed to exhaust administrative remedies. The Eleventh Circuit has made clear "time and again" that exhaustion of administrative remedies is "require[d]" in military cases. *Winck v. England*, 327 F.3d 1296, 1302 (11th Cir. 2003), *abrogated on other grounds by Santiago-Lugo v. Warden*, 785 F.3d 467, 471 (11th Cir. 2015) (collecting cases).

Plaintiffs rely exclusively on an out-of-circuit district court opinion for the proposition that the Court can ignore military exhaustion requirements because exhaustion would be futile. *See* Pls.' Supp. Br. 6. That decision is plainly wrong under precedent that binds this Court as well. But that district court also contravened its own Circuit's precedent. In *Hodges v. Callaway*, for example, the Fifth Circuit concluded that although the plaintiff seemed unlikely to prevail in challenging his discharge, he was required nonetheless to exhaust his military remedies, including challenging his discharge, and ordered dismissal of the action because "courts must—at least initially—indulge the optimistic presumption that the military will afford its members the protections vouchsafed by the Constitution, by the statutes, and by its own regulations." 499 F.2d 417, 424 (5th Cir. 1974). To do otherwise "might upset the

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receives an exemption or accommodation from the COVID-19 vaccination requirement, whether for religious or secular reasons, is not [physically qualified for special operations] unless he or she obtains separate medical clearance." *Id.* A medical exemption for the COVID-19 vaccination, like a religious exemption, only determines whether the service member will be required to receive the COVID-19 vaccination. In either circumstance, a service member will not be considered physically qualified for special operations duty and deployable until he or she receives separate medical clearance. *Id.*

balance between the civilian judiciary and the military" and involve "untoward, unreasonable interference with the efficient operation of the military's judicial and administrative systems and allow the military an opportunity to exercise its own expertise and rectify its own errors before a court is called to render judgment." *Id*. at 423. Neither the exemption process nor the separation process reasonably can be deemed an "empty formality"; all levels of military command are engaged in reasoned decision-making to find facts and make determinations about military needs. The Court should not foreclose that process, which could afford relief or partial relief to Plaintiffs and which allows the military to exercise its judgment and develop a record in the first instance. *See Church v. Biden*, 2021 WL 5179215, at *10 (D.D.C. Nov. 8, 2021); *Robert v. Austin*, No. 21-CV-02228-RM-STV, 2022 WL 103374, at *3 (D. Colo. Jan. 11, 2022).

Plaintiffs' demands for extraordinary preliminary relief with respect to the military's COVID-19 vaccination requirements are nothing more than an effort to short circuit both the administrative and normal judicial process. Their demand fails to satisfy any of the requirements for an injunction at this stage.

II. The Civilian Employee Plaintiffs Are Unlikely to Succeed on the Merits of Their Claims.

A. This Court Lacks Jurisdiction Over Plaintiffs' Challenge to EO 14043.

1. Plaintiffs' Challenge to EO 14043 is Not Ripe.

Because the civilian employee Plaintiffs present unripe claims, the Court lacks

jurisdiction to award any relief against EO 14043.[10] *See, e.g.*, *Dermer v. Miami-Dade Cnty.*, 599 F.3d 1217, 1220 (11th Cir. 2010). Each civilian employee alleges that he has submitted a request for a religious exception to the vaccination requirement that is currently pending with his employing agency. *See* Am. Compl. ¶¶ 66–68. While these exception requests are pending, Plaintiffs are not subject to discipline.[11] And because the requests might be granted, Plaintiffs' potential injuries depend "upon contingent future events that may not occur as anticipated, or indeed may not occur at all." *Texas v. United States*, 523 U.S. 296, 300 (1998) (citation omitted). As multiple courts have concluded in rejecting similar challenges to EO 14043 on ripeness grounds, potential injuries based on "hypothetical predictions of the outcomes of . . . exemption requests" are "insufficient to 'render an issue ripe for review.'" *Church*, 2021 WL 5179215, at *9; *accord Brnovich v. Biden*, ---F. Supp. 3d----, 2022 WL 252396, at *8 (D. Ariz. Jan. 27, 2022); *McCray v. Biden*, 2021 WL 5823801, at *8–9 (D.D.C. Dec. 7, 2021); *AFGE Local 501 v. Biden*, No. 21-23828-CIV, ECF No. 33, at 17 (S.D. Fla. Dec. 22, 2021); *Donovan v. Vance*, No. ---F. Supp. 3d----, 2021 WL 5979250, at *4–5 (E.D. Wash. Dec. 17, 2021).

This is especially true with respect to the civilian employee Plaintiffs' RFRA

[10] On January 21, 2022, a district court entered a nationwide preliminary injunction prohibiting the government from "implementing or enforcing Executive Order 14043 until this case is resolved on the merits." *Feds for Med. Freedom v. Biden*, ---F. Supp. 3d----, 2022 WL 188329, at *8 (S.D. Tex. Jan. 21, 2022). The government has appealed that ruling, *see* No. 22-40043 (5th Cir. Jan. 21, 2022), and motions to stay the injunction are pending before both the district court and the Fifth Circuit.

[11] The alleged State Department employee asserts that he has received a "Letter of Counseling threatening consequences of [*sic*] his failure to provide proof of full vaccination for COVID-19." Am. Compl. ¶ 68. Because Plaintiffs have not provided this individual's identity, Defendants cannot verify this allegation. But in any event, a letter of counseling is merely the first informal step in a multi-step disciplinary process, and no federal employee will be subject to any discipline while the *Feds for Medical Freedom* nationwide injunction remains in effect.

claims. Allowing their employing agencies to reach an initial decision with respect to the requests will make concrete the (at present abstract) dispute between the parties and create a record of, for example, Plaintiffs' job duties, any difficulties associated with accommodating a particular religious exemption request, and the extent to which the vaccination requirement as applied to an individual employee is narrowly tailored to serve the government's compelling interest in stopping the spread of COVID-19 among the federal workforce. *See, e.g., Toca Producers v. FERC*, 411 F3d 262, 266 (D.C. Cir. 2005) (dispute not ripe where an agency had "yet to pass conclusively upon whether the [applicants] are entitled to the only relief they now seek").

2. The Civil Service Reform Act Precludes Plaintiffs' Challenge to EO 14043.

Plaintiffs' claims are also precluded by the Civil Service Reform Act ("CSRA"), which "provides the exclusive procedure for challenging federal personnel decisions." *Hendrix v. Snow*, 170 F. App'x 68, 80 (11th Cir. 2006) (citing *United States v. Fausto*, 484 U.S. 439, 443, 454–55 (1988); *Broughton v. Courtney*, 861 F.2d 639, 643 (11th Cir. 1988)); *see* 5 U.S.C. §§ 7512, 7513(d), 7703(b)(1) ("adverse actions" reviewable by Merit Systems Protection Board and Federal Circuit); *id.* §§ 1214(a)(3), 2302 (review scheme for less severe "personnel action[s]"). The Supreme Court has concluded that, "[g]iven the painstaking detail with which the CSRA sets out the method for covered employees to obtain review of adverse employment actions," Congress "intended to deny such employees an additional avenue of review in district court." *Elgin v. Dep't of the Treasury*, 567 U.S. 1, 11–12 (2012). This comprehensive remedial scheme precludes Plaintiffs from challenging the employment condition set forth in EO 14043

in district court.[12]

B. The Civilian Employees Plaintiffs' First Amendment and RFRA Claims Are Unlikely to Succeed.

In support of their First Amendment and RFRA challenges to EO 14043, Plaintiffs continue to allege that the executive order "prohibit[s] Plaintiffs from seeking and receiving exemption and accommodation for their sincerely held religious beliefs against the COVID-19 vaccines." Am. Compl. ¶¶ 258, 282. But as the Court has already held in rejecting Plaintiffs' previous attempt to preliminarily enjoin EO 14043, the executive order "expressly require[s] religious exemption." Order 3, ECF No. 40. Plaintiffs offer nothing in either their amended complaint or renewed motion that would alter this conclusion—indeed, their motion simply adopts by reference Plaintiffs' arguments regarding the military vaccination requirement and contains no argument that EO 14043 violates either the First Amendment or RFRA. *See* Pls.' Supp. Br. 15.[13] Whatever showing Plaintiffs have made regarding that vaccination requirement (and as explained elsewhere in this brief, that showing does not establish a likelihood of success on Plaintiffs' First Amendment and RFRA challenges to the military order), the record is completely devoid of support for Plaintiffs' contention that civilian employees are "prohibited" from receiving religious exemptions from EO

[12] The alleged employees of the Bureau of Prisons and State Department have additionally failed to establish that any relief obtained in this lawsuit would redress their alleged injuries because they do not sue any official at either agency responsible for implementing EO 14043.

[13] Plaintiffs' motion argues only that EO 14043 is "not generally applicable" and thus "subject to strict scrutiny under the First Amendment," Pls.' Supp. Br. 13. Even assuming *arguendo* the truth of that contention, it is irrelevant here because Plaintiffs also bring a RFRA claim. *See* Order 20, ECF No. 40 (noting that RFRA provides "greater protection . . . than is available under the First Amendment").

14043 or that the Plaintiffs' pending religious exemption requests will be denied.[14] *See* Order 4 n.1, ECF No. 40 (in reviewing religious exemption requests, federal agencies should consider "the basis for the claim; the nature of the employee's job responsibilities' and the reasonably foreseeable effects on the agency's operations, including protecting agency employees and the public from COVID-19"). Plaintiffs' facial challenge to EO 14043 thus fails. *See Horton v. City of St. Augustine*, 272 F.3d 1318, 1329 (11th Cir. 2001) (facial challenges are "the most difficult challenge to mount successfully" because they require the challengers to "establish that no set of circumstances exists under which the [challenged government action] would be valid"); *Donovan*, 2021 WL 5979250, at *6–7 (rejecting facial challenge to EO 14043).

To the extent Plaintiffs assert an as-applied challenge to EO 14043, as described above, they present fundamentally unripe claims and there is no basis for the Court to consider them now. *See Church*, 2021 WL 5179215, at *9 ("absence of any factual record providing the basis for any denial of a religious accommodation request (if, in fact any plaintiff's request is denied) hamstrings the Court's ability to evaluate" First Amendment and RFRA challenges to EO 14043). In any event, Plaintiffs proceed anonymously and provide only conclusory allegations about the manner in which EO 14043 purportedly burdens their religious beliefs. But "an asserted belief must be 'sincere'; a [plaintiff's] pretextual assertion of a religious belief in order to obtain an

[14] As noted, EO 14043 is now enjoined on a nationwide basis. While that injunction remains in effect, the government is prohibited from disciplining any civilian employees for noncompliance with its vaccination requirement or from adjudicating (and denying) any pending exemption requests.

exemption . . . would fail." *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 717 n. 28 (2014). Until Defendants and this Court can examine their claims, "[n]either the government nor the court has to accept the [plaintiffs'] mere say-so." *United States v. Bauer*, 84 F.3d 1549, 1559 (9th Cir. 1996); *see also, e.g.*, *Fallon v. Mercy Cath. Med. Ctr. of Se. Pa.*, 877 F.3d 487, 492 (3d Cir. 2017); *Friedman v. Clarkstown Cent. Sch. Dist.*, 75 F. App'x 815, 819 (2d Cir. 2003). For this reason too, Plaintiffs' RFRA and First Amendment challenges are unlikely to succeed.

C. The Civilian Employee Plaintiffs' APA Claim Is Unlikely to Succeed.

Plaintiffs also press a claim, purportedly under the APA, that the "Executive Branch" lacks the "power to impose a vaccine mandate on all civilian federal employees." Pls.' Supp. Br. 16. As a threshold matter, the Court lacks jurisdiction over this claim because Plaintiffs fail to identify any "final agency action for which there is no other adequate remedy in a court." 5 U.S.C. § 704; *see Nat'l Parks Conservation Ass'n v. Norton*, 324 F.3d 1229, 1236 (11th Cir. 2003). Indeed, they point to no action by any agency to implement EO 14043 or apply its requirements to any federal employee (and indeed, do not even sue the agencies that employ the alleged Bureau of Prisons and State Department plaintiffs). Final agency action (1) "must mark the consummation of the agency's decisionmaking process," and (2) must determine legal "rights or obligations" or have other "legal consequences." *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (citations omitted). However, an agency has not consummated its decisionmaking process where it is clear that "further administrative

action is forthcoming." *Nat'l Parks Conservation Ass'n*, 324 F.3d at 1238. Here, the relevant "final agency action" applying EO 14043 to any particular civilian employee is the relevant employing agency's ultimate decision—which has not occurred for any of the civilian employee plaintiffs here—regarding whether an individual employee "receives an exemption, whether and what additional remedial measures and procedures should be taken, and whether and how [that employee] should be disciplined." *Rodden v. Fauci*, ---F. Supp. 3d----, 2021 WL 5545234, at *3 (S.D. Tex. Nov. 27, 2021).

In any event, EO 14043 is a valid exercise of the President's authority pursuant to Article II of the Constitution and multiple federal statutes (5 U.S.C. §§ 3301, 3302, and 7301). *See Rydie v. Biden*, No. 21-cv-2696, 2021 WL 5416545, at *3 (D. Md. Nov. 19, 2021), *appeal filed*, No. 21-2359 (4th Cir. Dec. 7, 2021); *Oklahoma v. Biden*, 2021 WL 6126230, at *10 (W.D. Okla. Dec. 28, 2021); *Brnovich*, 2022 WL 252396, at *12); *see also Brass v. Biden*, No. 21-cv-2778, 2021 WL 6498143, at *3 (D. Colo. Dec. 23, 2021) (report and recommendation), *adopted* 2022 WL 136903 (D. Colo. Jan. 14, 2022); *Smith v. Biden*, No. 21-cv-19457, 2021 WL 5195688, at *6 (D.N.J. Nov. 8, 2021), *appeal filed*, No. 21-3091 (3d Cir. Nov. 10, 2021). Plaintiffs ignore these persuasive authorities and rely instead on the lone district court decision to find that EO 14043 likely exceeds the President's authority. *See* Pls.' Supp. Br. 16–17 (citing *Feds for Med. Freedom*). That case was wrongly decided; just as private employers across the country have required their employees to be vaccinated against COVID-19, so too

can the President, as proprietor of the Executive Branch workforce, make COVID-19 vaccination a condition of federal employment.

The President has inherent constitutional authority under Article II to act as chief executive officer of the Executive Branch. *See, e.g.*, *Seila Law LLC v. CFPB*, 140 S. Ct. 2183, 2191 (2020). This includes "general administrative control over those executing the laws." *Id*. at 2197–98 (citation omitted). The Supreme Court has "[t]ime and again" emphasized the government's "wide latitude" in managing federal employees. *NASA v. Nelson*, 562 U.S. 134, 148, 154 (2011) (quotation marks omitted). Accordingly, the President may "prescribe the qualifications of [Executive Branch] employees and . . . attach conditions to their employment." *Friedman v. Schwellenbach*, 159 F.2d 22, 24 (D.C. Cir. 1946).

Plaintiffs err in contending that the Government recognizes "no limiting principle to the reach of" the President's power. Pls.' Supp. Br. 17 (quoting *Feds for Med. Freedom v. Biden*, 2022 WL 188329, at *6 (S.D. Tex. Jan. 21, 2022, *appeal filed*, 22-40043 (5th Cir. 2022). Most relevant here, the CSRA authorizes removal, suspension, and other enumerated discipline only "for such cause as will promote the efficiency of the service." 5 U.S.C. §§ 7503(a), 7513(a). Any covered plaintiff who might be disciplined for failing to become vaccinated pursuant to EO 14043 could seek review of such discipline under the extensive procedures set forth in the CSRA and contend that the discipline did not satisfy the statutory standard.

Moreover, even if explicit statutory authority were necessary, *see* Pls.' Supp. Br. 17, Congress has provided it here. *See Rydie*, 2021 WL 5416545, at *3; *Oklahoma*, 2021

WL 6126230, at *10; *see also Smith*, 2021 WL 5195688, at *6–7 (employee vaccination requirement is within the federal government's "broad[]" authority when acting as "an employer under 5 U.S.C. §§ 3301, 3302, 7301"). Most importantly, 5 U.S.C. § 7301 permits the President to "prescribe regulations for the conduct of employees in the executive branch." Plaintiffs and the court in *Feds for Medical Freedom* would have this statute apply to "workplace conduct," *Feds for Med. Freedom*, 2022 WL 188329, at *5, but there is no basis to read words into the statute that do not exist. Had Congress meant to limit its grant of authority to the "workplace"—as it did with its reference to "occupational safety" in the Occupational Safety and Health Act, *see Nat'l Fed'n of Indep. Bus. v. OSHA*, 142 S. Ct. 661, 665 (2022) (per curiam)—"it knew how to say so." *Rubin v. Islamic Republic of Iran*, 138 S. Ct. 816, 826 (2018). In any case, EO 14043 regulates workplace activity because it ensures that federal workers are vaccinated (or otherwise subject to a reasonable accommodation) when they enter the workplace and interact with their colleagues or the public.

EO 14043 is consistent with a long line of Presidential actions imposing conditions on federal employment with respect to conduct that occurs both on- and off-duty. *See, e.g.*, Exec. Order No. 12564, 51 Fed. Reg. 32,889, 32,890 (Sept. 15, 1986) (President Reagan prohibiting "[t]he use of illegal drugs by Federal employees, whether on duty or off duty"); Exec. Order No. 12674, 54 Fed. Reg. 15,159, 15,159 (Apr. 12, 1989) (President George H.W. Bush requiring that federal employees refrain from conduct on or off the job that would conflict with their official duties; satisfy all "just financial obligations," including by paying federal, state, and local taxes; and

refrain from soliciting or accepting gifts from persons doing business with their agencies, among other restrictions). As the Supreme Court has recognized, these kinds of employment-related executive orders are "plainly a reasonable exercise of the President's responsibility for the efficient operation of the Executive Branch," *Old Dominion Branch No. 496, Nat'l Ass'n of Letter Carriers, AFL-CIO v. Austin*, 418 U.S. 264, 273 n.5 (1974); *see also Biden v. Missouri*, 142 S. Ct. 647, 652 (2022) (per curiam) (looking to "longstanding practice of [the Executive Branch] in implementing the relevant statutory authorities" in upholding a federal vaccination requirement).

III. The Contractor Employer Plaintiff Is Unlikely to Succeed on the Merits of Its Claims.

The lone remaining Plaintiff challenging EO 14042 as alleged in the Amended Complaint, known as Federal Civilian Contractor Employer ("FCCE"), lacks standing to challenge EO 14042 because Plaintiffs' allegations are insufficient to show that FCCE is a covered contractor.[15] As this Court has already concluded, "the record remains devoid of material suggesting that any plaintiff's employer is a federal contractor 'covered' by" the EO.[16] Order 4, ECF No. 40. Despite the Court putting

[15] EO 14042's enforcement is enjoined nationwide. *Georgia v. Biden*, --- F. Supp. 3d ----, No. 1:21-CV-163, 2021 WL 5779939, at *12 (S.D. Ga. Dec. 7, 2021). This Court has also enjoined enforcement of EO 14042 within Florida. *State v. Nelson*, No. 8:21-CV-2524-SDM-TGW, 2021 WL 6108948, at *16 (M.D. Fla. Dec. 22, 2021). FCCE, however, is likely not subject to this Court's preliminary injunction because it is located in Michigan and does not allege to have any contracts—covered or otherwise—within Florida (or seemingly have any connection whatsoever to this forum). *See* Am. Compl. ¶ 69.

[16] This Court stated that "the record remains devoid of material suggesting that any plaintiff's employer is a federal contractor 'covered' by Executive Order 14043," Order 4, but Defendants understand this Court to be referring to EO 14042, which pertains to federal contractors. More specifically, the Safer Workforce Task Force Guidance that the Office of Management and Budget ("OMB") approved in implementing EO 14042 refers to covered contracts and covered contract employees and employers.

the FCCE on notice that it had failed to show standing, the amended complaint provides no further detail about FCCE's "current and future" contracts, which may or may not be covered contracts within the meaning of the EO.

Because EO 14042 only applies to certain kinds of federal contracts, FCCE must provide enough detail for this Court to determine that EO 14042 has caused it an actual or imminent injury-in-fact. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992). Notably, the EO does not apply to most contracts for procurement of goods (as opposed to services). *See* EO 14042, § 5; *see also* Determination of the Acting OMB Director Regarding the Revised Safer Federal Workforce Task Force Guidance for Federal Contractors and the Revised Economy & Efficiency Analysis, 86 Fed. Reg. 63,418, 63,420 (Nov. 16, 2021) (affirming that "contract[s] or subcontract[s] for the manufacturing of products" are "not covered or directly addressed by" the EO). The "land vehicles" and "Navy vessels" that FCCE and his company "develop and support," Am. Compl. ¶ 69, may well be product contracts, which would place FCCE's contracts outside the scope of the EO. Moreover, the EO does not apply to "contracts or subcontracts whose value is equal to or less than the simplified acquisition threshold, as that term is defined in § 2.101 of the Federal Acquisition Regulation." EO 14042 § 5(b)(iii). FCCE provides no information about the value of the "current and future" contracts his company holds. Because FCCE provides too little information to show that it is a covered contractor subject to EO 14042, it fails to establish an "actual," "imminent," or "concrete" injury, as opposed to one that is merely "conjectural" and "hypothetical." *Lujan*, 504 U.S. at 560.

Even if it were a "covered" contractor subject to EO 14042, FCCE lacks standing to bring a religious accommodation challenge because "Federal guidance commits to the employing contractor the responsibility 'for considering, and dispositioning, such requests for accommodations regardless of the covered contractor employee's place of performance." Order 4 n.1, ECF No. 40. FCCE is thus responsible "for considering, and dispositioning" his own request for religious accommodation. FCCE's "allege[d] confusion about the requirements of the process for granting a religious exemption"—allegations not expanded in the Amended Complaint—do not "successfully accomplish the formidable, if not impossible, task of elevating confusion to an injury that supports a claim for relief." *Id.* at 4 n.2.

Moreover, even if FCCE had standing to challenge EO 14042 and OMB's approval of the Task Force Guidance, its APA claims fail on the merits. First, the APA is provides no basis to challenge EO 14042 and its implementation. The APA does not apply to OMB's Determination, which FCCE challenges in Count IV, and FCCE identifies no final agency action that would be subject to the APA. The OMB Director's Determinations were issued under Presidential authority delegated to her under 3 U.S.C. § 301. When the President delegates his authority under § 301, the APA does not authorize judicial review of the action taken pursuant to that delegation. Officers exercising Presidential authority delegated to them through § 301 "stand[] in the President's shoes" and "exercis[e] purely presidential prerogatives." *Nat. Res. Def. Council, Inc. v. Dep't of State*, 658 F. Supp. 2d 105, 109 & n.5, 111 (D.D.C. 2009). Just as the President cannot be sued under the APA, *see Franklin v. Massachusetts*, 505 U.S.

788, 796 (1992), the Director's actions "cannot be subject to judicial review under the APA" either. *Nat. Res. Def. Council*, 658 F. Supp. 2d at 109; *see also Detroit Int'l Bridge Co. v. Gov't of Canada*, 189 F. Supp. 3d 85, 100 (D.D.C. 2016), *aff'd*, 875 F.3d 1132 (D.C. Cir. 2017), *aff'd*, 883 F.3d 895 (D.C. Cir. 2018). And to the extent FCCE generally challenges the federal contractor vaccine mandate under the APA in Counts V and VI, it cannot do so for failure to identify a final agency action.

Second, even if the APA applied, EO 14042 and OMB's Determination both comport with applicable law. EO 14042 is not contrary to law because it reflects the required nexus to the statutory objective of "an economical and efficient system" for contracting and procurement as set forth in the Procurement Act, 40 U.S.C. §101. The safeguards required by the EO "will decrease worker absence, reduce labor costs, and improve the efficiency of contractors and subcontractors at sites where they are performing work for the Federal Government." EO 14042 § 1. Those efforts, in turn, help to avoid delays and reduced performance quality in critical federal contracts. The safeguards also minimize the leave and health care costs that, in some contracts, might be passed along to the federal government. By ensuring that the federal government is entering into contracts that will be performed efficiently, EO 14042 contributes directly to establishing "an economical and efficient system,"40 U.S.C. § 101, for "[p]rocuring…property and nonpersonal services" and "performing related functions including contracting," *id.* § 101(1); *see also UAW-Labor Emp't & Training Corp. v. Chao*, 325 F.3d 360, 366 (D.C. Cir. 2003) (the Procurement Act accords the President both "necessary flexibility and 'broad-ranging authority'" in setting procurement policies)

(quoting *AFL-CIO v. Kahn*, 618 F.2d 784, 789 (D.C. Cir. 1979)).

And even if APA review applied to the OMB Determination—which it does not—the Determination does not violate the APA. The Determination was not issued in excess of OMB's authority because, as explained above, OMB used the authority the President expressly delegated to OMB in EO 14042 itself. EO 14042 § 2. Nor was the OMB Determination arbitrary and capricious: it likewise would meet that "deferential" standard of review. *Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 658 (2007). Indeed, a district court in Kentucky examined this same claim and concluded that the plaintiffs were unlikely to succeed in claiming that the OMB Determination was arbitrary and capricious. *Kentucky v. Biden*, 2021 WL 5587446, at *12 (E.D. Ky. Nov. 30, 2021) (noting that November OMB determination included a "thorough and robust economy-and-efficiency analysis"). FCCE's APA challenges to the federal contractor vaccine requirements accordingly fail.

IV. Plaintiffs Have Not Demonstrated Irreparable Harm.

"[E]ven if Plaintiffs establish a likelihood of success on the merits, the absence of a substantial likelihood of irreparable injury would, standing alone, make preliminary injunctive relief improper." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000) (citations omitted). Irreparable harm "must be neither remote nor speculative, but actual and imminent." *Ne. Fla. Chapter of Ass'n of Gen. Contractors of Am. v. City of Jacksonville*, 896 F.2d 1283, 1285 (11th Cir. 1990). "In cases involving claims related to military personnel decisions, moreover, courts have held that the

showing of irreparable harm must be *especially strong* before an injunction is warranted, given the national security interests weighing against judicial intervention in military affairs." *Shaw v. Austin*, 539 F. Supp. 3d 169, 183 (D.D.C. 2021).

Plaintiffs make no such showing. No service member is subject to forcible or involuntary vaccination. *See* ECF No. 23, at 34 (collecting regulation cites). Nor do they allege otherwise. Separation or discharge procedures could begin, but nothing indicates that the process has even been initiated as to these Plaintiffs, and such processes can take months, *see, e.g.*, Merz Decl. ¶¶ 17, 19, ECF No. 23-18. Even if Plaintiffs are ultimately separated based on their refusal of the vaccine, such a separation is neither imminent nor irreparable. Military administrative and disciplinary actions, including separation, are not *irreparable* injuries because the service member can later be reinstated and provided back pay if he prevails on his claim. *See, e.g.*, *Hartikka v. United States*, 754 F.2d 1516, 1518 (9th Cir. 1985); *Chilcott v. Orr*, 747 F.2d 29, 34 (1st Cir. 1984); *Guitard v. Sec'y of Navy*, 967 F.2d 737, 742 (2d Cir. 1992); *Church*, 2021 WL 5179215, at *17. Even a court-martial would not constitute irreparable injury. *See Schlesinger v. Councilman*, 420 U.S. 738, 755 (1975).

The federal employee Plaintiffs also fail to establish irreparable harm. As Plaintiffs recognize, the loss of employment—and any associated financial or reputational damages stemming therefrom—is "not typically irreparable harm." Pls.' Supp. Br. 21; *see Sampson v. Murray*, 415 U.S. 61, 91, 92 n.68 (1974). This is because injuries that "can be undone through monetary remedies" are not irreparable, *SME*

Racks, Inc. v. Sistemas Mecanicos Para, Electronica, S.A., 243 F. App'x 502, 504 (11th Cir. 2007), and "the simple loss of a job is loss of income [which] does not establish irreparable injury," *V.N.A. of Greater Tift Cnty., Inc. v. Heckler*, 711 F.2d 1020, 1030 (11th Cir. 1983); *see also Garcia v. United States*, 680 F.2d 29, 31-32 (5th Cir. 1982) (noting that it "[i]s is practically universal jurisprudence in labor relations in this country that there is an adequate remedy for individual wrongful discharge after the fact of discharge," *i.e.*, "reinstatement and backpay"). Even if any civilian employee Plaintiff were certain to be removed for refusal to be vaccinated—and as discussed above, there is no such certainty—any associated harm would not be irreparable, in part because of the availability of reinstatement under the CSRA and back pay under the Back Pay Act. *See Sampson*, 415 U.S. at 92 n.68. Several courts have thus held that a federal employee's choice between complying with a COVID-19 vaccination requirement and suffering job-related consequences is not irreparable harm. *See Rydie*, 2021 WL 5416545, at *5; *Church*, 2021 WL 5179215, at *13–15; *Smith*, 2021 WL 5195688, at *8-9; *Donovan*, 2021 WL 5979250, at *7; *Altschuld v. Raimondo*, No. 21-cv-2779, 2021 WL 6113563, at *3–5 (D.D.C. Nov. 8, 2021). This Court should do the same.

In any event, the civilian employee and contractor Plaintiffs face no risk of irreparable harm so long as the *Feds for Medical Freedom* and *Georgia* injunctions remain in place. *See Feds for Med. Freedom*, 2021 WL 188329, at *8 (denying request to preliminarily enjoin EO 14042 because it "is already subject to a nationwide injunction").

V. The Balance of Harms Tips Sharply in the Government's Favor.

The public has an exceptionally strong interest in national defense, *see Winter*, 555 U.S. at 24, and the military has a compelling interest in requiring its fighting forces to be vaccinated, healthy, and ready to deploy. As set forth above, an injunction that allows Plaintiffs to serve in a military setting without being vaccinated against COVID-19 would threaten harm to Plaintiffs and other service members serving alongside them. *See* Lescher Decl. ¶ 2. The heightened risk that an unvaccinated service member will contract COVID-19 necessarily heightens the risk that others in the unit will contract COVID-19. *See id.* ¶ 17. For these reasons, Plaintiffs' motion for preliminary injunctive relief should be denied as to all Plaintiffs, including the two identified Plaintiffs subject to the Court's TRO, and the TRO entered by the Court should be vitiated for the reasons set forth in Defendants' prior opposition. *See* ECF No. 66.

Military leaders, in their professional judgment, have concluded that the risks of these outcomes to military operations and national security are significantly higher when unvaccinated service members are deployed. *See, e.g.*, Lescher Decl. ¶ 25 (expressing "the Navy's judgment" "that COVID-19 vaccines are a critical defense against COVID-19 and mitigate risk both to our force and to our mission," "tak[ing] into account the environments our service members operate in, the operations the Navy conducts, and the absence of other effective COVID-19 mitigation measures in the environments in which we operate"). An order precluding the military from considering Plaintiffs' vaccination status in making assignments would therefore threaten "[t]he health, readiness, and mission execution" of Plaintiffs' units. *Id.* ¶ 2.

The requested injunction would also undercut the maintenance of military good order and discipline. *Id.* ¶ 16; Merz Decl. ¶ 23, ECF No. 23-18; Furness Decl. ¶ 23, ECF No. 23-19. No military can successfully function where service members feel free to define the terms of their own military service, including which orders they will choose to follow. *Chappell v. Wallace*, 462 U.S. 296, 300 (1983). The injunction Plaintiffs now demand here would encourage other members to attempt to bypass the military's process and ask courts to enter similar injunctive relief, which "in the aggregate present the possibility of substantial disruption and diversion of military resources" and is contrary to the public interest. *Parrish v. Brownlee*, 335 F. Supp. 2d 661, 669 (E.D.N.C. 2004); *see Chilcott*, 747 F.2d at 33 (noting the "strong judicial policy against interfering with the internal affairs of the armed forces"); *Shaw*, 539 F. Supp. 3d at 184 ("the public interest supports . . . limited intrusion in military affairs from civilian courts").

The public interest is especially high in ensuring that no preliminary injunction would direct the military to maintain service members in particular assignments. In particular, the Court's TRO, which keeps two Plaintiffs in command positions, is clearly improper under long-standing precedent and is causing immediate, irreparable harm to the military. *See* Defs.' TRO Opp'n 17–20, ECF No. 66. The Court's TRO has required the Navy to maintain in place the commander of a destroyer with a crew of 300 Sailors after the Navy has lost confidence in him and concluded he is unfit for duty for failure to follow lawful orders. Ex. 11 ¶¶ 4–9. Should the Navy need the destroyer to deploy in response to a geopolitical event or a national security crisis, the

Court's Order means that the Navy would have to deploy a destroyer with a commander who the Navy has assessed is unfit for command, and who could compromise the health and effectiveness of the ship. Ex. 11 ¶ 13. Similarly, because Plaintiff Lieutenant Colonel had been selected for a battalion command, the Court's Order forces the Marine Corps to place her in a leadership role, with the prospective authority, responsibility and accountability for mission accomplishment and the readiness, health and welfare of 300 Marines, even though the Marine Corps has lost confidence in her ability to follow orders. Ex. 10 (Decl. of Colonel Eric Thompson) ¶ 4. Moreover, Plaintiff Lieutenant Colonel had been selected for command of a unit that will be deploying overseas, but because certain countries have vaccination requirements, she would not be able to command her unit in those countries, which "will result in diminished unit effectiveness and mission accomplishment." *Id.* ¶ 9.

Wholly apart from the merits of the underlying RFRA claims, the Court's TRO is in clear conflict with authority that specific military assignment decisions are the province of the military, not the Courts. *See* Defs.' TRO Opp'n 17–20, ECF No. 66. A commanding officer who cannot adhere to military orders themselves has forever lost the ability to instill a culture of good order and discipline in their Sailors or Marines, which is absolutely crucial to mission success, and, thus, national security. Ex. 10 ¶ 4; Ex. 11 ¶¶ 4, 8, 11; *Chappell*, 462 U.S. at 300. For these reasons in particular, the Plaintiffs' demand for a preliminary injunction with respect to these two officers (Plaintiff Navy Commander and Plaintiff Marine Lt. Colonel) must be denied, and the TRO vitiated.

With respect to EO 14043, a preliminary injunction would harm the public interest in slowing the spread of COVID-19 among millions of federal employees and the members of the public with whom they interact. As several other courts have recognized, "barring enforcement of the vaccine requirement for federal employees would do substantial and irreparable harm to the public health." *Rydie*, 2021 WL 5416545, at *5; *see also Church*, 2021 WL 5179215, at *19; *Smith*, 2021 WL 5195688, at *9; *Altschuld*, 2021 WL 6113563, at *5. An injunction would also harm "[t]he effective administration of the federal government, in which Defendants and the public have a deep and abiding interest." *Rydie*, 2021 WL 5416545, at *5. The COVID-19 pandemic has interfered with numerous aspects of the government's work, and the essential services it provides, by, *e.g.*, forcing office closures, limiting official travel, and causing staffing shortages. *See generally* Pandemic Response Accountability Committee: COVID-19 Emergency Relief and Response Efforts, Top Challenges Facing Federal Agencies (June 2020), https://perma.cc/NUP9-V3XT. Enjoining EO 14043 would thus likely interfere with the government's ability to resume normal, pre-pandemic operations. *See Church*, 2021 WL 5179215, at *19. These significant harms outweigh any of the quintessentially reparable harms that might befall the civilian employee Plaintiffs if, in the absence of emergency relief, they faced the prospect of workplace discipline.

VI. Plaintiffs' Anonymous Allegations Cannot Satisfy the Burden for a Preliminary Injunction.

Finally, over three months into this litigation, Plaintiffs still have not complied

with Federal Rule of Civil Procedure 10(a) by filing a complaint that "name[s] all the parties." *See Doe v. Frank*, 951 F.2d 320, 322–24 (11th Cir. 1992). Plaintiffs finally filed their long-anticipated motion to proceed under a pseudonym but have provided neither the Court nor Defendants with their names. Plaintiffs' failure to do so inhibits Defendants from "contradict[ing] or explain[ing] assertions" in the Complaint and declarations or providing fulsome explanations to the Court regarding each Plaintiff's individual circumstances. *See KeyView Labs, Inc. v. Barger*, 2020 WL 8224618, at *6 (M.D. Fla. Dec. 22, 2020); *see also Oklahoma*, 2021 WL 6126230, at *2 ("Absent permission, the district court lacks 'jurisdiction over the unnamed parties, as a case has not been commenced with respect to them.'" (citation omitted)).

Rather than provide sufficient information for the Court to assess Plaintiffs' claims, they instead make arguments in the abstract based on their allegation that the entire military religious accommodation process is a "ruse" and thus the Court must grant all religious exemptions without regard to the individual request and without regard to the military's judgment as to military needs. But "Federal courts do not exercise general legal oversight of the Legislative and Executive Branches[.]" *TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2203 (2021). And Plaintiffs "must assert [their] own legal rights and interests, and cannot rest [their] claim to relief on the legal rights or interests of third parties." *Warth v. Seldin*, 422 U.S. 490, 499 (1975).

By failing to provide their names, Plaintiffs do not allow the Court to assess whether they are likely to succeed on the merits of their claims or whether they will suffer any irreparable harm. *See KeyView Labs*, 2020 WL 8224618 at *6, *13.

Accordingly, the Court cannot grant a preliminary injunction as to the "named" Plaintiffs, much less issue a preliminary injunction as to any purported class. *TransUnion*, 141 S. Ct. at 2208 ("Article III does not give federal courts the power to order relief to any uninjured plaintiff, class action or not.") (quoting *Tyson Foods, Inc.* v. *Bouaphakeo*, 577 U.S. 442, 466 (2016) (Roberts, C. J., concurring)).

CONCLUSION

For the foregoing reasons, and for those set forth in Defendants' Opposition to Plaintiffs' Motion for a Preliminary Injunction and in Defendants' Opposition to Plaintiffs' Emergency Motion for a Temporary Restraining Order, as well as their supporting exhibits and declarations, Plaintiffs' Motion for a Preliminary Injunction should be denied as to all Plaintiffs, including Plaintiff Navy Commander and Plaintiff Marine Lt. Colonel, and the TRO entered on February 2, 2022 (ECF No. 67).

Dated: February 4, 2022

Respectfully submitted,

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Table of Exhibits

Exhibit Number	Exhibit Description
1.	Department of Defense Instruction ("DoDI") 1332.45, Retention Determination for Non-Deployable Service Members
2.	Declaration of Captain Lanny F. Littlejohn, filed in *Navy SEALs 1-26 v. Biden*, 21-cv-01236 (N.D. Tex.)
3.	Declaration of Colonel Tonya Rans
4.	Declaration of Major Scott Stanley
5.	Declaration of Colonel Artemio Chapa
6.	Declaration of Major General Telita Crosland
7.	Declaration of Rear Admiral Gayle D. Shaffer
8.	Declaration of Rear Admiral Dana Thomas
9.	Declaration of Captain Joon Yun
10.	Declaration of Colonel Eric N. Thompson
11.	Declaration of Captain Frank Brandon

Exhibit 1

DoD INSTRUCTION 1332.45

RETENTION DETERMINATIONS FOR NON-DEPLOYABLE SERVICE MEMBERS

Originating Component:	Office of the Under Secretary of Defense for Personnel and Readiness
Effective: **Change 1 Effective:**	July 30, 2018 April 27, 2021
Releasability:	Cleared for public release. Available on the Directives Division Website at https://www.esd.whs.mil/DD/.
Incorporates and Cancels:	Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "DoD Retention Policy for Non-Deployable Service Members," February 14, 2018
Approved by:	Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness
Change 1 Approved by:	Virginia S. Penrod, Acting Under Secretary of Defense for Personnel and Readiness

Purpose: In accordance with the authority in DoD Directive 5124.02, this issuance:

- Establishes policy, assigns responsibilities, and provides direction for retention determinations for non-deployable Service members.
- Provides guidance and instructions for reporting deployability data for the Total Force.

TABLE OF CONTENTS

SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY.

This issuance applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the "DoD Components").

1.2. POLICY.

It is DoD policy that:

a. To maximize the lethality and readiness of the joint force, all Service members are expected to be deployable.

b. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for:

(1) A retention determination by their respective Military Departments.

(2) As appropriate, referral into the Disability Evaluation System (DES) in accordance with DoD Instruction (DoDI) 1332.18 or initiation of processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. This policy on retention determinations for non-deployable Service members does not supersede the policies and processes concerning referral to the DES or the initiation of administrative separation proceedings found in these issuances.

c. Implementation for this policy is October 1, 2018.

1.3. INFORMATION COLLECTIONS.

The Monthly Non-deployable Report, referred to in Paragraph 3.2. of this issuance, has been assigned report control symbol DD-P&R(M)2671 in accordance with the procedures in Volume 1 of DoD Manual 8910.01. The expiration date of this collection is listed in the DoD Information Collections Website at https://www.esd.whs.mil/Directives/collections_int/.

1.4. SUMMARY OF CHANGE 1.

The changes to this issuance:

a. Reflect updates to reporting tracking procedures (Paragraph 3.1. of this issuance) and timelines (Paragraph 3.2. of this issuance).

b. Provide additional clarity for reporting temporary non-deployable categories (Paragraph 3.5. of this issuance) and individual medical readiness (IMR) deficits (Paragraph 3.7. of this issuance).

c. Update the formatting according to new issuance template guidelines.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS (USD(P&R)).

The USD(P&R) establishes and oversees policy on retention determinations for non-deployable Service members.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER AND RESERVE AFFAIRS (ASD(M&RA)).

Under the authority, direction, and control of the USD(P&R), the ASD(M&RA):

a. Develops policy on the retention of non-deployable Service members.

b. Monitors the implementation of this guidance.

c. Tracks the number of non-deployable Service members and those non-deployable Service members retained in military service and the justification for such retention, in accordance with Section 3 of this issuance.

2.3. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS.

Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Health Affairs:

a. Develops policy recommendations to the USD(P&R) for uniform retention medical standards in coordination with the Secretaries of the Military Departments.

b. Provides oversight of related medical policies and programs.

2.4. SECRETARIES OF THE MILITARY DEPARTMENTS.

The Secretaries of the Military Departments:

a. Will:

(1) Determine the deployability status of Service members.

(2) Make retention determinations consistent with this issuance for Service members who have been non-deployable for more than 12 consecutive months.

(3) Submit monthly reports identifying the number of non-deployable Service members for all components within their Departments to the Office of the USD(P&R) in accordance with Paragraph 3.2. of this issuance.

(4) Monitor compliance with requirements established in DoDI 6025.19 to ensure required evaluations, assessments, and other medically related actions are accomplished to improve individual and overall unit readiness.

b. May:

(1) Retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit in Paragraph 1.2. of this issuance if determined to be in the best interest of the Military Service.

(2) Delegate the authority in Paragraph 2.4.(b)(1) of this issuance to retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit. Such a delegation must be in writing, and may only be made to Presidentially Appointed, Senate-Confirmed officials; Senior Executive Service members; or general/flag officers serving at the Military Department or Service headquarters.

(3) Initiate administrative separation processing, or referral to the DES, as appropriate, prior to a non-deployable Service member being in a non-deployable status for 12 months when the Military Service determines there is a reasonable expectation that the reason will not be resolved and the Service member will not become deployable.

SECTION 3: PROCEDURES

3.1. TRACKING.

a. The Military Departments will monitor and track the number of Service members by Military Service that are:

(1) Non-deployable in accordance with the categories established in Paragraphs 3.5. and 3.6. of this issuance.

(2) Deployable with limitations in accordance with Paragraph 3.3. of this issuance.

(3) Deployable but have IMR deficits in accordance with Paragraph 3.7. of this issuance.

(4) In training or in a transient status in accordance with the category defined in Paragraph 3.4. of this issuance.

b. To ensure accurate and consistent accounting across the DoD, Military Services will account for Service members in only one category.

(1) If a Service member can be accounted for in more than one category, the Service member will be counted only once and in the category with the highest priority listed in accordance with Paragraph 3.8. of this issuance.

(2) This restriction does not apply to Service members who may also be counted as IMR deficits in accordance with Paragraph 3.7. of this issuance. In addition to the categories listed in Paragraphs 3.3. through 3.6. of this issuance, Service members with IMR deficits will also be counted in accordance with Paragraph 3.8.g. of this issuance.

3.2. REPORTING.

a. The Secretaries of the Military Departments will report to the ASD(M&RA) the number of non-deployable personnel (and other categories as provided in this section) for all Military Services, and their respective components, on a monthly basis.

(1) The format for the Monthly Non-deployable Report can be found at https://prhome.defense.gov/M-RA/Inside-M-RA/MPP/OEPM/.

(2) Reports are due **no later than** the 20th of each month with data current as of the last day of the previous month. For example, the May Non-deployable Report is due by June 20th with non-deployable data as of May 31st. Reports will be accepted earlier if available.

b. The number of non-deployable Service members is reported by categories, either temporary or permanent, and grouped into medical, legal, or administrative sub-categories. Each sub-category is further broken down to account for the specific reasons or conditions that make a Service member non-deployable.

c. The number of Service members who are deployable with limitations, in accordance with Paragraph 3.3. of this issuance, will be categorized separately on the monthly report. Such Service members are not to be counted in the non-deployable populations.

d. The number of Service members who require urgent or emergent dental treatment for dental readiness (Dental Class 3), are overdue for annual dental screening (Dental Class 4), or are overdue for a Periodic Health Assessment (PHA) are reported as IMR Deficits in accordance with Paragraph 3.7. of this issuance. Such Service members are not counted in the non-deployable populations.

e. The number of Service members who are in a training or transient status are reported in one of the four categories listed in Paragraph 3.4. of this issuance.

3.3. DEPLOYABLE WITH LIMITATIONS.

Service members with a medical condition that requires additional medical screening, or Combatant Command approval prior to deployment outside the continental United States, will be categorized as Deployable with Limitations. This includes, but is not limited to, conditions referred to in DoDI 6490.07.

3.4. TRAINING AND TRANSIENT.

The Training and Transient category provides a means to track the human resources necessary to maintain a healthy force, within current end strength constraints. This category contains Service members who are not immediately ready for deployment and fall into one of the following four categories:

a. Initial Entry Training.

These Service members are:

(1) Enlisted Service members at recruit training, initial skill training, and other proficiency or developmental training accomplished before moving to the member's first permanent duty assignment. This includes all in-transit time commencing upon entry into active service, through completion of the final course of initial entry training that terminates enlisted trainee status.

(2) Enlisted trainees who enter officer candidate school, officer training school, and Service academy preparatory school following enlistment on active duty. These members will be considered:

(a) Enlisted trainees from initial entry on active duty until commissioning.

(b) Upon commissioning, officer accession students and will remain in the initial entry training category for any subsequent initial entry training, or until they begin travel to their first permanent duty assignment.

(3) Officers at officer basic courses, and all initial skill and proficiency training taken before travel to the Service member's first permanent duty assignment. This includes all in-transit time from entry on active duty until completion of the last initial entry course of instruction.

(4) Reserve Component (RC) Service members (enlisted and officer) who enter the Ready Reserve and are awaiting initial entry training.

b. Cadets and Midshipman.

These are individuals currently attending the U.S. Military Academy, the U.S. Air Force Academy, or the U.S. Naval Academy. In accordance with Section 115 of Title 10, United States Code (U.S.C.), cadets and midshipman are counted in the active duty end strength for their respective Service, but by policy are non-deployable while attending school.

c. All Other Training.

These are Service members who are attending training that is 20 weeks or more in length, and is conducted after their initial entry training. Examples include Command and Staff Colleges, Senior Service College, the United States Army Sergeants Major Academy, medical residencies, and all other post-graduate professional education opportunities.

d. Transient.

These are Service members who are not available for duty while executing permanent change of station orders at the time of the report. This category does not include military personnel who are:

(1) On temporary duty for training between permanent duty stations, or;

(2) Moving between entry-level courses of instruction, specifically Service members who have departed from one duty station and are in transit but have not yet reported for duty at the next permanent duty station.

3.5. TEMPORARY NON-DEPLOYABLE CATEGORIES.

a. Medical.

Service members are considered temporarily non-deployable for one of three reasons:

(1) Patient.

In accordance with DoDI 1120.11, Service members who are hospitalized and are projected to heal, recover, and return to full duty in less than 12 months are temporarily non-deployable.

(2) Medical Condition That Limits Full Duty.

Service members who have temporary profiles or are in limited duty status are counted as temporarily non-deployable. Light duty will not be reported as non-deployable unless the duration exceeds 30 days, with discretion given to the medical officer to extend light duty status for up to 60 days, making light duty no longer than 90 days for conditions expected to recover or stabilize within that time. Service members who are considered to be classified as light duty are considered deployable and expected to be able to deploy, at the local commander's discretion, despite the medical condition causing their light duty status.

(3) Pregnancy (including post-partum).

Service members who are pregnant or in the post-partum phase are temporarily non-deployable. The post-partum phase ranges from 6 to 12 months after childbirth for female Service members and is determined by individual Service policy.

b. Legal.

Service members are considered temporarily non-deployable for one of two reasons:

(1) Prisoner.

Service members convicted by civilian or military authorities and sentenced to confinement of more than 30 days, but for 6 months or less, are temporarily non-deployable. Service members confined for more than 6 months are not included in end strength numbers and will not be included in the monthly non-deployability report.

(2) Legal Action.

Service members who are under arrest, confined 30 days or less, pending military or civil court action, under investigation, a material witness, on commander directed hold, pending non-judicial punishment action under Section 815 of Title 10, U.S.C., also known as Article 15 of the Uniformed Code of Military Justice (UCMJ), or pending discharge based on action under the UCMJ are temporarily non-deployable.

c. Administrative.

These Service members are considered temporarily non-deployable for one of eight reasons:

(1) Absent Without Leave or Unauthorized Absence.

Service members who are absent without leave, as defined in Section 886 of Title 10, U.S.C., also known as Article 86 of the UCMJ, will be considered as temporarily non-deployable.

(2) Family Care Plan.

In accordance with DoDI 1342.19, Service members required but failing to have a family care plan in place are temporarily non-deployable.

(3) Adoption.

Service members who are single parents or one member of a dual military couple and are adopting a child are temporarily non-deployable. They are non-deployable for at least 6 months after the child is placed in the home, or longer dependent on the administrative stabilization period prescribed by the jurisdiction in which the adoption occurred.

(4) Service Member Under 18.

Service members who are not yet 18 years of age are temporarily non-deployable. The Child Soldier Prevention Act of 2007 prohibits Service members under the age of 18 from taking part in hostilities as a member of governmental armed forces.

(5) Humanitarian Assignment.

Service members assigned to a location to provide support to a family member are temporarily non-deployable. These Service members typically receive 12 to 24 months stabilization by Military Service policy.

(6) Service Discretion.

Military Services may designate Service members temporarily non-deployable when the previous categories do not apply. Examples include:

(a) Simultaneous Membership Program or Officer Candidate School.

(b) Education stabilization; mobilization deferral for affiliation after release from Active Component.

(7) Pending Administrative Separation.

Service members being processed for administrative separation are temporarily non-deployable.

(8) Unsatisfactory Participants or Administrative Action Pending (RC Only).

Service members who are determined to be unsatisfactory participants (defined in DoDI 1215.13 as a Service member that has nine unexcused absences within a 12-month period or fail to perform prescribed periods of active duty for training), are considered temporarily non-deployable, after the 90 day recovery period has elapsed. The Military Services will have no more than 90 days to recover the unsatisfactory participant before the unsatisfactory participant is counted as temporarily non-deployable. The Military Services will determine when an RC

Service member who was classified as an unsatisfactory participant is considered recovered, and no longer counted as non-deployable.

3.6. PERMANENT NON-DEPLOYABLE CATEGORIES.

a. Medical.

Service members are considered non-deployable for one of three reasons listed below.

(1) Permanent Limited Duty.

Service members with a medical condition that permanently prevents deployment are non-deployable. This includes Service members processed through the DES who are not deployable and were retained in the Military Service. In accordance with Section 1214a of Title 10, U.S.C., Service members cannot be involuntarily administratively separated or denied reenlistment due to unsuitability based solely on the medical condition considered in the evaluation unless the request to separate the Service member is approved by the Secretary of Defense. The Military Service may direct the Service member to reenter the DES process to be reconsidered for retirement or separation for disability.

(2) Enrolled in DES.

In accordance with DoDI 1332.18, Service members currently enrolled in the DES process are non-deployable. That includes those pending separation or retirement after receiving a "not fit for duty" determination through the DES.

(3) Permanent Profile Non-duty Related Action Needed (RC).

Those RC Service members who have a permanent profile and are pending a decision on a line of duty determination are non-deployable.

b. Administrative.

These Service members are considered non-deployable for one of three reasons:

(1) Sole Survivor, Surviving Family Member, or Deferred from Hostile Fire Zone.

Service members who acquired the status in accordance with DoDI 1315.15 are non-deployable.

(2) Unable to Carry a Firearm.

Service members who are subject to the provisions of Section 922 of Title 18, U.S.C. are non-deployable.

(3) Conscientious Objector.

Service members who are granted restriction of military duties in accordance with DoDI 1300.06 are non-deployable.

c. Approved for Retention.

This category accounts for Service members who are retained by the Military Department despite being in a non-deployable status for 12 months or longer. Service members who the Military Departments retained in Service and are considered non-deployable for one of two reasons:

(1) Combat Wounded.

These are Service members whose injuries were the result of hostile action, meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.

(2) Other.

These are Service members who are not designated as combat wounded but are non-deployable and retained in the Military Service by the Secretary of the Military Department in accordance with Paragraph 2.4. of this issuance.

3.7. IMR DEFICITS.

These IMR categories are not considered non-deployable conditions. While Service members who do not have a current PHA (completed) or whose dental readiness assessment is classified as either Dental Class 3 or Dental Class 4 are not medically ready to deploy, they will not be reported in the non-deployable population. Components are expected to immediately correct all IMR deficits to ensure Service members are medically ready to deploy.

a. Overdue PHA.

These Service members are not compliant with the requirement to complete a PHA in accordance with DoDI 6025.19.

b. Dental Readiness (Dental Class 3).

Service members who require urgent or emergent dental treatment.

c. Overdue Dental Screening (Dental Class 4).

Service members who are not compliant with the requirement to complete a dental screening in accordance with DoDI 6025.19.

d. Additional IMR Categories.

In addition to dental categories (Dental Classes 3 and 4) and PHAs, the Military Departments track three additional areas of IMR: immunization status, medical readiness and laboratory studies, and individual medical equipment. In accordance with DoDI 6025.19, Service members who are not current in these areas are considered partially-medically ready.

3.8. PRIORITIZATION OF SERVICE MEMBERS BY CATEGORY.

This paragraph sets the prioritization for the grouping of Service members into categories to provide consistent reporting among the Military Departments, in accordance with Paragraph 3.1.b. of this issuance. With the exception of Service members who may be accounted for in IMR deficits, in accordance with Paragraph 3.1.b.(2) of this issuance, Service members will be counted only once, in a single category; Service members who may fall into more than one category will be reported in the priorities established in this paragraph. These categories are listed below in descending order of priority.

a. Deployed.

This category includes Service members who are currently deployed. These Service members will not be counted in any other category (including deployable with limitations or approved for retention).

b. Deployable with Limitations.

c. Approved for Retention.

(1) Combat wounded – Non-deployable but retained.

(2) Other – Non-deployable but retained.

d. Permanent Non-Deployable.

(1) Medical permanent limited duty.

(2) Administrative.

(a) Sole survivor, surviving family member, or deferred from hostile fire zone.

(b) Unable to carry a firearm (e.g., Lautenberg Amendment).

(c) Conscientious objector.

(d) Ex-prisoner of war.

(3) Medical Enrolled in DES.

(4) Permanent profile non-duty related action needed (RC).

e. Training and Transient.

(1) Initial entry training.

(2) Cadets or Midshipmen.

(3) All other training.

(4) Transient (permanent change of station).

f. Temporary Non-Deployable.

(1) Medical.

(a) Patient (assigned to "Individuals Account").

(b) Medical condition that limits full duty.

(c) Pregnancy (including post-partum).

(2) Legal.

(a) Prisoner.

(b) Legal Action.

(3) Administrative.

(a) Absence without leave.

(b) Family Care Plan.

(c) Adoption.

(d) Service member under 18.

(e) Humanitarian assignment.

(f) Service Discretion.

(g) Pending Administrative Separation.

(h) Unsatisfactory participants or admin action pending (RC).

g. IMR Deficits.

Service members with IMR deficits may be counted as both overdue PHA and as either Dental Class 3 or Dental Class 4.

(1) Overdue PHA.

(2) Dental readiness (Dental Class 3).

(3) Overdue dental screening (Dental Class 4).

SECTION 4: RETENTION DETERMINATION

4.1. RETENTION AUTHORITY FOR NON-DEPLOYABLE SERVICE MEMBERS.

In accordance with Paragraph 2.4. of this issuance, the Secretaries of the Military Departments have retention authority.

4.2. RETENTION DETERMINATION.

a. The Secretaries of the Military Departments may retain Service members who are non-deployable in excess of 12 consecutive months, on a case-by-case basis, if determined to be in the best interest of the Service, based on:

(1) The Service member's ability to perform appropriate military duties commensurate with his or her office, grade, rank, or skill.

(2) The likelihood that the Service member will resolve the condition or reason that is the underlying cause of his or her non-deployable status.

b. The Secretaries of the Military Departments may approve retention for Service members who are non-deployable in excess of 12 consecutive months for up to:

(1) The length of time remaining on a Service member's enlistment contract; or

(2) Three years for officers, including warrant officers, and those enlisted members serving on indefinite contracts.

(3) Upon expiration of the retention period, the Secretary of the Military Department concerned may renew retention for a Service member on a case-by-case basis for periods stated in this paragraph.

c. The Secretaries of the Military Departments may establish procedures for Service members who are or will be non-deployable for 12 months or longer due to an administrative reason to request retention consideration.

d. Approval of the retention for Service members who are non-deployable for 12 months or longer will only be made for individual Service members, not an entire cohort or skill set of Service members.

e. Except as required by DoDI 1332.18, the Secretaries of the Military Departments may request from the Secretary of Defense the authority to automatically exempt Service members serving in specified positions from the requirement for a retention determinations pursuant to Paragraph 2.4.b.

f. When appropriate, Service members not recommended for further retention will be considered for processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30, or referral for disability separation in accordance with DoDI 1332.18.

4.3. SPECIAL CATEGORIES.

a. Pregnant and post-partum Service members, as a group, are exempt from Paragraph 2.4.a., for pregnancy-related health conditions during pregnancy through the post-partum period.

b. The Secretaries of the Military Departments have the authority to retain combat wounded Service members who have been evaluated through the DES and whose reason for non-deployability is a direct result of their combat wounds, if requested by the Service member.

(1) Disapproval of retention for non-deployable combat wounded Service members, who wish to be retained and whose reason for non-deployability is a direct result of their combat wounds, may not be delegated.

(2) Retention will be authorized in accordance with Paragraph 4.2.b.

c. Unless found unfit for duty through the DES, Service members serving in specified positions approved by the Secretary of Defense pursuant to Paragraph 4.2.e. are exempt from requiring a retention determination based solely on being in a non-deployable status for 12 months or longer. Upon reassignment, these Service members will again require a retention determination in accordance with Paragraph 4.2.a.

d. Unless sooner discharged or retired under another provision of law, or discharged due to misconduct or sub-standard performance, the Secretaries of the Military Departments may retain those Service members who are, or will be, non-deployable for 12 months or longer due to administrative reasons and who have attained such years of creditable service so as to be within 3 years of qualifying for:

(1) Regular retirement (or in the case of enlisted members of the Navy or Marine Corps, transfer to the Fleet Reserve or Fleet Marine Corps Reserve, as the case may be) pursuant to Sections 3911, 3914, 6323, 6330, 8911, or 8914 of Title 10, U.S.C.; or

(2) Non-regular retirement (but for age) pursuant to Sections 12731 and 12735 of Title 10, U.S.C., if, in the case of RC members other than RC members within 3 years of qualifying for regular retirement, they have attained at least 17 years of qualifying creditable service as computed in accordance with Section 12732 of Title 10, U.S.C., and continue to attain qualifying creditable service as computed under Section 12732 of Title 10, U.S.C. to become eligible for non-regular retirement within the 3-year period.

SECTION 5: AUTHORITIES FOR SEPARATIONS AND RETIREMENTS

5.1. In accordance with Paragraph 1.2. of this issuance, a Service member who has been non-deployable for an administrative reason (not medical or legal) for more than 12 consecutive months, will be processed for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. Military Services should ensure expeditious administrative separation proceedings in accordance with Military Department and Military Service policies.

5.2. A Service member who has been non-deployable due to a physical disability that makes him or her potentially unfit for the duties of his or her office, grade, rank, or rating for more than 12 consecutive months will be referred into the DES in accordance with DoDI 1332.18.

GLOSSARY

G.1. ACRONYMS.

ACRONYM	MEANING
ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
DES	Disability Evaluation System
DoDI	DoD instruction
IMR	individual medical readiness
PHA	periodic health assessment
RC	Reserve Component
UCMJ	Uniformed Code of Military Justice
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness.

G.2. DEFINITIONS.

Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

TERM	DEFINITION
active duty	Defined in the DoD Dictionary of Military and Associated Terms.
active service	Defined in Section 101(d)(3) of Title 10, U.S.C.
active status	Defined in Section 101(d)(4) of Title 10, U.S.C.
combat wounded	Service members whose injuries were the result of hostile action, who meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.
deployable	A Service member who does not have a Service-determined reason that precludes him or her from deployment.

TERM	DEFINITION
deployment	The movement of personnel into and out of an operational area or in support of operations. Deployment encompasses all activities from origin or home station through destination, specifically including inter-theater, and intra-theater movement legs, staging, and holding areas.
Military Departments	The Departments of the Army, Navy, and Air Force.
Military Service Headquarters	Headquarters, United States Army; Headquarters, United States Navy; Headquarters, United States Air Force; and Headquarters, United States Marine Corps.
Military Services	The United States Army, the United States Navy, the United States Air Force, the United States Space Force, and the United States Marine Corps.
military specialty	A military occupational specialty in the Army and the Marine Corps; an Air Force specialty code in the Air Force; or a rating or Navy enlisted classification in the Navy.
non-deployable	A Service member who has a Service-determined reason that precludes him or her from deployment.
permanently non-deployable	A Service member who has a reason that precludes them from deployment, and there is a Service expectation that the reason will not be resolved and the Service member will never be deployable.
profile	A document used to communicate to commanders the individual medical restrictions for Soldiers and Airmen.
Ready Reserve	Defined in the DoD Dictionary of Military and Associated Terms.
reason code	The term used to define non-deployable categories.
separation	A general term that includes discharge, release from active duty, release from custody and control of the Military Services, transfer to the Individual Ready Reserve, and similar changes in Active and Reserve status.
temporarily non-deployable	A Service member who has a reason or reasons that precludes him or her from deployment, and there is a Service expectation that the reason or reasons will be resolved and the Service member will be deployable.

REFERENCES

DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness (USD(P&R))," June 23, 2008

DoD Instruction 1120.11, "Programming and Accounting for Active Component (AC) Military Manpower," March 17, 2015

DoD Instruction 1215.13, "Ready Reserve Member Participation Policy" May 5, 2015

DoD Instruction 1300.06, "Conscientious Objectors," July 12, 2017

DoD Instruction 1315.15, "Special Separation Policies for Survivorship," May 19, 2017

DoD Instruction 1332.14, "Enlisted Administrative Separations," January 27, 2014, as amended

DoD Instruction 1332.18, "Disability Evaluation System (DES)," August 5, 2014, as amended

DoD Instruction 1332.30, "Commissioned Officer Administrative Separations," May 11, 2018, as amended

DoD Instruction 1342.19, "Family Care Plans," May 7, 2010, as amended

DoD Instruction 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014, as amended

DoD Instruction 6490.07. "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees" February 5, 2010

DoD Manual 8910.01, Volume 1, "DoD Information Collections Manual: Procedures for DoD Internal Information Collections," June 30, 2014, as amended

Office of the Chairman of the Joint Chiefs of Staff, "DoD Dictionary of Military and Associated Terms," current edition

The Child Soldier Prevention Act of 2007, 110th Congress, S.1175

United States Code, Title 10

United States Code, Title 18

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS

U.S. NAVY SEALs 1-26; U.S. NAVY SPECIAL WARFARE COMBATANT CRAFT CREWMEN 1-5; U.S. NAVY EXPLOSIVE ORDNANCE DISPOSAL TECHNICIAN 1; and U.S. NAVY DIVERS 1-3, Plaintiffs, v. **LLOYD J. AUSTIN, III,** individually and in his official capacity as United States Secretary of Defense; **UNITED STATES DEPARTMENT OF DEFENSE; CARLOS DEL TORO,** individually and in his official capacity as United States Secretary of the Navy, Defendants.	Case No. 4:21-CV-01236-O

SUPPLEMENTAL DECLARATION OF LANNY F. LITTLEJOHN

I, Lanny F. Littlejohn, hereby state and declare as follows:

1. I am a Captain in the United States Navy, currently serving as the Force Medical Officer of U.S. Naval Special Warfare Command (NSWC), located in Coronado, California, whose mission is to provide maritime special operations forces (SOF) to conduct full spectrum operations, unilaterally or with partners, to support national objectives. As the Force Medical Officer, I am the senior ranking medical professional at NSWC and have ultimate responsibility for medical readiness, combat casualty care, quality healthcare delivery, medical research oversight, medical waivers to physical standards, and am the credentialing and privileging authority for all providers within the NSW claimancy. I make this declaration in my official

capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

2. I have been assigned to my current position since January 10, 2020. Prior to my current assignment, I served as Command Surgeon, Naval Special Warfare Development Group; Chair of Emergency Medicine, Naval Medical Center Camp Lejeune; Diving Medical Officer, EOD Group TWO; and Flight Surgeon, VMAQ-4. I am also a board certified Emergency Physician, Assistant Professor of Military and Emergency Medicine at the Uniformed Services University, and Chair of the Technology Subcommittee for the Committee on Tactical Combat Casualty Care for the Defense Health Agency. In my current duties, I am responsible for setting policy and procedures relevant to the health, medical readiness, and medical capabilities of Naval Special Warfare operationally and in garrison.

3. I have reviewed the preliminary injunction order issued in the above captioned case on January 3, 2022. The order misinterprets Navy Instructions MANMED[1] § 15-105(3)(n)(9) and Trident Order[2] #12 and draws incorrect conclusions regarding applicable Navy policies. Citing to MANMED § 15-105(3)(n)(9) and Trident Order #12, the order determines, "[t]hose who receive religious accommodations are still 'medically disqualified.' That means Plaintiffs would be permanently barred from deployment, denied the bonuses and incentive pay

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[1] Navy's Manual of the Medical Department ("MANMED"), Chapter 15, *Physical Examinations and Standards for Enlistment, Commission, and Special Duty.*

[2] Trident Order #12 was issued on September 24, 2021. The directive does not set forth new policies concerning vaccination requirements or processes by which members request medical or administrative exemptions, though it does set forth deadlines for Naval Special Warfare (NSW) personnel (like for the 33 of the 35 Plaintiffs within the NSW claimancy in the above-referenced case) to submit such requests. Service members with questions related to medical exemptions were advised to consult with their medical provider. Trident Order #12 ¶ 6.b. Service members were advised to contact their chaplain for assistance with religious accommodation requests. *Id.* ¶ 6.c.

that accompany deployment, and deprived of the very reason they chose to serve in the Navy. By contrast, those receiving medical accommodations are not medically disqualified—they receive equal status as those who are vaccinated." Op. 11-12. The order also concludes, "even if the Navy were to grant a religious exemption, that exemption would still receive less favorable treatment than its secular counterparts. Those who receive religious exemptions are medically disqualified. Those who receive medical exemptions are not. But the activity itself—forgoing the vaccine—is identical." *Id.* at 14. These findings incorrectly conflate the COVID-19 exemption process with military medical readiness and deployability requirements.

4. A service member that meets all medical requirements for special operations (SO) duty is termed "Physically Qualified" (PQ). A service member that does not meet these medical requirements is termed "Not Physically Qualified" (NPQ). The MANMED provides that "[o]nly the most physically and mentally qualified personnel should be selected, and those who are or may be reasonably expected to become unfit or unreliable must be excluded." MANMED § 15-105(1). Special operations personnel are subject to stringent medical requirements by virtue of the nature of their military duties:

> Special operations (SO) duty takes place in every part of the world under harsh conditions at the extremes of human physical capabilities. Medical austerity and the presence of armed opposition are common. SO personnel, depending on service and warfare community, routinely engage in high-risk operations including parachuting, high angle activities, high-speed boat and unconventional vehicle operation, weapons operation, demolitions employment, and waterborne activities, to include SCUBA diving. As such, SO duty is among the most physically and mentally demanding assignments in the U.S. military.

Id.

5. MANMED § 15-105(4)(a) further describes the circumstances under which a Service member might become medically disqualified from special operations duty:

> Any disease or condition causing chronic or recurrent disability or frequent health care encounters, increasing the hazards of isolation, or having the potential for significant exacerbation by extreme weather, stress, hypobaric or hyperbaric environments, or fatigue is disqualifying. Conditions and treatments causing a significant potential for disruption of operations are disqualifying.

Anyone that is NPQ must have a "Waiver to Physical Standards" recommended by the Navy Bureau of Medicine (BUMED) and approved by the Navy Bureau of Personnel (PERS). A PQ finding, or a waiver to the physical standards if NPQ, is required to be medically fit for special operations and deployable.

6. A medical waiver to the physical standards is a separate determination that would come *after* a medical exemption *or* administrative exemption, such as religious accommodation, for the COVID-19 vaccine. Accordingly, if a service member receives an exemption/accommodation to the COVID-19 vaccine for any reason they would have to engage in this subsequent process to be cleared for full duty by the Navy. That is, a service member who receives an exemption or accommodation from the COVID-19 vaccination requirement, whether for religious or secular reasons, is not PQ unless he or she obtains separate medical clearance. Moreover, the service member may also need a separate medical waiver from the Combatant Command (CCMD) to enter that commander's geographic area of responsibility. Different CCMDs may have specific requirements for vaccination based on the endemic biomedical threats that naturally exist in their geographic area as well as any biowarfare threats from adversaries. An unvaccinated member who deployed to a geographic region where there is an endemic infectious disease would put not only his health at risk, but also the health of any other service member, any partner forces with which SOF work regularly, and other host nation personnel. Thus, a determination that a member is not deployable takes into account the risk to other personnel, the risk to mission as well as the unvaccinated member. These

deployability determinations do not take into account whether a member is unvaccinated for secular or religious reasons; all unvaccinated service members are treated the same for purposes of determining whether they should receive a medical waiver that would render them fit for special operations duty.

7. Receiving a medical exemption for the COVID-19 vaccine does not automatically render a service member deployable; he or she must undergo the process described in the prior paragraph. Indeed, many of the common reasons that a service member may receive a medical exemption from an immunization requirement may also make the service-= member NPQ and nondeployable. For example, BUMEDINST 6230.15B ¶ 2.6 lists immune competence, pharmacologic or radiation therapy, pregnancy and/or previous adverse response to immunization as common reasons for a medical exemption from an immunization.[3] The first three conditions would almost certainly lead to a NPQ finding for NSW and an inability for the service member to get underway on conventional Navy units. The remaining example—previous adverse response to immunization—may provide the basis for a permanent medical exemption request, but as I explained in my prior declaration, ECF 44, Ex. 14 (Decl. of Lanny Littlejohn) ¶ 10 (App 278–79), all requests for permanent medical exemptions from COVID-19 vaccination for personnel falling under NSWC authority have been denied. Moreover, MANMED § 15-105(4)(a) specifically states that "SO personnel reporting for duty following an absence of greater than 14 days due to illness or injury, hospitalization for any reason, or reported on by a medical board must have a properly documented UMO [undersea medical

[3] BUMEDINST 6230.15B ¶ 2.6 also lists evidence of immunity based on serologic tests, documented infection, or similar circumstances as a possible basis for a medical exemption for an immunization. However, pursuant to DoD policy a prior COVID-19 infection, by itself, is not grounds for a medical exemption to the COVID-19 vaccination requirement.

officer] evaluation to determine fitness for continued SO duty." Again many of the reasons a service member might receive a medical exemption for an immunization would fall into this category. This is why a service member who cannot receive the COVID-19 vaccine for medical reasons (or any other reason) will still be NPQ from SO duty until a separate medical waiver is granted by BUMED and PERS. This requirement is specifically delineated in Trident Order #12[4] which states:

> For Special Operations qualification requires a separate waiver that is in addition to waiver of the COVID-19 vaccine requirement for all service members.
> *Id.* ¶ 6.d.

8. Clinical Trials. I am not aware of any NSW personnel participating in clinical research trials concerning COVID-19 vaccines or other COVID-19 medications or treatments. Furthermore, I am not aware of DoD or the Navy conducting or sponsoring any such trials or studies. *See DoDI 3612.02 and SECNAVINST* 3900.39E CH-1 (promulgating standards for human research and clinical studies conducted or sponsored by DoD and the Navy). Choosing to participate in a clinical trial outside the DoD health care system or sponsorship is participating in an elective medical procedure. Navy personnel are required to receive counseling from a military health care provider prior to receiving or engaging in elective medical care outside the military health care system. BUMEDINST 6320.103, Encl. 2 ¶4.a. Personnel who do not receive counseling prior to receiving or engaging in elective medical care will be

[4] Trident Order #12 was issued on September 24, 2021. The directive does not set forth new policies concerning vaccination requirements or processes by which members request medical or administrative exemptions, though it does set forth deadlines for Naval Special Warfare (NSW) personnel (like for the 33 of the 35 Plaintiffs within the NSW claimancy in the above-referenced case) to submit such requests. Service members with questions related to medical exemptions were advised to consult with their medical provider. Trident Order #12 ¶ 6.b. Service members were advised to contact their chaplain for assistance with religious accommodation requests. *Id.* ¶ 6.c.

counseled and could undergo a fitness for duty determination. *Id.* at ¶4.e. If NSW personnel were to participate in such a study or trial that required him to remain unvaccinated, he would very likely be found NPQ as discussed in the preceding paragraphs.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 19th day of January, 2022.

LANNY F. LITTLEJOHN

Captain, Medical Corps, U.S. Navy

Exhibit 3

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

NAVY SEAL #1, et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States, et al., Defendants.	)	Civil Action No. 8:21-cv-02429-SDM-TGW

DECLARATION OF COLONEL TONYA RANS

I, Colonel Tonya Rans, hereby state and declare as follows:

1. I am currently employed by the U.S. Air Force as the Chief, Immunization Healthcare Division, Defense Health Agency – Public Health Directorate, located in Falls Church, Virginia. I have held the position since June 2017. I am a medical doctor and have been board certified in Allergy/Immunology since 2008 and was a board certified Pediatrician from 2001-2015.

2. In my current role, my responsibilities include directing a responsive, evidence-based, patient-centered organization promoting optimal immunization healthcare for all DoD beneficiaries and those authorized to receive immunization from DoD. This includes assisting in policy development, providing implementation guidance and education, and engaging in clinical studies and research through clinical collaboration. The Defense Health Agency-Immunization Healthcare Division (DHA-IHD) routinely engages with the medical representatives from the military departments, U.S. Coast Guard, Joint Staff, Combatant Commands, and others to develop

standardized immunization implementation guidance in accordance with published policy for consistency across DoD where possible.

3. I am aware of the allegations set forth in the pleadings filed in this matter. This declaration is based on my personal knowledge, as well as information made available to me during the routine execution of my official duties.

Coronavirus Disease 2019 (COVID-19)

4. As part of my official duties, I served as a member of the COVID-19 Vaccine Distribution Operational Planning Team (OPT), which was directed to develop and implement DoD's COVID-19 Vaccine Distribution plan. The Coronavirus Task Force (CVTF) provided overarching guidance to the OPT. The OPT provided routine and ad hoc updates on COVID-19 vaccine deliveries, administration, and adverse events to the CVTF.

5. The virus that causes COVID-19 disease is SARS-CoV-2, a ribonucleic acid (RNA) virus from the Coronavirus family. Like any RNA virus, the SARS-CoV-2 virus mutates and evolves constantly and regularly as it infects and replicates in host cells. Mutations that are beneficial to the virus (i.e., make the virus more easily spread between hosts, evade the immune system) are integrated into the viral genome, thereby increasing "survival" and replication opportunity. This has been seen with the SARS-CoV-2 "Delta" variant, which is twice as contagious as previous variants.[1] However, not all mutations are beneficial to the virus – some can result in virus death and therefore do not infect the host. This is part of the normal biology cycle of all viruses.

[1] https://www.cdc.gov/coronavirus/2019-ncov/variants/delta-variant.html, last accessed January 24, 2022.

6. The latest reports from the U.S. Centers for Disease Control and Prevention (CDC) indicate that the SARS-CoV-2 virus spreads when an infected person breathes out droplets and very small particles that contain the virus.[2] These droplets and particles can be inhaled by other people or land on their eyes, noses, or mouth. In some circumstances, viral particles may contaminate surfaces. People who are closer than 6 feet from the infected person are most likely to get infected, especially in areas where there is poor ventilation.

7. COVID-19 disease can cause acute symptoms such as fever/chills, cough, shortness of breath, fatigue, muscle aches, headache, nausea, vomiting, diarrhea, loss of sense of smell or taste and/or sore throat. Symptoms appear 2-14 days (usually within 4-5 days) after viral exposure.[3] The infection can affect people in different ways: from asymptomatic, to limited and mild (for 2-3 days) to more severe (such as trouble breathing, chest pain, inability to think straight and inability to stay awake). Even with the availability of aggressive medical management and ventilator support in an intensive care setting for those with severe symptoms, hundreds of thousands with COVID-19 disease have died. As of January 19, 2022, CDC reports that over 68 million individuals in the U.S. have been diagnosed with COVID-19 disease, over 4 million have been hospitalized, and over 856,000 have died (approximately 1 in 500 in the total U.S. population of 330 million).[4] Per the CDC, the elderly and those with underlying medical conditions such as cardiovascular disease, diabetes, chronic respiratory disease, obesity, pregnancy,

[2] https://www.cdc.gov/coronavirus/2019-ncov/faq.html, last accessed January 24, 2022.

[3] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, last accessed January 24, 2022.

[4] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, last accessed January 24, 2022.

immunocompromising conditions, or cancer are more likely to develop serious illness.[5] However, it is a misguided assumption that those who are otherwise healthy will not develop severe, or even fatal, disease. During the acute infectious stage, the virus causes inflammatory cell death, resulting in the release of pro-inflammatory cytokines (proteins which are important in cell signaling). Pro-inflammatory cytokines can cause inflammatory cell death within multiple organs. Cell death releases cellular and viral fragments, which results in production and release of more inflammatory cytokines.[6] Disease progression can be curtailed by controlling the inflammatory process through immune system clearing of the virus. However, as depicted in the figure below, if the immune system is overwhelmed, either by viral immune evasive mechanisms or by an impaired host response, the pro-inflammatory cytokine process may continue unabated, causing increasingly severe disease such as acute respiratory distress syndrome and cytokine storm. Recognition of the viral and hyperinflammatory phases informs treatment strategies for those with COVID-19 disease, including, but not limited to vaccines, anti-SARS-CoV-2 monoclonal antibodies, and effective pooled antibodies (convalescent plasma) for prevention/mitigation and antivirals for treatment in the viral phase, and targeted immunobiologics and systemic steroids for those in the hyper-inflammatory phase.[7]

[5] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, last accessed January 24, 2022.

[6] Bordallo B, et al. Severe COVID-19: What Have We Learned With the Immunopathogenesis? *Adv Rheumatol* (2020) 60(1):50. doi: 10.1186/s42358-020-00151-7.

[7] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/, last accessed January 29, 2022.

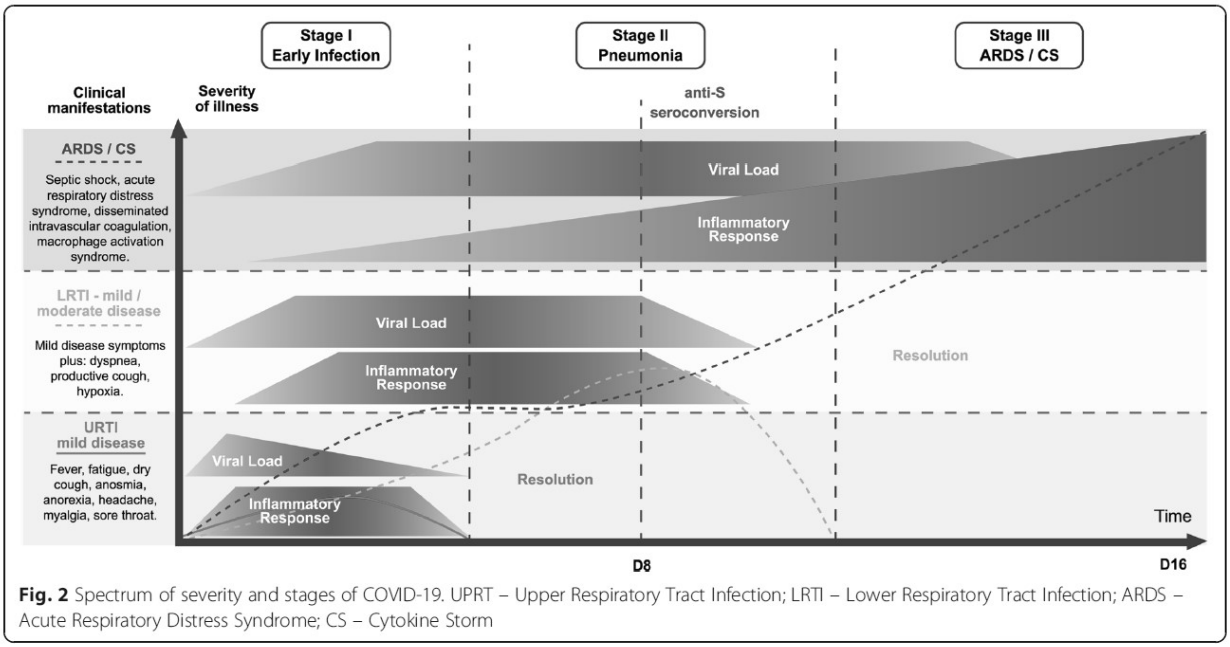


Fig. 2 Spectrum of severity and stages of COVID-19. UPRT – Upper Respiratory Tract Infection; LRTI – Lower Respiratory Tract Infection; ARDS – Acute Respiratory Distress Syndrome; CS – Cytokine Storm

8. Treatment for COVID-19 disease, even in the outpatient environment, is not without risks. The strongest recommendation for pre-exposure to COVID-19 disease remains vaccination, with highest level of evidence demonstrated through robust randomized control trials.[8] Although anti-SARS-CoV-2 monoclonal antibody combinations may be prescribed in the outpatient setting, the indication and level of evidence in use differs when considering pre-exposure prophylaxis, post-exposure prophylaxis, or treatment. Additionally, effectiveness of monoclonal antibodies is impacted by the variant in the infected person. Currently, only one SARS-CoV-2 monoclonal antibody is anticipated to be effective against the omicron variant (sotrovimab), resulting in inadequate supply to meet demand nationwide. What this means to DoD is that even if otherwise healthy service members develop COVID-19 disease, an individual's immune system response may not be able to adequately manage the virus, resulting in a hyperinflammatory state, with variable outcomes, depending on the individual's medical history and immune response. Of the

[8] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/ last accessed January 29, 2022.

treatments currently available, only sotrovimab is anticipated to be a clinically effective mAb against omicron. Of the outpatient antiviral medications, only one comes with a strong recommendation, based on randomized trials. Just as it is acknowledged that there are potential adverse events to COVID-19 vaccines, it should also be understood that there are risks to treatment of COVID-19 disease, even in the outpatient setting. A non-exhaustive list includes cardiovascular events, liver toxicity, and drug interactions. Further, some treatment must be administered shortly after diagnosis – within a matter of days – in order to be effective.[9]

9. Although most people with COVID-19 are better within weeks of illness, some people experience post-COVID-19 conditions (aka long/long-haul COVID, Postacute Sequelae of COVID-19 (PASC), long-term effects of COVID, or chronic COVID). Post-COVID-19 conditions include a wide range of new, returning, or ongoing health problems four or more weeks after infection. Those who were asymptomatic during their COVID-19 infection may still develop post-COVID-19 conditions. One systematic review assessing short and long-term rates of long-COVID in more than 250,000 COVID-19 survivors from 57 studies with an average age of 54 years demonstrated that more than 50% of these COVID-19 survivors continued to have a broad range of symptoms six months after resolution of the acute COVID-19 infection, of which the most common were functional mobility impairments, respiratory abnormalities, and mental health disorders.[10] Another study comparing outcomes in patients referred to outpatient rehabilitation clinics after COVID-19 reported poorer general, mental, and physical health and functioning

[9] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/ last accessed January 29, 2022.

[10] Groff, et al, *JAMA Network Open*, Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2784918.

compared with patients with no previous diagnosis of COVID-19 referred for cancer rehabilitation. Those referred for rehabilitation following COVID-19 were more likely to be male, younger, and employed.[11] A study assessing clinical patterns and recovery time from COVID-19 illness in 147 international-level Paralympic and Olympic athletes showed that 86% had symptoms lasting ≤ 28 days, whereas 14% had symptoms of longer duration. In both groups, fatigue, dry cough, and headache were the predominant symptoms.[12]

COVID-19 Impacts on the Force

10. Infectious diseases have been the single greatest threat to the health of those involved in military operations. As the standard military unit shrinks and becomes more mobile to rapidly respond to global threats, any decrease in personal or unit readiness can significantly decrease operational efficiency and result in military ineffectiveness. Similar to other viruses, SARS-CoV-2 virus can be easily transmitted to others prior to symptom development and therefore may infect significant numbers before being identified. DoD personnel, including service members, especially those in an operational setting (such as those working on ships, submarines, or engaged in the operation of aircraft and vehicles; those deployed to austere environments; or those engaged in routine field training and airborne exercises), work in environments where duties may limit the ability to strictly comply with mitigation measures such as wearing a face mask, avoiding crowded areas, maintaining physical distancing of at least 6 feet, increasing indoor ventilation, maintaining good hand hygiene, and quarantining if in close contact

[11] Rogers-Brown JS, et al. CDC Morbidity and Mortality Weekly Report, Vol 70(27) 9 July 2021 https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7027a2-H.pdf.

[12] Hull JH, et al. Clinical patterns, recovery time and prolonged impact of COVID-19 illness in international athletes: the UK experience. *Br J Sports Med* 2021;0:1-8. Doi 10.1136/bjsports-2021-104392.

with a COVID-19 case. Therefore, upon exposure, these individuals may be at higher risk to be diagnosed with COVID-19 compared to those who can robustly maintain all recommended mitigation strategies. Further, although the elderly population and those with medical conditions are more likely to have severe disease, otherwise healthy Service members have developed "long-haul" COVID-19, potentially impacting their long-term ability to perform their missions. Data presented from DoD's COVID-19 registry has demonstrated that of 111,767 active duty service members who had COVID-19 disease between February 1, 2020 to August 12, 2021, 37,838 (33.9%) had diagnoses for conditions requiring a healthcare visit 30-180 days following their illness, the most common being joint/muscle pain (15,614 or 14%) followed by chest pain/cough (7,887 or 7.1%). In comparison, only 8.3% and 1.81%, respectively, of active duty service members had a healthcare visit for those diagnoses 30-180 days after vaccination. All diagnoses associated with "Long-COVID-19 Syndrome" were found to be more common after COVID-19 disease than after COVID-19 vaccination. Some service members have unfortunately succumbed to the disease, as described further below. Service members and federal civilian employees are the military's most valuable asset; without a medically ready force and ready medical force, the military mission is at high risk of failure. Recommendations from evidence-based medicine must remain the core approach to medical readiness. These evidence-based recommendations will continue to be updated as our understanding of the disease, complications, and impact from vaccination continues to evolve.

11. Between February 2020 and December 2021, there were 234,563 new and repeat cases of COVID-19 among active duty service members (see "Table" below). The largest monthly peak in cases occurred in January 2021, with 28,351 cases identified, followed by the second highest peak in December 2021 with 25,102 cases identified (see "Figure" below). Other

peaks occurred in August 2021 with 22,072 cases and in July 2020 with 11,610 cases. The percentage of cases that were hospitalized was highest at the start of the pandemic and trended downward through January 2021. The percentage of hospitalized cases then increased from 0.9% in January 2021 to 2.1% in May 2021, and decreased to 1.5% in September and October 2021. The percentage of hospitalized cases decreased to 1.1% in November 2021 and 0.3% in December 2021, but this trend should be interpreted with caution due to data lags. In total, 31 active duty service members have died from COVID-19 as of the end of December 2021. The number of active duty service members who died from COVID-19 remained very low throughout the first year of the pandemic, with a slight increase in the numbers of deaths occurring between December 2020 and February 2021, and a greater increase occurring between August and October 2021, coinciding with the increased spread of the Delta variant. More than one-half of the 31 deaths in active duty service members occurred between August and October 2021 (n=17). One active duty service member died from COVID-19 in November 2021. No active duty service member deaths have yet been reported for December 2021.

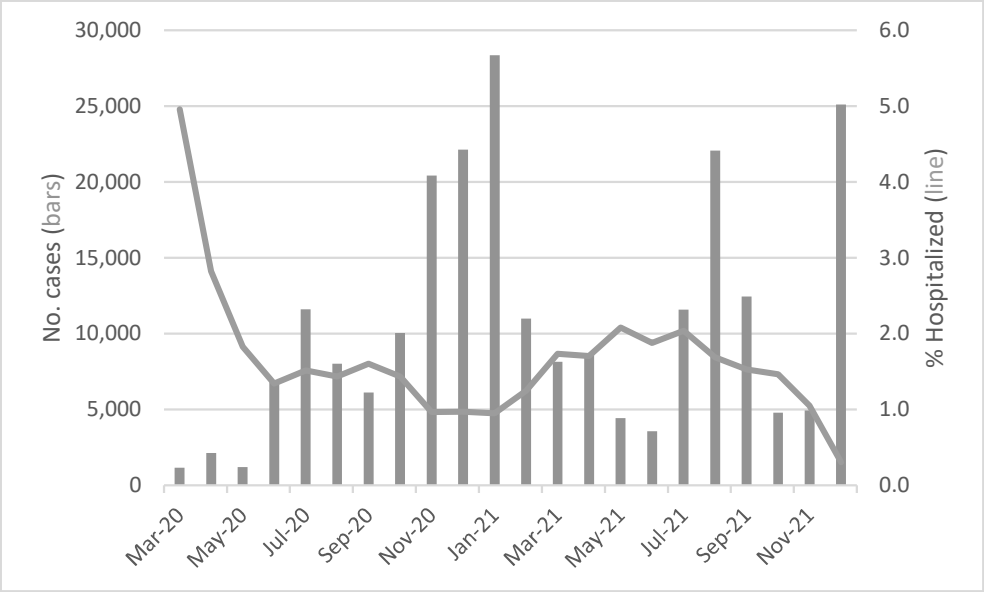
Table. COVID-19 cases, hospitalizations, and deaths among active duty service members, February 2020 - December 2021

	No. cases	No. hospitalizations	% hospitalizations	No. deaths
Feb-20	7	2	28.6	0
Mar-20	1,150	57	5.0	0
Apr-20	2,126	60	2.8	1
May-20	1,204	22	1.8	0
Jun-20	6,790	91	1.3	0
Jul-20	11,610	176	1.5	0
Aug-20	8,010	115	1.4	0

Sep-20	6,118	98	1.6	0
Oct-20	10,048	144	1.4	1
Nov-20	20,422	197	1.0	0
Dec-20	22,119	215	1.0	2
Jan-21	28,351	269	0.9	2
Feb-21	10,981	137	1.2	5
Mar-21	8,136	141	1.7	0
Apr-21	8,575	146	1.7	1
May-21	4,420	92	2.1	0
Jun-21	3,569	67	1.9	0
Jul-21	11,585	236	2.0	1
Aug-21	22,072	372	1.7	5
Sep-21	12,438	190	1.5	6
Oct-21	4,786	70	1.5	6
*Nov-21	4,944	52	1.1	1
*Dec-21	25,102	76	0.3	0

*Hospitalization and death data not complete due to data lags

Figure. COVID-19 cases among active duty service members and percentage of cases that were hospitalized, March 2020 – December 2021



Note: February 2020 is not shown due to the very small number of cases. Hospitalization data for November-December 2021 not complete due to data lags

12. The DoD has provided information on its website concerning the number of vaccinations provided by DoD, the vaccination of the force, and health impact of those who developed COVID-19 infections.[13] As depicted below, data through January 19, 2022 demonstrated that of the 490,202 COVID-19 cases within the DoD 5,817 individuals were hospitalized and 660 have died, including 90 military service members (service members include Active Duty, Reserves, and National Guard personnel). In both the civilian sector and in the

[13] https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/, last accessed January 24, 2022.

military, the overwhelming majority of individuals hospitalized or who died were not vaccinated or not fully vaccinated.

DOD COVID-19 CUMULATIVE TOTALS

	Cases	Hospitalized	Recovered	Deaths
Military	320,601	2,413	280,609	90
Civilian	92,022	2,182	72,588	401
Dependent	47,868	516	43,408	34
Contractor	29,711	706	25,559	135
Total	490,202	5,817	422,164	660

13. The bed capacity at DoD's military medical treatment facilities (MTFs) has generally followed local civilian hospital utilization, with some MTFs having high admission rates and a need to temporarily curtail medical services. Throughout the pandemic, the National Guard has been called on extensively to provide medical support to the civilian population. Over the last few months, DoD has increasingly been deploying military doctors, nurses, paramedics and other personnel to U.S hospitals to assist in preventing the country's medical system from collapsing from demand.

Vaccine Impacts

14. Immunization is a global health and development success story, saving millions of lives across the age spectrum annually from illness, chronic conditions, and potentially death. Immunizations provide benefit at both the individual and community level. First, by stimulating an active immune response, vaccinated individuals are largely protected from the disease of concern. Second, when a high proportion of individuals are immune (i.e., herd immunity) human-to-human transmission is disrupted, thereby protecting those who remain susceptible (i.e., those

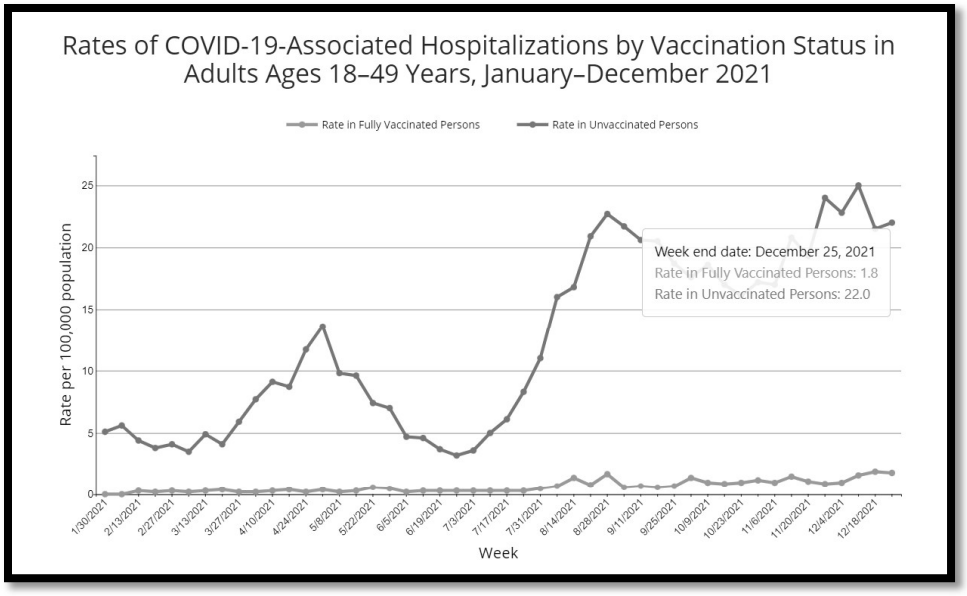
who may not be able to receive a vaccine or do not mount an adequate antibody response). Disease prevention through immunization also mitigates the need for pharmacologic treatment (antibiotics for sepsis, etc.), reducing the risk of drug-resistant pathogen development.

15. A key component of primary health care, the U.S. Food and Drug Administration (FDA) provides regulatory allowance for immunizations and has licensed vaccines for over 20 different infectious diseases. The Advisory Committee on Immunization Practices (ACIP), an advisory committee of the CDC, develops recommendations on how to use vaccines to control diseases in the United States. The military also maintains awareness, surveillance, and provides guidance to DoD personnel and beneficiaries on vaccine-preventable diseases in the global setting.

16. According to the CDC, over 529 million doses of COVID-19 vaccine have been given in the United States from December 14, 2020, through January 18, 2022.[14] Evidence continues to show that the incidence of SARS-CoV-2 infection, hospitalization, and death is higher in unvaccinated than vaccinated persons. Although weekly rates can vary, the cumulative rate of COVID-19 associated hospitalizations in unvaccinated adults ages 18-49 years was over 12 times higher than fully vaccinated adults aged 18-49 years for the week ending December 25, 2021.[15]

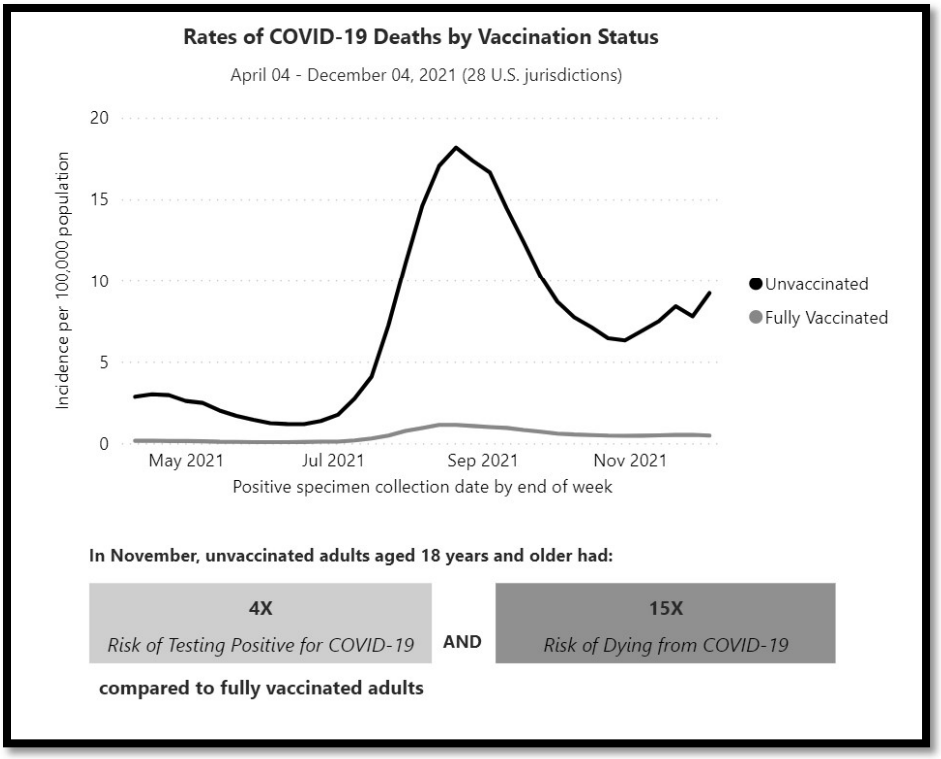
[14] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html, last accessed January 24, 2022.

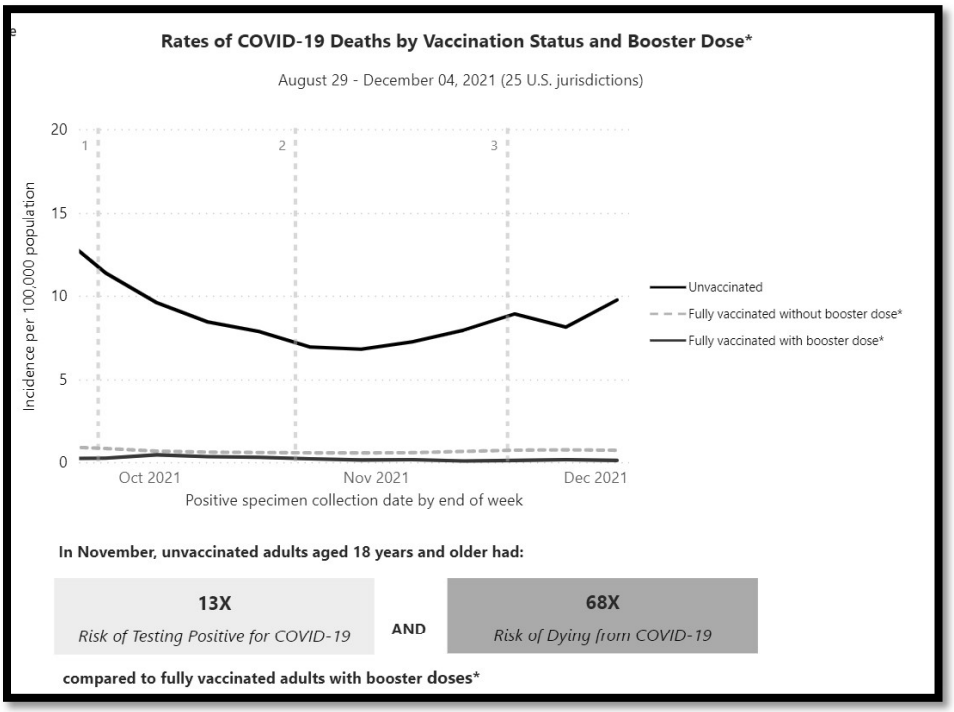
[15] https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, last accessed January 24, 2022.



Also, according to CDC data, deaths by vaccination status in November 2021, demonstrated that unvaccinated persons 18 years of age and older had a 4 times greater risk of testing positive for COVID-19 and a 15 times greater risk of dying from COVID-19 compared to fully vaccinated individuals, and unvaccinated persons 18 years of age and older had a 13 times greater risk of testing positive for COVID-19 and 68 times greater risk of dying from COVID-19 compared to fully vaccinated adults with a booster dose.[16]

[16] https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status, last accessed January 24, 2022.


Rates of COVID-19 Deaths by Vaccination Status
April 04 - December 04, 2021 (28 U.S. jurisdictions)
Incidence per 100,000 population
20
15
10
5
0
May 2021
Jul 2021
Sep 2021
Nov 2021
Positive specimen collection date by end of week
Unvaccinated
Fully Vaccinated
In November, unvaccinated adults aged 18 years and older had:
4X
Risk of Testing Positive for COVID-19
AND
15X
Risk of Dying from COVID-19
compared to fully vaccinated adults


Rates of COVID-19 Deaths by Vaccination Status and Booster Dose*
August 29 - December 04, 2021 (25 U.S. jurisdictions)
Incidence per 100,000 population
20
15
10
5
0
1
2
3
Oct 2021
Nov 2021
Dec 2021
Positive specimen collection date by end of week
Unvaccinated
Fully vaccinated without booster dose*
Fully vaccinated with booster dose*
In November, unvaccinated adults aged 18 years and older had:
13X
Risk of Testing Positive for COVID-19
AND
68X
Risk of Dying from COVID-19
compared to fully vaccinated adults with booster doses*

17. As of January 19, 2022, DoD immunization sites have administered over 6.71 million doses of COVID-19 vaccine. Vaccine adverse events that are temporally associated with vaccine administration are centrally captured by CDC and FDA's Vaccine Adverse Event Reporting System (VAERS) through passive surveillance, meaning that information is voluntarily reported by health care providers and the public. VAERS is not designed to determine whether a vaccine caused a health issue of concern, but it is useful for detecting unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. As of January 14, 2022, a total of 7,927 unique VAERS reports (approximately 11 VAERS reports/10,000 doses administered) were submitted by DoD beneficiaries or those authorized to receive vaccine from DoD. Note that the number of VAERS reports/10,000 doses administered for DoD beneficiaries is likely to be lower, as the denominator does not take into account beneficiaries who receive vaccine in the civilian sector though DoD would still receive their VAERS report if the submitter indicated military affiliation. Additionally, individuals who had an adverse event but did not submit a VAERS would not be known and therefore would not be counted. It must be stressed that a VAERS submission to the CDC does not mean that the vaccine of concern caused or contributed to the medical issue reported.

18. The DoD has received hundreds of thousands of Pfizer-BioNTech BLA-manufactured, EUA-labeled COVID-19 vaccine doses and continues to use them.

19. Approach to immunizations within DoD are outlined in DoD Instruction 6205.02, "DoD Immunization Program" dated June 19, 2019, which states that it is DoD policy that all DoD personnel and other beneficiaries required or eligible to receive immunizations will be offered immunizations in accordance with recommendations from the CDC and its ACIP. Army Regulation 40-562, Navy Bureau of Medicine and Surgery Instruction 6230.15B, Air Force

Instruction 48-110_IP, Coast Guard Commandants Instruction M6230.4G, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," October 7, 2013, further states the Military Service policy concerning immunizations follows the recommendations of the CDC, ACIP, and the prescribing information on the manufacturer's package inserts, unless there is a military-relevant reason to do otherwise. This document also describes general examples of medical exemptions, which include "evidence of immunity based on serologic tests, documented infection, or similar circumstances." Some interpret this as a diagnosis of COVID-19 disease and/or results of a COVID-19 serologic test means that a medical exemption should be granted. However, of significance is the phrase "evidence of immunity." CDC defines immunity as "protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected."[17] There are two major types of testing available for COVID-19: diagnostic tests, which assess for current infection, and antibody tests, which assess for antibody production, which is indicative of past infection and (in some tests) a history of vaccination. The FDA states, "We do not know how long antibodies stay in the body following infection with the virus that causes COVID-19. We do not know if antibodies give you protective immunity against the virus, so results from a serology test should not be used to find out if you have immunity from the virus. The FDA cautions patients against using the results from any serology test as an indication that they can stop taking steps to protect themselves and others, such as stopping social distancing or discontinuing wearing masks."[18] As described below, lab tests for serology also state

[17] https://www.cdc.gov/healthyschools/bam/diseases/vaccine-basics.htm, accessed January 24, 2022.

[18] https://www.fda.gov/consumers/consumer-updates/coronavirus-disease-2019-testing-basics, accessed January 24, 2022.

that it is unclear at this time if a positive antibody result infers immunity against future COVID-19 infection. Therefore, given the scientific evidence available, a medical exemption based on the history of COVID-19 disease or serology results does not meet "evidence of immunity". The presence of antibodies is not the same thing as being immune.

20. The CDC states that "COVID-19 vaccination is recommended for everyone aged 5 years and older, regardless of a history of symptomatic or asymptomatic SARS-CoV-2 infection. This includes people with prolonged post-COVID-19 symptoms and applies to primary series doses, additional primary doses for those who are moderately or severely immunocompromised, and booster doses. Viral testing to assess for acute SARS-CoV-2 infection or serologic testing to assess for prior infection is not recommended for the purpose of vaccine decision-making. Present data are insufficient to determine an antibody titer threshold that indicates when an individual is protected from SARS-CoV-2 infection. There is neither any FDA-authorized or FDA-approved test nor any other scientifically validated strategy that vaccination providers or the public can use to reliably determine whether a person is protected from infection. Data from multiple studies indicate that the currently approved or authorized COVID-19 vaccines can be given safely to people with evidence of a prior SARS-CoV-2 infection."[19]

21. Further, CDC states "current evidence suggests that the risk of SARS-CoV-2 reinfection is low after a previous infection but may increase with time due to waning immunity. Among individuals infected with SARS-CoV-2, substantial heterogeneity exists in their immune response. (The term "heterogeneity" means that those individuals have diverse or varying immune

[19] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, accessed January 24, 2022.

responses which, when compared to the subsequent response of those receiving the COVID-19 vaccine, are not as reliable or consistent.) Conversely, the immune response following COVID-19 vaccination is more reliable, consistent, and predictable. A primary vaccination series decreases the risk of future infections in people with prior SARS-CoV-2 infection. Numerous immunologic studies have consistently shown that vaccination of individuals who were previously infected enhances their immune response, and growing epidemiologic evidence indicates that vaccination following infection further reduces the risk of subsequent infection, including in the setting of increased circulation of more infectious variants."[20]

22. Although natural infection for some diseases, in some cases, can result in long-standing immunity (e.g., measles), there is risk of untoward outcomes from the disease itself, which can be chronic or even fatal. Examples include Pneumonia or invasive group B Strep from chickenpox, meningitis or epiglottitis from *Haemophilis influenza* type B, birth defects from rubella, liver cancer from Hepatitis B, and death from measles.

23. Examples of natural infections that do not mount long-standing immunity include, in addition to COVID-19, Influenza, Respiratory Syncytial Virus, Malaria, Whooping cough, and rotavirus. In other words, re-infection is possible. Multiple serotypes of a pathogen like influenza, pneumococcus, and possibly with the COVID-19 variants, also make determination of a protective serologic level more difficult, especially to say there is lifelong immunity.

[17] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fvaccines%2Fcovid-19%2Finfo-by-product%2Fclinical-considerations.html, accessed January 24, 2022.

24. "Herd immunity" is an epidemiologic concept that explains how a community may be protected from an infectious disease that is human-to-human transmitted.[21]-[22] Herd immunity can be achieved through vaccination or through natural infection, if enough individuals 1) survive the disease and 2) mount a life-long immune response. Safe and effective vaccines are unequivocally considered the safer approach to a vaccine-preventable disease as compared to the unpredictable response that an individual may have to exposure to disease, as described above. When a large proportion of a community is immune, vulnerable members of the community are indirectly protected because their chance of infection exposure is very low. Herd immunity does not eliminate risk, but the phenomenon means that population risk is greatly reduced. Herd immunity is only possible when humans are the only source of infection transmission, when immunity can be clearly established to prevent lifelong infection and transmission, and when an adequate proportion of the population can safely develop immunity to protect all others. Measles (rubeola virus infection) is a classic example of the successful application of the concept of herd immunity. It is important to recognize that there is no disease where a vaccination program would cease once a certain level of immunity is reached, unless the disease is considered eradicated (i.e. smallpox in humans). Children continue to receive routine immunizations for diseases that we have not seen in this country for many years (i.e., polio) or rarely see (i.e. epiglottitis from *Haemophilus influenza*) so the vaccine preventable disease does not resurge. The Department of Defense vaccine program follows these same principles.

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[21] Desai AN, Majumder MS. What Is Herd Immunity? *JAMA.* 2020;324(20):2113. doi:10.1001/jama.2020.20895

[22] McDermott A. Core Concept: Herd immunity is an important-and often misunderstood-public health phenomenon. *Proc Natl Acad Sci U S A*. 2021;118(21):e2107692118. doi:10.1073/pnas.2107692118

25. The percentage of the population needing to be immune to drive herd immunity varies from disease to disease. Generally, the more contagious a disease is, the greater proportion of the population needs to be immune to stop its spread. For example, with regards to the highly contagious measles disease, approximately 95% immunity within a population is needed to interrupt the chain of transmission. When the immunity levels of a population falls, local outbreaks can, and have, occurred. In 2019, 1,282 individual cases of measles were confirmed in 31 states, the highest level since 1992. The majority of those cases were among those who were not vaccinated.[23,24]

26. This herd immunity threshold – the level above which the spread of disease will decline – is currently unknown for COVID-19. As described above, in order to interpret an antibody response as it pertains to immunity, a correlate of protection (i.e. what antibody number do I need to be considered immune?) must be determined and validated. No FDA antibody test has validated a correlate of protection at this time. Nonetheless, it is generally agreed that the more severe the COVID-19 disease is in an individual, the more antibodies a survivor would produce and therefore likely would have a higher degree of protection and possibly be protected longer than those asymptomatic or with mild symptoms.

27. Those who receive the COVID-19 vaccine contribute to the information available from studying the outcomes from 529 million doses administered in the US and over the 9.93 billion doses administered globally. Responses to vaccination are more consistent and there is minimal risk compared to the complications and treatments needed to treat the disease. Although

[23] https://www.cdc.gov/measles/cases-outbreaks.html, accessed 25 January 2022

[24] https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6840e2-H.pdf, accessed 25 January 2022

breakthrough infections do occur depending on the circulating variant and the longer the interval from vaccination, vaccines (especially when a booster is also received) remain highly effective in preventing hospitalizations and death.

28. Given the data available from the global scientific community and considering the risks and benefits realized from a history of infection versus a history of vaccination and an unequivocal need for a healthy force, the Department of Defense determined, after considering the available evidence from FDA guidance and CDC recommendations, that vaccination would provide the minimal risk to service members while maintaining a necessary state of readiness.

29. In October 2021, prior to the presentation of the Omicron variant, the newest SARS-CoV2 variant of concern, CDC summarized a review of 96 peer-reviewed and preprint publications, providing an overview of current scientific evidence regarding infection-induced immunity.[25] Key findings include the following:

- Available evidence shows that fully vaccinated individuals and those previously infected with SARS-CoV-2 each have a low risk of subsequent infection for at least 6 months. Data are presently insufficient to determine an antibody titer threshold that indicates when an individual is protected from infection. At this time, there is no FDA-authorized or approved test that providers or the public can use to reliably determine whether a person is protected from infection.
    - The immunity provided by vaccine and prior infection are both high but not complete (i.e., not 100%).

[25] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html, accessed January 24, 2022.

- Multiple studies have shown that antibody titers correlate with protection at a population level, but protective titers at the individual level remain unknown.
- Whereas there is a wide range in antibody titers in response to infection with SARS-CoV-2, completion of a primary vaccine series, especially with mRNA vaccines, typically leads to a more consistent and higher-titer initial antibody response.
- For certain populations, such as the elderly and immunocompromised, the levels of protection may be decreased following both vaccination and infection.
- Current evidence indicates that the level of protection may not be the same for all viral variants.
- The body of evidence for infection-induced immunity is more limited than that for vaccine-induced immunity in terms of the quality of evidence (e.g., probable bias towards symptomatic or medically-attended infections) and types of studies (e.g., observational cohort studies, mostly retrospective versus a mix of randomized controlled trials, case-control studies, and cohort studies for vaccine-induced immunity). There are insufficient data to extend the findings related to infection-induced immunity at this time to persons with very mild or asymptomatic infection or children.

30. Debate continues about whether natural immunity versus vaccine-induced immunity is more protective against breakthrough infections (a reinfection in someone who was previously infected versus an infection in a previously not infected individual who was fully immunized). A frequently cited, though not peer-reviewed, retrospective study from Israel found that the rates of SARS-CoV-2 breakthrough infections in vaccinated individuals, while very low (highest rate = 1.5%) were 13 times higher than the rates of reinfection and

hospitalization in previously infected individuals[26]. These findings have not been reproduced in a peer-reviewed or prospective publication. However, an observational study,[27] also out of Israel, compared adverse events in Pfizer-BioNTech vaccinated versus unvaccinated individuals in addition to those who had a history of COVID-19 disease versus those who did not. As previously identified in multiple studies, vaccination with an mRNA vaccine like Pfizer-BioNTech was associated with an elevated risk of myocarditis compared to those unvaccinated (risk difference 2.7 events/100,000 people). However, when assessing the relative risk in those with a history of COVID-19 disease with those who did not have disease, the risk of myocarditis was substantially higher in those who had COVID-19 disease (risk difference of 11 events/100,000 persons). The risk difference is calculated as the difference between the observed risks in the two groups.

[26] https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1, last accessed January 24, 2022.

[27] Barda N, et al. Safety of the BNT162b2 mRNA COVID-19 Vaccine in a Nationwide Setting N Engl J Med 2021; 385:1078-1090.

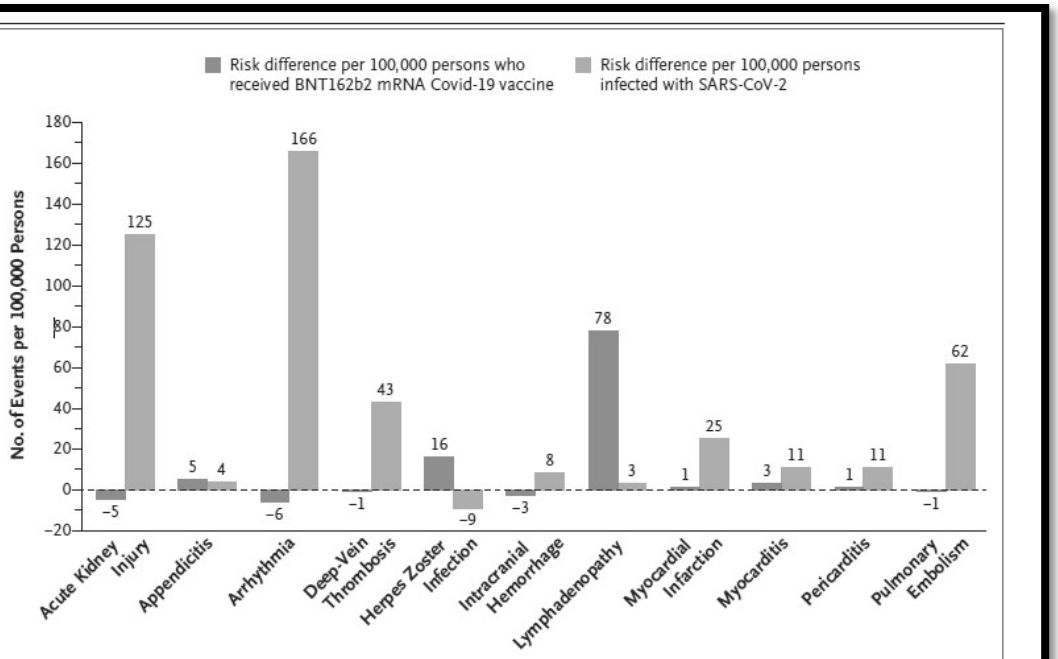


Figure 4. **Absolute Excess Risk of Various Adverse Events after Vaccination or SARS-CoV-2 Infection.**
Point estimates of the risk differences for selected adverse events are shown. Estimates were derived 42 days after vaccination or SARS-CoV-2 infection with the use of the Kaplan–Meier estimator. Risk differences are shown per 100,000 persons and rounded to the nearest integer. Negative differences (decreased risk) are represented as negative values on the y axis, and positive differences (increased risk) are represented as positive values on the y axis. The abbreviation mRNA denotes messenger RNA.

The Omicron variant

31. On November 26, 2021, the World Health Organization (WHO) designated the Omicron variant (Pango lineage B.1.1.529), first identified in November 2021 in Botswana and South Africa, a "variant of concern" upon recommendations of the Technical Advisory Group on SARS-CoV-2 Virus Evolution, which assesses if specific mutations and combinations of mutations alter the behavior of the virus.[28] The United States designated Omicron as a variant of concern on November 30, 2021, and following first detection in the United States on December 1,

[28] https://www.who.int/news/item/26-11-2021-classification-of-omicron-(b.1.1.529)-sars-cov-2-variant-of-concern, last accessed January 24, 2022.

2021, it has rapidly spread throughout the United States.[29] Those infected with the Omicron variant in South Africa were initially reported in the media as not having severe outcomes and therefore concluding that this would be a "mild" variant. In attempt to address that misconception, on January 6, 2022, Dr. Tedros Adhanom Ghebreyesus, the WHO Director-General, stated that "while Omicron does appear to be less severe compared to Delta, especially in those vaccinated, it does not mean it should be categorized as 'mild'. Hospitals are becoming overcrowded and understaffed, which further results in preventable deaths from not only COVID-19 but other diseases and injuries where patients cannot receive timely care. First-generation vaccines may not stop all infections and transmission but they remain highly effective in reducing hospitalization and death from this virus."[30]

32. The Omicron variant has approximately 32 mutations on the spike (S) protein with approximately 15 of the 32 occurring within the receptor binding domain (RBD). The RBD is what the virus uses to bind to our cells and initiate viral infection process. Antibodies produced from previous infection or vaccination, as well as the monoclonal antibodies (mAb) given to treat those infected, target the RBD. The degree to which antibodies bind or "neutralize" the virus, determines the degree of resultant illness – the better antibodies bind, the less likely a person will become ill. This is why any mutation on the S protein RBD would cause concerns about the efficacy of existing vaccines, antibodies produced from previous infection, and the mAb given to treat people in preventing Omicron infection. One study, using an artificial intelligence (AI)

[29] https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html, last accessed January 24, 2022.

[30] https://twitter.com/WHO/status/1479167003109859328, posted January 6, 2022.

model, revealed that "Omicron may be over 10 times more contagious than the original virus or about 2.8 times as infectious as the Delta variant."[31]

33. Multiple investigators turned their attention to assessing the effectiveness of antibodies following COVID-19 disease and current vaccines against Omicron. One study assessed the neutralization of 9 monoclonal antibodies (mAb), sera from 34 COVID-19 vaccine (Pfizer or Astra Zeneca) primary series recipients who had not previously been infected, sera from 20 recipients who had received a Pfizer-BioNTech booster dose, and sera from 40 convalescent sera (blood serum obtained from individuals who had a history of infection) donors, 22 of whom had also been vaccinated.[32] The better the neutralization, the better the protection a person. Omicron was totally or partially resistant to neutralization by all mAbs tested. Sera from those vaccinated, sampled 5 months after being fully vaccinated, had limited inhibition of Omicron. Blood sera from those with a history of COVID-19 disease demonstrated no or low neutralizing activity against Omicron. Those who received a booster dose did generate an anti-Omicron neutralizing response, though lower than what has been seen against the Delta variant. A second study[33] also demonstrated that those who had a history of infection and were fully vaccinated (whether disease then vaccinated or vaccinated then disease (i.e., a breakthrough infection) were better able to neutralize the Omicron variant as compared to those who had only a history of disease or had a history of being fully vaccinated. An additional small study investigated the neutralizing

[31] Chen J, et al. Omicron Variant (B.1.1.529): Infectivity, Vaccine Breakthrough, and Antibody Resistance J. Chem. Inf. Model. 2022, 62, 2, 412-422 https://doi.org/10.1021/acs.jcim.1c01451.

[32] Planas, D. et al. Considerable escape of SARS-CoV-2 Omicron to antibody neutralization. *Nature* https://doi.org/10.1038/s41586-021-04389-z (2021).

[33] Rossler A., et al SARS-CoV-2 Omicron Variant Neutralization in Serum from Vaccinated and Convalescent Persons NEJM, published January 12, 2022 doi:10.1056/NEJMc2199236.

activity of sera from convalescent (history of disease), mRNA double vaccinated (BNT162b2 = Pfizer-BioNTech; mRNA-1273 = Moderna), mRNA boosted, convalescent double vaccinated, and convalescent boosted individuals against the original SARS-CoV-2 strain, Beta variant (B.1.351), and Omicron (B1.1.529) variant in a laboratory (in vitro) setting.[34] In the figures depicted below, Figures 1c–1j provide the results of different combinations of sera studied. What would be interpreted as the "best" combination to work against the Omicron variant is the highest level of red dots on the y-axis seen with the B.1.1.529 on the x-axis. For example, Figure 1c shows the results of those individuals with a history of COVID-19 disease. In an oversimplified interpretation, Figure 1c shows that those with a history of COVID-19 disease had no measurable neutralizing activity for Omicron. In Figures 1d and 1e, (2 doses of either Pfizer-BioNTech or Moderna), there is some neutralization against Omicron. Those who received a booster (Figure 1f and 1g) had higher levels of neutralization against Omicron compared to the two-dose primary series. Those who had a history of disease and were then vaccinated with a two-dose primary series or a two-dose primary series and a booster (Figures 1h-1j) had better Omicron neutralization. In summary, the study found that neutralizing activity against Omicron "is most impacted in unvaccinated, convalescent individuals and in naïve individuals who acquired immunity through two mRNA COVID-19 vaccine doses" and that "boosted individuals had, at least within the short time after the booster dose, significant protection against symptomatic disease in the range of 75%."[35]

[34] Carreno, J.M. et al. Activity of convalescent and vaccine serum against SARS-CoV-2 Omicron. *Nature* https://doi.org/10.1038/s41586-022-04399-5 (2021).

[35] *Id.* at 2.

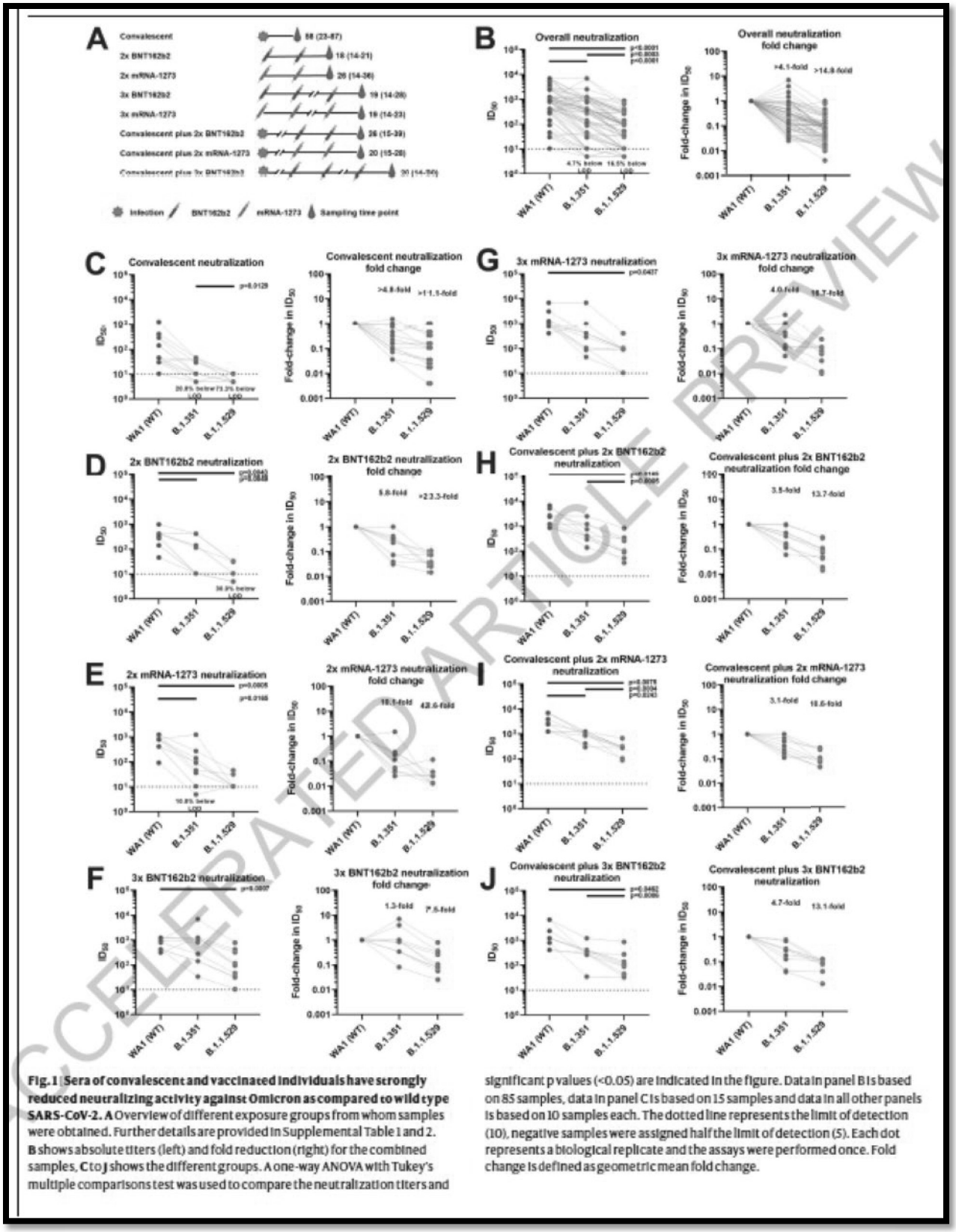
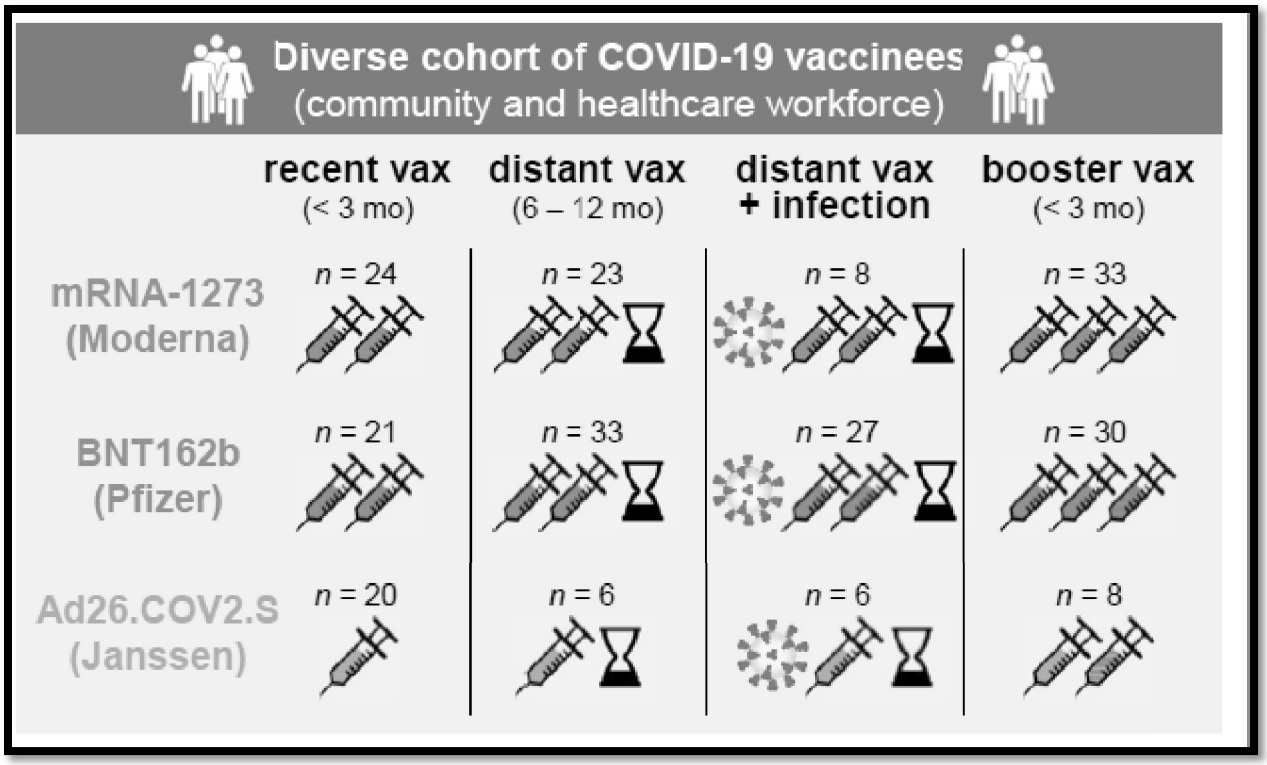


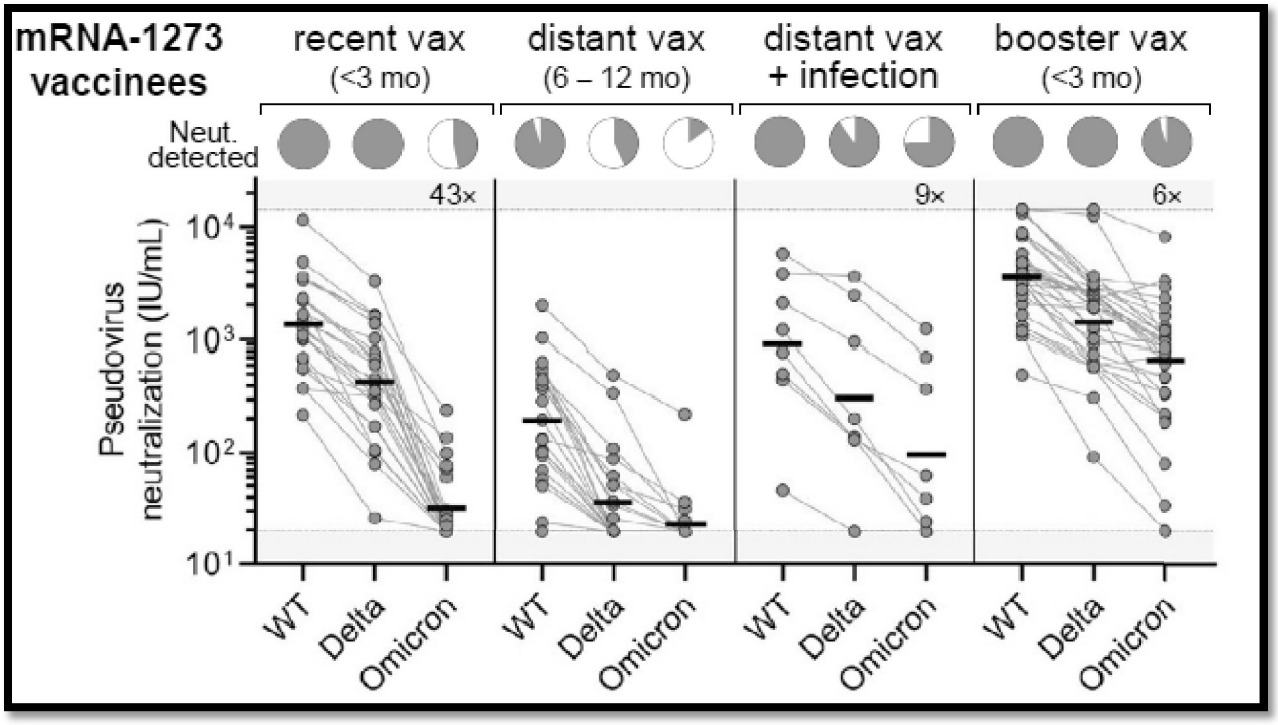
Fig. 1 | Sera of convalescent and vaccinated individuals have strongly reduced neutralizing activity against Omicron as compared to wild type SARS-CoV-2. A Overview of different exposure groups from whom samples were obtained. Further details are provided in Supplemental Table 1 and 2. **B** shows absolute titers (left) and fold reduction (right) for the combined samples, **C** to **J** shows the different groups. A one-way ANOVA with Tukey's multiple comparisons test was used to compare the neutralization titers and significant p values (<0.05) are indicated in the figure. Data in panel B is based on 85 samples, data in panel C is based on 15 samples and data in all other panels is based on 10 samples each. The dotted line represents the limit of detection (10), negative samples were assigned half the limit of detection (5). Each dot represents a biological replicate and the assays were performed once. Fold change is defined as geometric mean fold change.

34. An additional study[36] assessed the neutralizing potency of sera from 88 mRNA-1273 (Moderna), 111 BNT162b (Pfizer-BioNTech), and 40 Ad26.COV2.S (Janssen) vaccine recipients against wild-type, Delta, and Omicron COVID-19 variants, based on recent vaccination, distant vaccination (6-12 months), history of infection and distant vaccination, and recent booster vaccination, as depicted below.

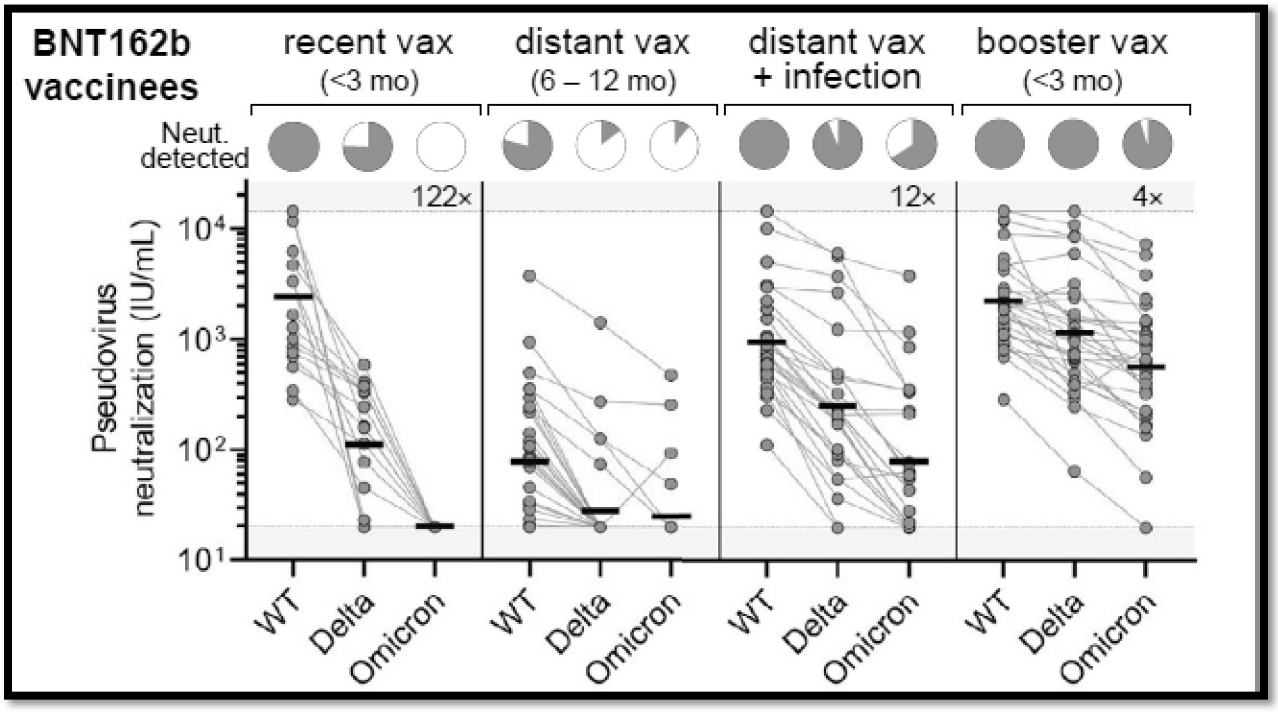


35. Against the Omicron variant, recent (< 3 months) vaccine recipients exhibited a 43-fold lower neutralization than the wild type (WT). Those with a history of vaccination and infection had a 9-fold decrease in neutralization than WT, whereas those who received a booster dose less than 3 months ago had a 6-fold decrease in neutralization compared to WT.

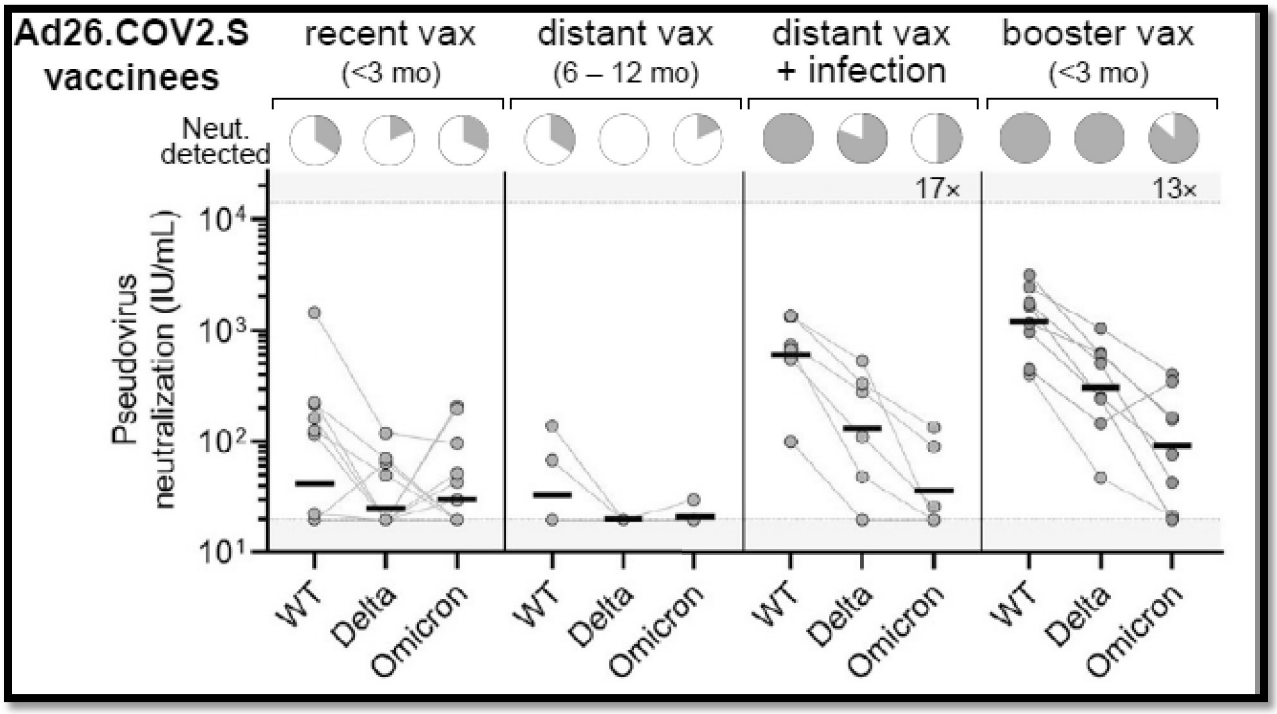
[36] Garcia-Beltran WF, et al mRNA-based COVID-19 vaccine boosters induce neutralizing immunity against SARS-CoV-2 Omicron variant. Cell 185, 1-10, accessed January 29, 2022.



36. Similar results were seen in Pfizer-BioNTech recipients, with the best protection against Omicron seen in those who recently received a booster dose.



37. Of the three vaccines, Janssen recipients had the least neutralization against the Omicron variant, with those who recently received a booster dose demonstrating a 13-fold decrease in neutralization as compared to the WT.



38. In contrast to the above studies, the CDC recently published a study examining the impact of primary COVID-19 vaccination and previous SARS-CoV-2 infection on COVID-19 incidence and hospitalization rates from California and New York.[37] The findings demonstrated that prior to Delta variant, being vaccinated with or without a history of COVID-19 resulted in lower incidence of laboratory-confirmed COVID-19 disease and hospitalizations as compared to those who were unvaccinated with a history of disease. However, after the Delta variant became dominant, those with a history of COVID-19 disease, with or without a history of vaccination, had

[37] Leon TM, Dorabawila V., Nelso L, et al. COVID-19 Cases and Hospitalizations by COVID-19 Vaccination Status and Previous COVID-19 Diagnosis – California and New York, May-November 2021. MMWR Morb Mortal. Wkly Rep 2022;71:125-131. DOI: http://dx.doi.org/10.15585/mmwr.mm7104e1.

a lower incidence of laboratory-confirmed COVID-19 disease than those who were vaccinated without a history of COVID-19. Excluded in the study was discussion of severity of COVID-19 disease and outcomes of those who had disease (complications, etc). CDC concludes with reminding readers that more than 130,000 California and New York residents died from COVID-19 through November 30, 2021, and that "vaccination remains the safest and primary strategy to prevent SARS-CoV-2 infections, associated complications, and onward transmission."

39. Clinical data of DoD breakthrough rates and hospitalizations as of January 20, 2022, taking into account the prior 6 weeks (where 78.8% of all breakthrough cases were seen) revealed the following results: Of the 1,578,364 active duty fully vaccinated individuals without a booster dose, 116,513 (7.38%) had a breakthrough infection. The hospitalization rate in active duty after full vaccination without a booster was 12 per 100,000 active duty service members. Of those active duty service members who were unvaccinated, the hospitalization rate was 782 per 100,000. Those who were unvaccinated had a higher percentage of critical and severe disease.

40. In summary, unvaccinated persons without a history of disease are most vulnerable to COVID-19 disease. Vaccination was highly effective against the initial SARS-CoV-2 strain it was developed to protect against. The longer the interval from vaccination, the increased risk for disease. Vaccination and a history of disease was shown to be less protective than vaccination and booster dose against both the Delta and Omicron variants. Clinically, breakthrough infections during the time of Omicron dominance have been increasingly seen in those fully vaccinated; however, the hospitalization rate during Omicron dominance in the unvaccinated active duty population was 65 times higher than the hospitalization rate in those fully vaccinated without a booster. CDC states "primary COVID-19 vaccination, additional doses, and booster doses are recommended by CDC's Advisory Committee on Immunization Practices to ensure that all eligible

persons are up to date with COVID-19 vaccine, which proves the most robust protection against initial infection, severe illness, hospitalization, long-term sequelae, and death."[38]

Risks from COVID-19 Vaccination

41. Risks from immunization, including COVID-19 vaccines are rare. CDC provides routine updates on specific adverse events temporally associated with COVID-19 vaccines.[39] CDC updates as of January 18, 2022, include the following:

A. **Anaphylaxis after COVID-19 vaccination is rare** and has occurred in approximately 5 people per million vaccinated in the United States.

B. **Thrombosis with thrombocytopenia syndrome (TTS) after Johnson & Johnson's Janssen (J&J/Janssen) COVID-19 vaccination is rare.** As of January 13, 2022, more than 17.8 million doses of the J&J/Janssen COVID-19 Vaccine have been given in the United States. CDC and FDA identified 57 confirmed reports of people who got the J&J/Janssen COVID-19 Vaccine and later developed TTS. Women 30-49 years of age, especially, should be aware of the rare but increased risk of this adverse event. There are other COVID-19 vaccine options available for which this risk has not been seen.

C. Guillain-Barre Syndrome - CDC and FDA are monitoring reports of Guillain-Barré Syndrome (GBS) in people who have received the J&J/Janssen COVID-19 Vaccine. GBS is a rare disorder where the body's immune system damages nerve cells, causing

[38] Leon TM, Dorabawila V., Nelso L, et al. COVID-19 Cases and Hospitalizations by COVID-19 Vaccination Status and Previous COVID-19 Diagnosis – California and New York, May-November 2021. MMWR Morb Mortal. Wkly Rep 2022;71:125-131. DOI: http://dx.doi.org/10.15585/mmwr.mm7104e1.

[39] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html, last accessed January 24, 2022.

muscle weakness and sometimes paralysis. Most people fully recover from GBS, but some have permanent nerve damage. After more than 17.8 million J&J/Janssen COVID-19 Vaccine doses administered, there have been around 301 preliminary reports of GBS identified in VAERS as of January 13, 2022. These cases have largely been reported about 2 weeks after vaccination and mostly in men, many 50 years and older. CDC will continue to monitor for and evaluate reports of GBS occurring after COVID-19 vaccination and will share more information as it becomes available.

D. **Myocarditis and pericarditis after COVID-19 vaccination are rare.** As of January 13, 2022, VAERS has received 2,103 reports of myocarditis or pericarditis among people ages 30 years and younger who received COVID-19 vaccines. Most cases have been reported after mRNA COVID-19 vaccination (Pfizer-BioNTech or Moderna), particularly in male adolescents and young adults. Through follow-up, including medical record reviews, CDC and FDA have confirmed 1,213 reports of myocarditis or pericarditis.

E. **Reports of death after COVID-19 vaccination are rare**. More than 529 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through January 18, 2022. During this time, VAERS received 11,468 reports of death (0.0022%) among people who received a COVID-19 vaccine. FDA requires healthcare providers to report any death after COVID-19 vaccination to VAERS, even if it's unclear whether the vaccine was the cause. **Reports of adverse events to VAERS following vaccination, including deaths, do not necessarily mean that a vaccine caused a health problem.** A review of available clinical information, including death certificates, autopsy, and medical records, has not established a causal

> link to COVID-19 vaccines. A review of reports indicates a causal relationship between the J&J/Janssen COVID-19 vaccine and TTS. Continued monitoring has identified additional deaths for a total of 9 deaths causally associated with J&J COVID-19 vaccination.

42. Additionally, on October 27 2021, the COVID-19 subcommittee of the WHO Global Advisory Committee on Vaccine Safety (GACVS) provided an updated statement regarding myocarditis and pericarditis reported with COVID-19 mRNA vaccines, stating, in part: The GACVS COVID-19 subcommittee notes that myocarditis can occur following SARS-CoV-2 infection (COVID-19 disease) and that mRNA vaccines have clear benefit in preventing hospitalisation and death from COVID-19. Countries should continue to monitor reports of myocarditis and pericarditis following vaccination by age, sex, dose and vaccine brand. Countries should consider the individual and population benefits of immunization relevant to their epidemiological and social context when developing their COVID-19 immunisation policies and programs.[40]

[40] https://www.who.int/news/item/27-10-2021-gacvs-statement-myocarditis-pericarditis-covid-19-mrna-vaccines-updated, last accessed January 24, 2022.

COVID-19 Antibody Tests

43. As described above, testing to assess for acute SARS-CoV-2 infection or serologic testing to assess for prior infection is not recommended for the purposes of vaccine decision-making. Last updated December 3, 2021, the FDA's EUA Authorized Serology Test Performances[41] lists approximately 90 products, of which all of them had one of the following three statements about immunity interpretation:

A. "You should not interpret the results of this test as an indication or degree of immunity or protection from reinfection."[42]

B. "It is unknown how long antibodies to SARS-CoV-2 will remain present in the body after infection and if they confer immunity to infection. Incorrect assumptions of immunity may lead to premature discontinuation of physical distancing requirements and increase the risk of infection for individuals, their households and the public."[43]

C. "It is unknown how long (IgA, IgM or IgG) antibodies to SARS-CoV-2 will remain present in the body after infection and if they confer immunity to infection. A positive result for XXX test may not mean that an individual's current or past symptoms were due to COVID-19 infection."[44]

[41] https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/eua-authorized-serology-test-performance, last accessed January 24, 2022.

[42] https://www.fda.gov/media/146369/download, last accessed January 24, 2022.

[43] https://www.fda.gov/media/138627/download, last accessed January 24, 2022.

[44] https://www.fda.gov/media/137542/download, last accessed January 24, 2022.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Executed on February 4, 2022, in Falls Church, Virginia

RANS.TONYA.SUE.1081263031 Digitally signed by RANS.TONYA.SUE.1081263031 Date: 2022.02.04 07:42:49 -05'00'

Tonya S. Rans
Colonel, Medical Corps, U.S. Air Force
Director, Immunization Healthcare Division
Public Health Directorate
Falls Church, Virginia

Exhibit 4

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

NAVY SEAL #1, et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States, et al., Defendants.	)	Civil Action No. 8:21-cv-02429-SDM-TGW

DECLARATION OF MAJOR SCOTT STANLEY

I, Major Scott Stanley, hereby state and declare as follows:

1. I am an Army Preventive Medicine Officer. I hold a PhD in genetics and have over 10 years of experience working in novel drug and vaccine development prior to joining the Army. I am currently employed by the U.S. Army as the Joint Force Health Protection Officer. I have held this position since June of 2021. I previously served as the Medical Advisor to the Assistant Secretary of State for the Bureau of Population, Refugees, and Migration, Department of State. My responsibilities as the Joint Force Health Protection Officer include: coordinating with the Office of the Secretary of Defense, the Combatant Commands, and the Services on health service support and preventive medicine; providing expert analyses and medical recommendations impacting the Joint Force; providing Military medical advice to the Chairman of the Joint Chiefs of Staff through the Joint Staff Surgeon on all matters related to force health protection, including: Public Health, comprehensive health surveillance and risk management, laboratory services, and veterinary services; and providing expertise across the continuum of force health protection

activities including medical intelligence, health threat analysis, infectious disease prevention, industrial hygiene, chemical, biological and toxic materials and medical countermeasures.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. This declaration is based on my personal knowledge, as well as information made available to me during the routine execution of my official duties.

COVID-19 IMPACTS ON THE FORCE

3. As of January 27, 2022, there have been 355,099 cases of Coronavirus Disease 2019 (COVID-19) in service members across the Department of Defense (DoD) which have led to 92 deaths (three of which had some level of vaccinations: two were partially vaccinated, while one had received the single-dose Johnson and Johnson vaccine and was one day short of the booster eligibility window of at least two months after the primary J&J dose). There have been no deaths among active duty personnel since the vaccination deadlines when approximately 98% of active duty personnel are at least partially vaccinated.

4. COVID-19 impacted all elements of DoD simultaneously, and required significant operational oversight by the Secretary of Defense, the Chairman of the Joint Chiefs of Staff, Secretaries of the Military Departments, the Under Secretaries of Defense, and all geographic and functional combatant commands (CCMD) (i.e., military commands that carry out broad missions and are composed of forces from the military departments) to execute their statutory responsibilities.

5. On March 25, 2020, then-Secretary of Defense Mark Esper enacted a 60-day stop movement order for all DoD uniformed and civilian personnel and their sponsored family members overseas. This measure was taken to aid in further prevention of the spread of COVID-19, to protect U.S. personnel and preserve the operational readiness of our global force.

6. Building upon previously enacted movement restrictions governing foreign travel, permanent change of station moves, temporary duty and personal leave, this stop movement order also impacted exercises, deployments, redeployments, and other global force management activities. Approximately 90,000 service members slated to deploy or redeploy within 60 days of its issuance were impacted by this stop movement order.

7. Specific examples of cancelled or curtailed training resulting from the dangers posed by the SARS-CoV-2 virus, which causes COVID-19, include the following. In March of 2020, 63 Fort Jackson recruits in a class of 940 had tested positive for the virus and caused a rescheduling of basic training activities. Also in March 2020, the United States Military Academy at West Point was on spring break when the seriousness of the pandemic came to light, forcing a pause in the academic year until a plan could be developed to bring the cadets back to campus safely. In early April 2020, Secretary Esper authorized the Secretaries of the Military Departments to pause accessions training (i.e., training for new recruits) for two weeks. In May 2020, the Defender Europe 2020 exercise was originally supposed to deploy the largest force (20,000 service members) from the United States to Europe in over 20 years, but the event was modified to about 6,000 service members to limit troop movement. Reserve and National Guard units suspended monthly battle assemblies and drill as early as March and April 2020, and moved to virtual training. For instance, the Army Reserve announced on March 18, 2020, that it was suspending monthly battle assemblies. The Navy Reserve announced about the same time the suspension of drill weekends, and then on April 16 it announced that suspension would be extended. In Korea, United States Forces Korea (the command responsible for military operations in the country) was forced to limit travel outside of the country, and travel to and from Daegu was limited to mission-essential personnel only. In addition, the spread of the virus caused the DoD Education Activity (DoDEA)

to cancel school for children in all of the schools in Daegu, and military commanders were forced to cancel all meetings, formations, and training events greater than 20 people, which severely impacted unit training which routinely requires service members to practice maneuvers and operations in large group settings.

8. Perhaps one of the more well-known examples of how the spread of COVID-19 could impact military operations, particularly among unvaccinated service members, is that of the U.S.S. Theodore Roosevelt, a nuclear-powered aircraft carrier with 4,779 personnel onboard. While conducting operations in the Pacific Ocean, the U.S.S. Theodore Roosevelt had to be diverted to the U.S. Naval Base Guam after an outbreak of SARS-CoV-2 occurred in an estimated 1,331 crew members, killing one, and resulting in the ship becoming non-operational.[1] Since the U.S. Navy only has 11 aircraft carriers in the total inventory, this event represented a significant reduction in the Navy's operational capacity. This example highlights not only the operational impact unmitigated spread of SARS-CoV-2 could have on the military's ability to carry out operations, but also the increased risk of transmission to those who must carry out their duties in close-quarters environments, such as service members who must work in close contact with others, sleep in open bays with tightly packed bunks, or must work in the confined areas of a ship where it is believed that such close, confined working environments contributed to higher exposure to the virus and a higher risk of infection.

9. Over the past twenty months, approximately 19 major training events, many of which involved preparedness and readiness training with our foreign partners, had to be canceled as a result of COVID-19. These included major training events involving tens of thousands of

[1] The New England Journal of Medicine, An Outbreak of Covid-19 on an Aircraft Carrier, https://www.nejm.org/doi/full/10.1056/NEJMoa2019375.

personnel that focus on readiness and response to events spanning a wide range of national security and international objectives, including: responses to catastrophic natural disasters, multi-national exercises with international partners to defend against military aggression, training symposiums and exercises to enhance defenses to information infrastructures, and partner capacity training for security and stability operations.

10. Further, unvaccinated individuals were unable to participate in some international training events because some partner nations had COVID-19 vaccination requirements or additional testing and quarantine requirements for country entry that degraded training value and involvement for unvaccinated individuals. There are still countries with vaccine requirements or quarantine requirements for unvaccinated individuals which would preclude an unvaccinated individual from participating in a military-to-military engagement with partner nations.

11. The loss of these training opportunities not only inhibited the development and sustainment of intra- and international relationship development that would otherwise allow for increased cooperation and understanding, but it prevented invaluable training opportunities that allow our forces, and our foreign partners, to practice interoperability and to strengthen their abilities to plan and execute combat, humanitarian, and security operations that are vital to the preservation of national security and the protection of our foreign interests.

12. As in the civilian health care system, in the early weeks and months of the pandemic, the DoD cancelled all non-essential medical procedures and surgeries and was further limited in its ability to provide medical appointments due to access restrictions to military treatment facilities (MTFs), the lack of available beds in the MTFs, and the burden on the military health system associated with caring for COVID-19 patients. This had the effect of reducing readiness as service members were, in some cases, unable to receive the care they needed to

address non-emergency conditions and undergo routine medical and health assessments that are required under military directives to maintain medical readiness.

13. The military health system was also called on to support the COVID-19 response in the United States. In April of 2020, the Department of Defense converted the Jacob K. Javits Center in New York into an alternative care facility for more than 2,000 COVID-19 patients. The United States Naval Ship (USNS) Comfort arrived in New York Harbor on March 30, 2020, while the USNS Mercy arrived in Los Angeles on March 27, 2020, to relieve pressure on local hospital systems so they could focus on life-saving COVID-19 related care. In December of 2021, the President announced plans to send an additional 1,000 military medical personnel to U.S. hospitals to join the roughly 240 personnel already deployed to seven states. Since this announcement, the DoD has already sent over 400 personnel, made an additional nearly 500 available as of 15 January, and is preparing to send 500 more. These and other examples of DoD support to civil authorities served as a resource drain on the military health system and obviously directly exposed DoD personnel to the SARS-CoV-2virus.

14. Vaccinations for COVID-19 enabled the return to higher levels of occupancy in DoD facilities, and hold in-person training, meetings, conferences, and other events. Vaccinations also permit service members to engage in joint training exercises with other countries that have vaccine requirements. It also reduced the testing burden on the DoD since in many instances individuals who are fully vaccinated are not required to submit to COVID-19 testing.

15. On May 26, 2020, the Secretary of Defense issued conditions-based guidance that enabled the resumption of some unrestricted official DoD travel based on the White House's Opening Up America Guidelines. On April 12, 2021, the Under Secretary of Defense for Personnel and Readiness published guidance removing some travel restrictions for fully vaccinated

individuals and on September 24, 2021, the Deputy Secretary of Defense lifted travel restrictions for fully vaccinated DoD personnel.

16. According to the Director of the National Institute of Allergy and Infectious Diseases (NIAID), Dr. Anthony Fauci, the latest statistics for the U.S. population show that an unvaccinated person has a 10-times greater chance of getting infected, a 17-times greater chance of getting hospitalized, and a 20-times chance of dying compared to a vaccinated person.[2] Rates of COVID-19 cases between October and November of 2021 were lowest among fully vaccinated persons with a booster dose compared to those with just the primary series, and much lower than rates among unvaccinated persons (25.0, 87.7, and 347.8 per 100,000 population, respectively). In December of 2021, when Omicron was circulating widely, the same pattern holds (148.6, 254.8, and 725.6 per 100,000 population, for boosted, primary series only, and unvaccinated, respectively).

17. Although COVID-19 vaccine effectiveness (VE) has decreased in terms of preventing infections with the emergence of the new variants and with the waning of vaccine-induced immunity, protection against hospitalization and death has remained high. The CDC published a study on January 19, 2022 that showed VE in terms of preventing hospitalization during the period when Omicron has been the dominant variant was 81% following the initial 2-shot series and 90% in those who were up to date with the recommended booster dose, compared to only 57% in those who were not up to date (meaning beyond the recommended time for booster dose eligibility without receiving a booster dose). In November of 2021, the CDC found that unvaccinated individuals were 4-times more likely to test positive and 15-time more likely to die

[2] 20 January 2022 Blue Star Families forum. Panel Speakers: Dr. Anthony Fauci, NIAID; LTG Ronald Place, Defense Health Agency; and Maj Gen Paul Friedrichs, Joint Staff Surgeon.

than a fully vaccinated individual. In December of 2021, unvaccinated individuals were 16 times more likely to be hospitalized with COVID-19. For hospitalized adults, the CDC found that unvaccinated people with a previous COVID-19 diagnosis were more than 5 times more likely to get re-infected than fully vaccinated people with no prior history of SARS-CoV-2 infection. This demonstrates that COVID-19 vaccines are effective reducing the risk of becoming infected but, more importantly, are highly effective at preventing hospitalizations and deaths and highlights the importance of being up to date with your COVID-19 vaccine.

18. DoD specific data is equally compelling in terms of demonstrating the value of vaccinations. Between July and November of 2021, non-fully-vaccinated active-duty service members had a 14.6-fold increased risk of being hospitalized when compared to fully vaccinated active-duty service members. In December 2021 unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults. Furthermore, unvaccinated adults over 50 years of age were 44 times more likely to be hospitalized than individuals who were vaccinated and received a booster dose. Of all active duty personnel hospitalized with COVID-19 since December of 2020 thru this month, only 0.012% were vaccinated. This amounts to 13 active duty personnel with boosters and breakthrough infections requiring hospitalization – an extremely rare occurrence. And as mentioned previously, of the 92 deaths among uniformed service members, only one had completed a primary series of a COVID-19 vaccine (the J&J vaccine) and had not yet received a booster dose. It is also worth noting that there have been no COVID-19 related deaths among active duty personnel since the vaccination deadlines have passed.

19. While some have pointed to the increase in the number of breakthrough cases in general, and with the Delta and Omicron variants in particular, as a reason to question the effectiveness of the vaccines, it is important to keep in mind that as vaccination rates increase among service members, vaccinated service members will make up a larger percentage of the

population available to become infected. In other words, vaccinated personnel are disproportionately represented in the pool of individuals exposed to the virus that causes COVID-19. Taken to the extreme, if *every* service member were vaccinated, only vaccinated service members *could* have infections. So it is important to view the number of breakthrough infections in this light and not as a reflection of vaccine effectiveness.

20. Given the tangible protection the vaccines afford service members against infection, serious illness, hospitalization, and death, it is clear that COVID-19 vaccines improve readiness and preserve the DoD's ability to accomplish its mission. If an individual tests positive for COVID-19, they are required to isolate and are unavailable to perform their duties, even if they are asymptomatic or have mild symptoms. They also put their fellow service members at risk of infection and hospitalization and further degrade the readiness of their units, their service, and the DoD. Additionally, if an unvaccinated service member in a hostile area becomes seriously ill and requires a medical evaluation, it may risk the lives of other service members or may ultimately not be possible, thus endangering the member's life and affecting the unit's mission.

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Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed on February 4, 2022 in Washington, DC.

STANLEY.SCOTT.E.1169637659 Digitally signed by STANLEY.SCOTT.E.1169637659 Date: 2022.02.04 08:58:17 -05'00'

Scott Stanley, PhD
Major, United States Army
Joint Staff Force Health Protection Officer
Office of the Joint Staff Surgeon

Exhibit 5

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

NAVY SEAL #1, et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States, *et al.*, Defendants.	)	No. 8:21-cv-02429

DECLARATION OF COLONEL ARTEMIO C. CHAPA

I, Artemio C. Chapa, hereby state and declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as the Division Chief for Medical Operations at the Air Force Medical Readiness Agency. I have been in this position since July 2018. As a part of my duties, I am responsible for medical operations in the COVID-19 pandemic policy.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as the Division Chief for Medical Operations and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. Medical exemptions from immunization requirements are accomplished in accordance with Air Force Instruction (AFI) 48-110_IP, *Immunizations and Chemoprophylaxis for the*

Prevention of Infectious Diseases, dated October 7, 2013 (certified current February 16, 2018).[1] I am familiar with the medical exemption policy and process as it falls within the scope of my professional duties. Medical exemptions are vaccine-specific and are determined "based on the health of the vaccine candidate and the nature of the immunization under consideration."[2] Accordingly, there is no automatic presumptive exemption from a vaccine.

4. A service member may request a medical exemption from the COVID-19 immunization requirement by notifying their commander.[3] The service member must make an appointment with the Military Treatment Facility (MTF) to be evaluated by a military medical provider. The provider will counsel the service member to ensure the member is making an informed decision, including providing specific information about COVID-19, the potential risks of infection, benefits of vaccination, and vaccine-specific information about the product constituents, risks, and benefits.

5. Additionally, the military medical provider will evaluate the service member to determine if a medical exemption is warranted. The military medical provider's decision to grant or deny a medical exemption request is based on the provider's individualized assessment of the service member's medical situation. By way of example, individuals who are granted a medical exemption from the COVID-19 vaccine may include (1) people who previously received passive antibody therapy within the last 90 days, including treatment with monoclonal antibodies or convalescent plasma; (2) Multisystem Inflammatory Syndrome in Adults (MIS-A); (3) acute current COVID-19 infection; (4) pregnancy; (5) myocarditis or pericarditis following first dose

[1] AFI 48-110_IP is an inter-service publication. The Army identifies is at Army Regulation (AR) 40-562, Navy as Bureau of Medicine and Surgery Instruction (BUMEDINST) 6230.15B, and Coast Guard (CG) Commandant Instruction (COMDTINST) M6230.4G.
[2] AFI 48-110_IP, paragraph 2-6.(a).
[3] A military medical provider can be a military service member, civilian, or contractor so long as they are privileged at a "Military Treatment Facility."

or current unresolved myocarditis/pericarditis; (6) prior anaphylaxis to Pfizer COVID vaccine or a component of the vaccine;[4] or (7) immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine.[5] A military medical provider may seek further consultation if medically indicated.

6. If a military medical provider makes a determination that a medical exemption applies to a service member, the provider documents the exemption in the Aeromedical Services Information Management System (ASIMS),[6] which is used to track Individual Medical Readiness,[7] and the Electronic Health Record. At this time, all medical exemptions to the COVID-19 vaccination requirement granted by the Air Force are temporary. The duration of a medical exemption depends on the underlying reason for the medical exemption. It may be as short as 30 days and as long as one year. Because additional COVID-19 immunization products may be approved, permanent medical exemptions are not permitted at this time. After the medical exemption expires, the member may be reevaluated to determine if a new exemption is warranted. Additionally, a military medical provider may revoke a medical exemption when it is no longer clinically warranted. The military medical provider will also submit a Memorandum For Record to the service member's commander notifying them if the medical exemption was approved or denied.

7. A service member's commander may review the member's Individual Medical Readiness to ensure the member has met all the medical requirements directed. Once a medical exemption is annotated in ASIMS, the service member's Individual Medical Readiness will display that the

[4] This is defined as the onset within 4 hours of urticarial, wheezing/dyspnea, vomiting or diarrhea, hypotension, or angioedema.
[5] Air Force Medical Readiness Agency, "COVID-19 Vaccine Exemptions Guidance for AFMS Medical Personnel" (Sept. 3, 2021).
[6] An alternative database it can be entered is Military Health System Genesis.
[7] The Individual Medical Readiness displays a member's medical readiness, including what immunization requirements have been accomplished, which are coming due, and which are outstanding.

member is medically exempt for the COVID-19 vaccination requirement and it will no longer display the member as coming due or overdue for the requirement.

8. If a military medical provider determines that a service member does not meet the criteria for a medical exemption, the provider will document the denial in the member's Electronic Health Record and provide the rationale for disapproval. Like any other medical condition, a service member may seek a second opinion.[8] To qualify for a medical exemption, the second opinion must come from a military medical provider, whether at the same or different Medical Treatment Facility. If the second medical evaluation denies the medical exemption as well, the provider annotates this denial in the Electronic Health Record and it is considered a final medical exemption disposition. If the medical evaluations conflict, the Chief of Medical Staff and military medical provider may consult with the facility's allergist or with the Defense Health Agency Immunization Healthcare Division for resolution and final adjudication by the Chief of the Medical Staff for the Military Treatment Facility.

9. The timeline for resolution of a medical exemption request will vary depending on the purported medical issues involved and the appointment availability at the individual Military Treatment Facilities.

Temporary Nature of Medical Exemptions

10. Medical exemptions are granted based on concerns that a COVID-19 vaccine would place the individual service member at a heightened health risk. Healthcare determinations are based upon individual provider encounters with each patient, with the provider assessing the service member's medical history and considering all relevant aspects of that patient's unique medical circumstances and needs. Decisions concerning vaccination, to include the medical

[8] This is true of any medical condition, including if the service member was granted a medical exemption.

necessity to issue a temporary exemption are no exception to this rule and are tailored to the individual patient.

11. As previously noted, Department of the Air Force policy is to only grant temporary medical exemptions from immunization requirements. The majority of medical conditions warranting an exemption for the COVID-19 vaccine are temporary in nature. The duration of these exemptions necessarily vary based on the medical conditions and history of the patient at the time of evaluation, along with the specifics of the vaccine. Circumstances under which a temporary exemption could be granted are wide-ranging. A temporary medical exemption for allergic reaction to the vaccine or components of the vaccine is a good example. While a service member may have a severe allergic reaction to an ingredient, it may not occur with a future COVID-19 vaccine of a different formulation. A temporary exemption allows the Air Force to reassess individuals with allergies or severe adverse reactions to determine whether an updated or new vaccine has been approved with constituents the member can safely take.[9] An exemption may also be temporarily granted for other medical reasons and conditions, such as when receiving the vaccine caused myocarditis or pericarditis following the first dose, or when the vaccine could create a confusing clinical diagnostic assessment during an active COVID-19 infection (e.g., is a fever due to a side effect from a COVID-19 vaccine or due to the COVID-19 infection), or for a pregnancy (which is time limited).

12. The period of an exemption is dependent on the underlying medical reason, but can be as short as 30 days (or less) for someone who has an acute COVID-19 infection to 365 days for an individual with a severe allergic reaction. Many exemptions are limited to 30, 60, or 90 days.

[9] For example, the FDA's recent approval of the Moderna vaccine, now marketed under the name "SPIKEVAX."

13. Denying medical exemptions where they are not warranted protects the member, unit, and mission by ensuring the member gets vaccinated and is medically ready. Granting medical exemptions when warranted also serves the military interests in readiness and promoting the health of the force. If giving the vaccine would undermine the health of that particular service member, the military's interests in readiness and force health protection would be degraded in that circumstance by vaccination. After the individual health risk to vaccination has subsided, the member is again required to vaccinate.

14. As a physician, this process of individual service member review with individual vaccine medical review to adjudicate proper temporary medical exemption clearly consolidates an un-biased alignment with policy,[10] occupational health, member protection and military interest. Both granting a temporary medical exemption and requiring service members without a medical condition to be vaccinated are evidence of the goal of the military interest in preserving a healthy, responsive force and medical readiness.

15. During the period a member is medically exempt from receiving the vaccine, they are unprotected and at an increased risk of contracting COVID-19. This is mitigated by maximizing the number of people around the service member that are vaccinated to prevent the spread of the disease in the community. Maximizing vaccinations within the Air Force for those medically able helps protect those that cannot otherwise receive the vaccine. The greater the number of required medical exemptions, the more important maximizing vaccinations becomes.

16. On February 3, 2022, the numbers of "Medical Temporary" exemption from the COVID-19 vaccine in the ASIMS data was 1,532 Total Force Service Members (746 U.S. Air Force, 11

[10] Per AFI 48-110, medical exemptions are vaccine-specific and are determined "based on the health of the vaccine candidate and the nature of the immunization under consideration."

U.S. Space Force, 488 Air National Guard and 287 Air Force Reserve Command).[11] The "Medical Temporary" code documents all exemptions due to medical conditions (e.g., pregnancy, allergic reaction). The Department of the Air Force cannot readily ascertain how many service members, if any at all, have medical exemptions for each particular medical condition.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 3rd day of February 2022.

CHAPA.ARTEMIO.CERDA.1169367589 Digitally signed by CHAPA.ARTEMIO.CERDA.1169367589 Date: 2022.02.03 19:27:08 -05'00'

ARTEMIO C. CHAPA, Colonel, USAF
Division Chief, Medical Operations,
AFMRA SG3

[11] This is a snapshot in time. Medical exemptions from COVID-19 are all temporary in nature.

Exhibit 6

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

NAVY SEAL #1, et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States, *et al.*, Defendants.	)	No. 8:21-cv-02429

DECLARATION OF MAJOR GENERAL TELITA CROSLAND

I, Major General Telita Crosland, hereby state and declare as follows:

1. I am a Major General in the United States Army currently assigned as The Deputy Surgeon General of the U.S. Army. I have been in this position since August 2019. As a part of my duties, I am responsible for supervising the thorough and efficient processing of all requests for religious accommodations involving vaccination. I am familiar with the religious exemption request and review process, which falls within the scope of my official duties, and I have reviewed requests from Soldiers for administrative immunization exemptions to accommodate religious beliefs. In addition, I am thoroughly familiar with the medical exemption process, the procedures under which these exemptions are evaluated and adjudicated, and the number of exemptions processed.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as The Deputy Surgeon General and based upon

personal knowledge and information that has been provided to me in the course of my official duties.

3. U.S. Army service members who desire an exemption from vaccination requirements may submit requests for exemptions, whether administrative or medical, in accordance with the procedures outlined under existing Army Regulations, to include the Multi-Service Regulation (AR 40–562, BUMEDINST 6230.15B, AFI 48–110_IP, CG COMDTINST M6230.4G), "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," dated October 7, 2013; Army Regulation 600-20, "Army Command Policy," dated July 24, 2020; and Army Directive 2021-33, "Approval and Appeal Authorities for Military Medical and Administrative Immunization Exemptions," dated September 24, 2021. As previously reported to the Court on January 21, 2022, the Army has received more than 2,000 religious exemption requests and 675 permanent medical exemption requests.[1] As discussed further below, the majority of medical exemptions are temporary in nature (i.e., limited to a maximum period of 365 days), and only 6 permanent medical exemptions from the COVID-19 vaccine been granted – all of which were granted after the individual suffered severe medical complications after they received a first dose of a COVID-19 vaccine.

Temporary Medical Exemptions

4. Medical exemption decisions are made on an individualized basis and only after a clinical evaluation of potential risk factors applicable to the patient concerned. Individual medical providers may give a temporary medical exemption from a particular vaccination, to include the COVID-19 vaccination, on a clinical discretionary basis. Healthcare across the Army is based upon individual provider encounters with each Soldier as a patient, with the provider assessing

[1] The U.S. Army's most recent report on exemption requests was filed on the docket at ECF No. 52-2.

the Soldier's medical history and considering all relevant aspects of that patient's unique medical circumstances and needs. Decisions concerning vaccination, to include the medical necessity to issue an exemption, temporary or permanent, are no exception to this rule and are tailored to the individual patient.

5. The majority of medical exemptions that have been considered and granted with respect to COVID-19 are temporary in nature. The duration of these exemptions necessarily vary based on the medical conditions and history of the patient at the time of evaluation, and circumstances under which a temporary exemption could be granted are wide-ranging. However, while individual circumstances may vary, the underlying reason to issue such an exemption does not: to prevent physical, medical harm to the patient that has been deemed likely to result if they receive the vaccine at that time. Health care providers are responsible for "determin[ing] a medical exemption based on the health of the vaccine candidate and the nature of the immunization under consideration." Army Reg. 40-562, para. 2-6a. Temporary exemptions could be granted for as little as a day or up to 365 days, depending on a number of factors to include anticipated changes in a patient's medical condition, or the need for further evaluation at a future time. For example, a Soldier may arrive to receive a vaccination but have a fever or other minor illness that day which would preclude vaccination at that time. Accordingly, a temporary exemption may be authorized and a future evaluation date set to determine the continued need, if at all, for the exemption. Even if something like a fever would not necessarily impede the effectiveness of a given vaccine, the provider would want to ensure the patient was starting from a place of ideal health, to better enable that provider to monitor for adverse side effects from any vaccine. This is true of virtually all vaccinations, not just COVID-19. However, a prolonged medical exemption would not be needed for a fever; just a few days would normally resolve a

minor issue such as this example. These practices are routine and are applicable to not only vaccinations, but to a plethora of other medical treatment decisions that are made on a daily basis across the Army healthcare system. There is no specific rule that dictates the length of a temporary medical exemption in these circumstances; that is entirely dependent upon the individual provider's assessment of the patient's individual needs.

6. In accordance with CDC guidance, those who experienced a recent COVID-19 infection or are currently experiencing symptoms because of a COVID-19 infection are also among those who have received temporary medical exemptions from vaccination.[2] Similarly, the CDC recommends that people who were treated for COVID-19 with monoclonal antibodies or convalescent plasma, or people who have a history of multisystem inflammatory syndrome in adults or children, may need to wait a while after recovering before they can get vaccinated.[3]

7. Of course, more serious medical conditions may require a longer temporary exemption (or, in some cases, the issuance of a permanent exemption). Even in these cases, however, the duration of each temporary exemption will vary on the circumstances. In addition, an individual's circumstances could change after the expiration of the initial exemption, which then require additional exemptions for the same or other reasons. By way of example, an individual diagnosed with cancer may be eligible for an exemption depending upon the type of cancer, the effects the cancer is having on the individual's body and immune system, and/or the types of treatment that individual is receiving. A Soldier presently undergoing chemotherapy or radiation therapy might require an exemption from immunizations for a period of time surrounding the treatment, while another Soldier who is able to have their cancer treated through a surgical

[2] https://www.cdc.gov/vaccines/covid-19/hcp/faq.html, last accessed February 4, 2022.

[3] Id.

procedure, but who is otherwise not suffering from a suppressed immune system or other side effects, may only require an exemption through the period of surgery or perhaps not at all.

8. Some temporary medical exemptions have a more predictable time period than others. A primary example is pregnancy, which could qualify for a temporary medical exemption. Such an exemption could be granted for any number of reasons, including contraindications based on the patient's current health or medical complications that have arisen as a result of the pregnancy. It is important to note, however, that a temporary medical exemption for vaccines due to pregnancy would not cover all vaccines; some, including the COVID-19 vaccine, are strongly recommended during pregnancy by the American College of Obstetrics and Gynecology. Nonetheless, if a temporary medical exemption is given based on pregnancy, there is a predictable end point when the medical exemption will expire and the Soldier will be required to receive the vaccine.

9. Regardless of the underlying reason for the temporary exemption, these exemptions are temporary in nature and upon expiration of the exemption, the Soldier will be required to receive the vaccine in order to come into compliance with military medical readiness standards. Immunizations are a part of a Soldier's medical readiness requirements, which inform commanders' decisions on whether a Soldier "is deployable and able to perform the unit's core designated mission or assigned mission."[4] Accordingly, once recovered, and any exemption expires, the individuals must receive required vaccines, unless another exemption is requested and approved. For many who receive temporary medical exemptions, the underlying conditions will also affect their deployability. For example, a Soldier who is pregnant or post-partum is deemed "not medically ready and is non-deployable." See Army Reg. 40-502, para. 2-4c.(3).

[4] Army Regulation 40-502, Medical Readiness (June 27, 2019), provides policies and guidance for medical readiness.

Permanent Medical Exemptions

10. To date, there are only six permanent medical exemptions granted for COVID-19 immunizations. This is an exceptionally small number and, as previously mentioned, all were granted for cases where the individuals received at least one dose and suffered a severe adverse reaction specifically to that vaccine. In such instances, granting the medical exemption still serves the military interest in preserving a healthy, responsive force and medical readiness because there is evidence that giving that particular soldier another dose of the vaccine would undermine the health of that Soldier, thereby degrading the military goals of readiness and force health protection. Further, such Soldiers already have at least some modicum of protection from having received the initial dose, which will increase the effectiveness of mitigation measures. Finally, these cases will continue to be reviewed by the provider as new treatments and vaccines are developed, with the potential for the permanent medical exemption to be adjusted or rescinded.

****

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February 2022.

CROSLAND.TELITA.1017383040 Digitally signed by CROSLAND.TELITA.1017383040 Date: 2022.02.04 14:03:28 -05'00'

Telita Crosland
Major General, U.S. Army
Deputy Surgeon General
Office of The Surgeon General
United States Army
Washington, DC

Exhibit 7

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

NAVY SEAL #1, *et al.* Plaintiffs, v. **JOSEPH R. BIDEN**, in his official capacity as President of the United States, *et al.* Defendants.	Case No. 8:21-cv-02429-SDM-TGW

DECLARATION OF REAR ADMIRAL GAYLE D. SHAFFER

I, Rear Admiral Gayle D. Shaffer, U.S. Navy, hereby state and declare as follows:

1. I am the Deputy Surgeon General and Deputy Chief, U.S. Navy Bureau of Medicine and Surgery, and I am currently stationed in Falls Church, Virginia. I make this declaration in my official capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

2. I began serving as the Navy Deputy Surgeon General and Deputy Chief, U.S. Navy Bureau of Medicine and Surgery February 28, 2020. In that capacity, I am one of four Flag Officers authorized to grant permanent medical exemptions to members of the Navy and Navy Reserve. In addition, I am thoroughly familiar with both the temporary and permanent medical exemption processes, the procedures under which these exemptions are evaluated and adjudicated, and the numbers of exemptions granted.

3. Medical exemptions to vaccination, including vaccination to COVID-19, are available when a documented medical contraindication to the COVID-19 vaccine exists.

Regulations and procedures are found in BUMEDINST 6230.15B, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," dated October 7, 2013; BUMEDNOTE 6300, Navy Coronavirus Disease 2019 Vaccine Medical Temporary, and Medical Permanent Exemption for Medical Contraindication Approval Process, dated September 3, 2021; and BUMED NOTICE 6150 (Corrected Version), Guidance for Coronavirus Disease 2019 Vaccination Deferral Status Reporting, dated September 22, 2021.

4. As discussed further below, the vast majority of medical exemptions are temporary in nature (i.e., limited to a maximum period of 30 days). Only 11 permanent medical exemptions from COVID-19 vaccines have been granted in the Navy and Navy Reserve as of this date.

5. Medical exemption decisions are made on an individualized basis, and only after a clinical evaluation of potential risk factors applicable to the patient concerned. Health care providers are responsible for "determin[ing] a medical exemption based on the health of the vaccine candidate and the nature of the immunization under consideration."[1] Health care across the Navy is based upon individual provider encounters with each Sailor as a patient, with the provider assessing the member's medical history, and considering all relevant aspects of that patient's unique medical circumstances and needs. Decisions concerning vaccination, to include the medical necessity to issue an exemption, temporary or permanent, are no exception to this rule and are tailored to the individual patient. Individual medical providers may give a temporary medical exemption from a particular vaccination, to include the COVID-19 vaccination, on a clinical discretionary basis.

[1] BUMEDINST 6230.15B, para. 2-6a.

6. The vast majority of medical exemptions granted with respect to COVID-19 are temporary in nature. Temporary medical exemptions are in effect for only 30 days, but subject to renewal by a medical provider in 30-day increments. They are based on the medical conditions and history of the patient at the time of evaluation, and circumstances under which a temporary exemption could be granted are wide-ranging. Common categories of temporary medical exemptions include 1) individuals undergoing workup for Medical Contraindication to vaccination; 2) confirmed COVID-19 cases awaiting recovery; 3) or pregnancy or other temporary medical contraindication as determined by a medical provider.[2] Although it is not possible to analyze all temporary medical exemptions without reviewing all of the individual patients' medical records, some data about temporary medical exemptions—also called deferrals—was gleaned from the Navy's Medical Readiness Reporting System (MRRS) and is in the chart below.[3] The chart reflects that nearly 70% of the temporary medical exemptions granted by the Navy for active duty Sailors were related to pregnancy or current or recent infection with COVID-19 or another acute illness.

Branch Service	Medical Temporary (MT) Deferrals*	Pregnancy Related	COVID or Acute Illness	Total Accounted	Percent MT
USN	176	85	38	123	69.89%
USNR	89	17	4	21	23.60%
USMC	186	104	41	145	77.96%
MCR	31	8	4	12	38.71%
Total	**482**	**214**	**87**	**301**	**62.45%**

[2] BUMEDNOTE 6150 dated 22 September 2021 paragraph 5.b.(5).
[3] Although the Navy and the Marine Corps both report medical readiness through MRRS, the two services have separate programs for granting temporary and medical exemptions from vaccination. Aside from the data presented in this chart, this declaration is limited to medical exemptions for members of the Navy and Navy Reserve only.

7. Some temporary medical exemptions have a more predictable time period than others. A primary example is pregnancy, which may result in a temporary medical exemption for any number of medical reasons, including contraindications based on the patient's current health or medical complications that have arisen as a result of the pregnancy. It is important to note, however, that a temporary medical exemption for vaccines due to pregnancy would not cover all vaccines; rather it is specific to a particular vaccine considering the patient's medical condition and history. Some vaccines, including the COVID-19 vaccine, are strongly recommended during pregnancy by the American College of Obstetrics and Gynecology. Nonetheless, if a temporary medical exemption is given based on pregnancy, there is a predictable end point when the medical exemption will expire and the member will be required to receive the vaccine.

8. Another example is current or recent infection with COVID-19. In accordance with Centers for Disease Control and Prevention (CDC) guidance, the Navy has granted temporary medical exemptions for individuals who are currently infected or were recently infected with COVID-19. Current CDC guidance is to wait until acute symptoms from SARS-CoV-2 infection have passed and criteria for isolation have been met before receiving a first or second dose of COVID-19 vaccine.[4] However, once the requisite time has passed after infection, the temporary medical exemption will expire and the Sailor will be required to get the COVID-19 vaccine.

[4] https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html. "For people who previously received passive antibody therapy as part of COVID-19 treatment, defer vaccination for at least 90 days after receipt of passive antibody therapy (monoclonal antibodies or convalescent plasma)." https://www.cdc.gov/vaccines/covid-19/hcp/faq.html

9. Regardless of the underlying reason for the temporary exemption, the facts remain that these exemptions are temporary in nature and limited in time. Upon expiration of the exemption, the member will be required to receive the vaccine in order to come into compliance with military medical readiness standards.

10. A total of 11 permanent medical exemptions have been approved in the Navy as of February 4, 2022. Ten of the 11 members received an initial dose of the COVID-19 vaccine and experienced a serious and documented medical reaction to the first dose with recommendations to avoid further COVID-19 vaccination. The eleventh member had medical conditions that precluded vaccination due to family history of vaccine reaction and severe cardiac disease, with a recommendation for medical board separation processing due to these underlying conditions. In all 11 cases, the decision was in alignment with CDC guidelines for vaccine exemption and retention medical standards per Department of Defense Instruction 6130.03 Volume 2. The decision authority determined that the potential health risk of vaccination to the Sailor outweighed the benefit of the vaccine. Navy Medicine will continue to review these cases as new tests, treatments, and vaccines are developed, with the potential to adjust or rescind permanent medical exemptions where appropriate and restore Sailors to full military medical readiness.

11. Navy Medicine's focus includes ensuring the warfighter is medically ready. A fundamental responsibility in ensuring medically ready Sailors is not to harm them by administering a vaccine in the rare situation in which it is medically contraindicated. But Navy Medicine's responsibility does not end there. We harness our personnel, equipment, infrastructure, and analytical capabilities to produce medically ready forces. Producing medically

ready forces includes treating Sailors in order to restore their full military medical readiness when possible.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February, 2022.

G. D. SHAFFER
Rear Admiral, U.S. Navy

Exhibit 8

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

NAVY SEAL #1, et al., Plaintiffs, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States, *et al.*, Defendants.	)	No. 8:21-cv-02429

DECLARATION OF REAR ADMIRAL DANA THOMAS

I, Rear Admiral Dana Thomas, hereby state and declare as follows:

1. I am a Rear Admiral in the United States Coast Guard currently assigned as the Director of Health, Safety, and Work-Life for the Coast Guard. I have been in this position since March 2019. As a part of my duties, I am responsible for the Coast Guard's health care system of 41 clinics and 150 sick bays, as well as operational and off-duty mishap prevention, response and investigation. Prior to this assignment, I served with the Centers for Disease Control and Prevention (CDC), Division of State and Local Readiness, as a Career Epidemiology Field Officer in New Jersey and Puerto Rico. Also, while working for the National Center for Emerging and Zoonotic Infectious Diseases, I responded to the Ebola epidemic in Sierra Leone and dengue outbreaks in Tanzania and Texas. I completed a dual degree, receiving a Doctor of Medicine and Master of Public Heath from the George Washington School of Medicine and Public Health and am board certified in Aerospace and Occupational Medicine. Including my current assignment, I have served ten years with the U.S. Coast Guard, seven years with the Centers for Disease Control and Prevention, and seven years with the U.S. Army. I am familiar

with the religious exemption request and review process within the Coast Guard and am thoroughly familiar with the medical exemption process, the procedures under which these exemptions are evaluated and adjudicated, and the number of exemptions processed.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as the Director of Health, Safety and Work-Life and based upon personal knowledge and information provided to me in the course of my official duties.

3. Coast Guard service members who desire an exemption from vaccination requirements may submit requests for exemptions, whether administrative or medical, in accordance with the procedures outlined under existing Coast Guard regulations, to include the Multi-Service Regulation Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases (AR 40–562, BUMEDINST 6230.15B, AFI 48–110_IP, CG COMDTINST M6230.4G). As previously reported to the Court on January 21, 2022, the Coast Guard has received more than 1,300 religious exemption requests and just 12 permanent medical exemption requests.[1] As discussed further below, the majority of medical exemptions are temporary in nature (i.e., limited to a maximum period of 365 days), and only 6 permanent medical exemptions from COVID-19 vaccines have been granted – all of which were granted after the individual suffered severe allergic reactions after they received a first dose of a COVID-19 vaccine, or had a preexisting allergy to a component of the COVID-19 vaccine.

4. Medical exemption decisions are made on an individualized basis and only after a clinical evaluation of potential risk factors applicable to the patient concerned. Individual medical providers may give a temporary medical exemption from a particular vaccination, including the

[1] The Coast Guard's most recent report on exemption requests was filed on the docket at ECF No. 52-6.

COVID-19 vaccination, on a clinical discretionary basis. The authority to authorize permanent medical exemptions from vaccination requirements, however, is centrally managed at Coast Guard Headquarters. Decisions concerning vaccination, including the medical necessity to issue an exemption, temporary or permanent, are tailored to the individual patient based on the provider's assessment of the member's unique medical circumstances and needs.

5. The Coast Guard has only granted six permanent medical exemptions (four have been denied and two more are pending). These few exemptions were granted only in situations where the members either 1) received at least one dose of the vaccine and suffered a severe adverse reaction specifically to the COVID-19 vaccine or 2) had a pre-existing allergy to one of its ingredients. Requiring the member to receive another dose of vaccine would seriously undermine the health of that member, thereby degrading the military goals of readiness and force health protection. Medical providers will continue to review these exemptions as new vaccines emerge, with the potential for the permanent medical exemption to be adjusted or rescinded.

6. The vast majority of medical exemptions that have been considered and granted with respect to the COVID-19 vaccine are temporary in nature. The duration of these exemptions necessarily vary based on the medical conditions and history of the patient at the time of evaluation, and circumstances under which a temporary exemption could be granted are wide-ranging. However, while individual circumstances may vary, the underlying reason to issue such an exemption is to prevent physical or medical harm to the patient if they receive the vaccine. It would not serve the Coast Guard's interests in readiness and health of their members to vaccinate individuals whose health would be harmed by receiving the vaccine. Health care providers are responsible for "determin[ing] a medical exemption based on the health of the vaccine candidate and the nature of the immunization under consideration." CG COMDTINST M6230.4G, para.

2-6a. Temporary exemptions could be granted for as little as a day or up to 365 days, depending on a number of factors to include anticipated changes in a patient's medical condition, or the need for further evaluation at a future time. For example, a Coast Guard member may have a fever or other acute illness that would preclude vaccination on a particular day. Accordingly, a temporary exemption may be authorized, and the vaccination rescheduled. This is true of all vaccinations, not just COVID-19. A permanent medical exemption is not required; just a few days would normally resolve a minor issue such as the one in this example. There is no specific rule that dictates the length of a temporary medical exemption in these circumstances; that is dependent upon the individual provider's assessment of the patient's individual needs.

7. Consistent with CDC guidance, Coast Guard members who experienced a recent COVID-19 infection are also among those who have received temporary medical exemptions from vaccination. The CDC recommends that people with a COVID-19 infection defer vaccination until they have recovered from the acute illness (if they had symptoms) and have met the criteria to discontinue isolation. Once that period has passed, the member will be required to get vaccinated.

8. Other medical conditions may require a longer temporary exemption with the duration of each temporary exemption dependent on the circumstances. For example, a Coast Guard member undergoing chemotherapy or radiation therapy for cancer might require an exemption from specific immunizations for a period of time surrounding the treatment because their immune system is suppressed. A member whose cancer was treated through a surgical procedure may only require an exemption through the period of surgery or perhaps not at all.

9. Some temporary medical exemptions have a more predictable time period than others. A primary example is pregnancy, which could qualify for a temporary medical exemption. Such an

exemption could be granted for any number of reasons, including contraindications based on the patient's current health or medical complications that have arisen as a result of the pregnancy. A temporary medical exemption based on pregnancy has a end point when the medical exemption will expire and the member will be required to receive the vaccine.

10. Regardless of the underlying reason for the temporary medical exemption, these exemptions are temporary in nature and limited in time. Upon expiration of the exemption, the Coast Guard member will be required to receive the vaccine in order to come into compliance with military medical readiness standards. The underlying conditions that give rise to the temporary exemption may themselves impact a Coast Guard member's fitness for duty and deployability. For example, a member undergoing chemotherapy likely is neither deployable, not fully fit for duty. Similarly, a member who is pregnant or post-partum is not deployable. CG COMDTINST M6000.1F, Chapter 6.A.5.f.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February, 2022.

THOMAS.DANA.LYNN.1044078313

Digitally signed by THOMAS.DANA.LYNN.1044078313
Date: 2022.02.04 17:49:21 -05'00'

Dana Thomas
Rear Admiral, U.S. Coast Guard
Director
Health, Safety, and Work-Life

Exhibit 9

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

NAVY SEAL #1, *et al.* Plaintiffs, v. **JOSEPH R. BIDEN**, in his official capacity as President of the United States, *et al.* Defendants.	Case No. 8:21-cv-02429-SDM-TGW

DECLARATION OF JOON YUN

I, Captain Joon Yun, United States Navy, hereby state and declare as follows:

1. I am a Captain in the United States Navy, currently serving as CTF-80 Surgeon, located in U. S. Fleet Forces Headquarter, Norfolk, Virginia. I make this declaration in my official capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

2. As the Fleet Chief Medical Officer, I am primarily responsible for overseeing quality healthcare delivery within the Fleet and supervision of the credentialing and privileging process. I make this declaration in my official capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. I have been assigned to my current position since July 30, 2021. Prior to my current assignment, I served as the Chief Medical Informatics Officer at Naval Medical Forces Atlantic, Director of Medical Services at Naval Medical Center Portsmouth, Director of Medical Services at U. S. Naval Hospital Okinawa and as the Navy Specialty Leader for the Pulmonary

and Critical Care Community. I am board certified in Pulmonary Medicine, Critical Care Medicine and Internal Medicine and serves as an Assistant Professor of Medicine at the Uniformed Services University of Health Sciences.

4. I have reviewed the temporary restraining order (TRO) issued in the above captioned case on February 2, 2022. The order states, "the military faces a trivial, if any, prospect of material injury as a result of permitting the service members continued service under the same terms and conditions and with the same privileges and emoluments as currently prevail, especially because the military permits a large group of unvaccinated persons to serve without adverse consequence." ECF No. 67 at 9. This is statement is incorrect.

5. I first explain why there is far more than a "trivial" prospect of material injury by permitting Plaintiff to remain in command of a destroyer at sea. The judgment of the Military Services is that vaccines are the most effective and readily available tool the Armed Forces has to keep Sailors safe, fully mission capable and prepared to execute the Commander-in-Chief's orders to protect vital United States' national interests. As of January 5, 2022, 261,504 members of the Armed Forces have contracted the COVID-19 virus, resulting in 2,320 hospitalizations and 82 deaths. Eighty of 82 members who have died were unvaccinated. Of all active duty personnel hospitalized with COVID-19, 0.8% had received a booster shot. This amounts to six active duty personnel with boosters and breakthrough infections requiring hospitalization – an extremely rare occurrence. Among the active duty force, 12% of hospitalizations received a full course of vaccination without the booster shot. Hospitalizations among unvaccinated or partially vaccinated active duty personnel is 79%. Among non-active duty personnel (e.g., Reserve officers and enlisted), the statistical breakdown is even more stark: 0.2% with boosters hospitalized, 3% with primary vaccinations but no booster hospitalized and 97% unvaccinated or

partially vaccinated hospitalized. Furthermore, DoD has seen increasingly convincing data supporting that people are more likely to have "Long COVID"[1] after a COVID infection if they are unvaccinated, compared to those who are vaccinated and have a breakthrough infection. If Plaintiff were deployed and became seriously ill with the COVID-19 virus, the destroyer has limited medical capabilities to treat him. Depending on the location of the ship, a medical evacuation via helicopter may not be possible or extremely difficult, complex and lengthy. Additionally, Plaintiff sets the wrong example for anyone else in the crew of over 300 who does not wish to be vaccinated.

6. Second, the TRO is premised on an incorrect assumption that there are a large group of unvaccinated personnel who continue to serve without "adverse consequence." The TRO, as well as and the Court's previous order of November 23, 2021, ECF No. 40 at 24, incorrectly accepts Plaintiffs' contention that personnel with pending or approved medical exemptions are given preferable treatment and status as compared to those with pending or approved religious accommodations. Medical exemptions only pertain to the requirement to receive the COVID-19 vaccination. A service member with a medical exemption is still subject to restrictions and/or limitations related to the fact that they are unvaccinated (e.g., deployment

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[1] The CDC describes "long COVID" as the following:

> **Post-COVID conditions** are a wide range of new, returning, or ongoing health problems people can experience **four or more weeks** after first being infected with the virus that causes COVID-19. Even people who did not have COVID-19 symptoms in the days or weeks after they were infected can have post-COVID conditions. These conditions can present as different types and combinations of health problems for different lengths of time.
>
> These post-COVID conditions may also be known as long COVID, long-haul COVID, post-acute COVID-19, long-term effects of COVID, or chronic COVID.

Available at: https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html.

eligibility, foreign country entry restrictions, frequent COVID-19 testing or extended quarantine requirements, restrictions from all non-mission essential travel, etc.). Therefore, receipt of a medical exemption is not a "golden ticket" that permits the recipient to continue to freely perform any and all duties without consequences. That member will likely be reassigned and non-deployable just as any other unvaccinated person with or without a pending religious accommodation. Moreover, receiving any type of exemption from the vaccine requirement may require an additional medical waiver in order to deploy overseas, go on sea duty, or engage in other special duties or assignments.

7. A medical waiver to the physical standards is a separate determination that would come after a medical exemption or administrative exemption, such as religious accommodation, for the COVID-19 vaccine. Accordingly, if a service member receives an exemption to the COVID-19 vaccine for any reason they would have to engage in this subsequent process to be cleared for full duty by the Navy. That is, a service member who receives an exemption from the COVID-19 vaccination requirement, whether for religious or secular reasons, may not be medically qualified for certain duties unless he or she obtains separate medical clearance. Moreover, the service member may also need a separate medical waiver from the Combatant Command[2] to enter that commander's geographic area of responsibility. Different Combatant Commands may have specific requirements for vaccination based on the endemic biomedical threats that naturally exist in their geographic area as well as any biowarfare threats from adversaries. An unvaccinated member who deploys to a geographic region where there is an

[2] Since the passage of the Goldwater-Nicholas Department of Defense Reorganization Act of 1986, combatant commanders are vested with vast authorities and responsibilities for military operations within their area of responsibility. The Navy and other branches of the Armed Forces provide forces to the combatant commanders to execute those responsibilities and functions. The combatant commanders exercise authority, direction and control over the commands and forces assigned to them and employ those forces to accomplish missions assigned to the combatant commander. Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 1, ¶1.a through d.

endemic infectious disease would put not only his health at risk, but also the health of any other service member. Thus, a determination that a member is not deployable takes into account the risk to other personnel, the risk to mission as well as the unvaccinated member. These deployment determinations do not take into account whether a member is unvaccinated for secular or religious reasons; all unvaccinated service members are treated the same for purposes of determining whether they should receive a medical waiver that would render them fit for certain types of duty.

8. Receiving a medical exemption for the COVID-19 vaccine does not automatically render a service member deployable; he or she must undergo the process described in the prior paragraph. Indeed, many of the common reasons that a service member may receive a medical exemption from an immunization requirement may also make the service member not medically qualified and non-deployable. For example, BUMEDINST 6230.15B ¶ 2.6 lists immune competence, pharmacologic or radiation therapy, pregnancy and/or previous adverse response to immunization as common reasons for a medical exemption from an immunization.[3] The first three conditions would almost certainly lead to a finding of unsuitability for deployment and an inability for the service member to get underway on Navy vessels.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February, 2022.

JOON YUN

[3] BUMEDINST 6230.15B ¶ 2.6 also lists evidence of immunity based on serologic tests, documented infection, or similar circumstances as a possible basis for a medical exemption for an immunization. However, pursuant to DoD policy a prior COVID-19 infection, by itself, is not grounds for a medical exemption to the COVID-19 vaccination requirement.

Exhibit 10

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

NAVY SEAL #1, *et al.* Plaintiffs, v. **JOSEPH R. BIDEN**, in his official capacity as President of the United States, *et al.* Defendants.	Case No. 8:21-cv-02429-SDM-TGW

DECLARATION OF ERIC N. THOMPSON

[WITH REGARD TO PLAINTIFF LIEUTENANT COLONEL #2]

I, Colonel Eric N. Thompson, United States Marine Corps, hereby state and declare as follows:

1. I am a Colonel in the United States Marine Corps, currently serving as the Chief of Staff, Marine Forces Special Operations Command, located in Camp Lejeune, NC. I make this declaration in my official capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

2. I have been assigned to my current position since June 2021. Prior to my current assignment, I served as Commanding Officer, Marine Raider Support Group (2019-2021).

3. My Platoon Commander tours were with 2nd Battalion, 4th Marines (1997-1999), 1st Force Reconnaissance Company (1999-2002), and Marine Corps Special Operations Detachment 1 (2003-2005). I served as Company Commander, Operations Officer, and Executive Officer with 1st Battalion, 3d Marines (2005-2008), and Battalion Commander, 3d Reconnaissance Battalion (2012-2014). My professional military education includes Infantry

Officers Course, Expeditionary Warfare School, a Master of Arts Degree in Military Studies from Marine Corps Command and Staff College, the Massachusetts Institute of Technology Security Studies Program in Cambridge, and Joint Professional Military Education Phase 2 at Joint Forces Staff College. I am also a Marine Combat Diver, Military Freefall Parachutist, and a graduate of U.S. Army Ranger School and Marine Corps Basic Reconnaissance Course.

4. "The fundamental goal of the Marine Corps is the maintenance of a force that is ready, responsive and capable of fighting whenever and wherever called upon." Marine Corps Manual § 1005 ¶ 1. In order to achieve this goal, one of many objectives is "[t]o maintain a high degree of readiness to deploy responsively, engage quickly, and sustain itself in combat for whatever period is required." *Id.* at ¶ 2.b. Plaintiff has been selected for battalion command with the prospective authority, responsibility and accountability for mission accomplishment and the readiness, health and welfare of more than 300 Marines. Plaintiff had her leadership's full trust and confidence in her ability to command and recognizes her, and every Marine's, right to seek accommodation of their religious beliefs. That trust and confidence significantly diminished, however, once Plaintiff refused to obey a lawful order following the denial of her religious accommodation appeal. After the denial of her appeal, she received an order to be vaccinated by February 2, 2022. At this point, she has failed to obey that lawful order. The Marine Corps cannot accomplish its mission, functions, and service to the Nation if its commanding officers do not obey the same orders they are demanded to enforce among the Marines under their charge. Adherence to orders cannot be taught during a crisis or on the battlefield. For a Marine Corps unit to successfully accomplish its mission, compliance with military orders must be instinctive with little time for debate or reflection. This is imperative in combat, but conduct in combat invariably reflects the training that precedes combat. It is the commanding officer's

responsibility to create a culture where immediate obedience to orders and military procedures is habit for when such conditions arise. A commanding officer who cannot adhere to military orders themselves has forever lost the ability to instill a culture of good order and discipline in their Marines. This is why a Marine is ineligible for command once that officer is suspended from duty or under investigation or arrested for allegations of misconduct. In that circumstance, "[the] officer is deprived of all authority to give orders or exact obedience from junior personnel or to perform any other duties that go with the exercise of command." *Id.* at ¶3.c. In this regard, the temporary restraining order (TRO) issued on February 2, 2022 intrudes upon nearly 250 years of Marine Corps and U.S. military leadership by keeping an insubordinate officer in a position to assume command and lead Marines.

5. In accordance with the Marine Corps Manual, "[t]he responsibility of the commanders for their commands is *absolute* except to the extent that the commander is relieved of responsibility by competent authority or by regulations." *Id.* at 2.a (emphasis added). With this awesome responsibility also comes accountability. Every commanding officer is accountable to a superior officer within the chain of command, up to and including the Commander-in-Chief, who is accountable to the American people. The TRO gives Plaintiff the absolute responsibility and authority for her command and Marines but without any accountability since this officer is not subject to any accountability under the TRO. The truly breathtaking aspect of the TRO is that it forces the Marine Corps to place an insubordinate officer in command and allows her to lead Marines and then prohibits the Marine Corps from holding the Plaintiff to account if she fails to meet the exacting standards demanded of all officers entrusted with command. This is anathema to the Constitution that every Marine Corps officer swears to defend.

6. Marine Corps policy and COVID vaccination implementing guidance balances the safety, health, and readiness of the Force with the ability of members to seek medical exemptions and religious accommodations to the vaccination requirement while — to the maximum extent possible — maintaining their current assignments and responsibilities. Specific to those in command or selected for command, such as Plaintiff, officers are allowed to remain in command while unvaccinated with proper mitigation measures while their accommodation or exemption requests are pending. If an officer has exhausted his or her exemption processes and is ultimately denied an exemption, he or she faces a choice: get vaccinated or do not assume command:

> Marines who have refused the vaccine may not serve in a command assignment (e.g., Commanding Officers, Inspector-Instructors, Senior Enlisted Advisors, or Officers-in-Charge) without an approved administrative or medical exemption, religious accommodation, or pending appeal. Commanders will relieve for cause unvaccinated Marines without an approved administrative or medical exemption, religious accommodation, or pending appeal currently serving in command assignments. Unvaccinated Marines without a pending or approved exemption or accommodation request or appeal will not assume a command assignment.

MARADMIN 612/21 ¶ 3.g.

7. The scope of the order, which forces the Marine Corps to allow Plaintiff to assume command with no ability to hold her to account will irreparably harm good order and discipline in the unit and will ripple across the Marine Corps. More than 300 Marines will be expected to follow Plaintiff's orders or face discipline and adverse administrative action. If other Marine Corps personnel learn that plaintiff has refused to comply with a lawful order, Plaintiff's ability to effectively command Marines will be seriously undermined. In addition, some junior personnel will see an example that some lawful orders need not be followed. In either case, the result will be harm to good order and discipline and the effectiveness of the force.

8. "A Marine who has not been fully vaccinated is not considered worldwide deployable and shall be assigned or reassigned, locally, to billets which account for health risks to the unvaccinated Marine and those working in proximity to the Marine." *Id.* at 3.c. Plaintiff's prospective command is currently slated to deploy as part of a Marine Expeditionary Unit (MEU), which will mean that her unit could travel anywhere in the world. The MEU is the standard forward-deployed Marine expeditionary organization. Forward-deployed MEUs are maintained in the Mediterranean Sea, the western Pacific, and the Indian Ocean or Arabian Gulf region. The MEU can be thought of as a self-contained operating force capable of missions of limited scope and duration. The MEU's mission is to provide the President, Secretary of Defense, and Combatant Commanders with a forward-deployed, sea-based, rapid crisis response capability to execute a full range of military operations. It is organized, trained, and equipped as a self-sustaining, general-purpose expeditionary unit that possesses the capability to conduct a range of military operations in support of various contingency requirements. Embarked aboard the ships of a Navy amphibious ready group, a deployed MEU provides operational commanders with a quick, sea-based reaction force for a wide variety of situations. In many cases, the MEU embarked on amphibious warfare ships may be the first US force at the scene of a crisis and can conduct enabling actions for larger follow-on forces. It can provide a visible and credible presence in many potential trouble spots and can demonstrate the willingness of the United States to protect its interests overseas.

9. Travel to other countries will be a requirement for personnel assigned to the MEU. That is to say, Plaintiff and members of her unit could be required to enter several foreign countries during the duration of Plaintiff's assignment to command. The TRO directs the Department of Defense and the Marine Corps to maintain the status quo, but the TRO will not

supersede another country's sovereignty to control who is allowed to enter their country. For example, key partner nations such as Israel,[1] and Kuwait,[2] which has American military facilities, require those who enter their country to be vaccinated, and other nations have varying testing requirements and quarantine periods for unvaccinated personnel. By remaining unvaccinated yet court-ordered to remain eligible for command in the TRO, Plaintiff will face a situation in which she cannot travel to countries she may be required to visit in her capacity as the commanding officer. Therefore, Plaintiff has requested and the TRO has enabled a situation in which Plaintiff's ability to command, and to travel to U.S. or foreign facilities in key partner nations, and to engage foreign partners is seriously impaired and will result in diminished unit effectiveness and mission accomplishment.

10. The military makes demands on its personnel — and its commanding officers in particular — that have no counterpart in civilian life. The TRO does not recognize these inescapable demands of the military establishment and the overriding requirements for good order and discipline that are necessary for the Marine Corps to fight and win the Nation's wars. The business of the Marine Corps is conducted in the deserts, jungles, mountains, and shores of dangerous places, not from board rooms, cubicles, and home offices. For centuries, the Marine Corps has successfully accomplished its missions by adhering to its Core Values of Honor, Courage, and Commitment. Plaintiff is selected for command of a unit that will be deploying; she cannot effectively lead Marines when she herself cannot deploy with them. Her unvaccinated status jeopardizes the health and welfare of personnel in her unit and prevents her from being world-wide deployable, which is a necessary component of her command position. Moreover, if allowed to assume command while in defiance of a lawful order, she will erode the

[1] https://corona.health.gov.il/en/abroad/arriving-foreign-nationals/
[2] COVID-19 Information - U.S. Embassy in Kuwait (usembassy.gov)

good order and discipline of her unit and degrade the unit's ability to successful accomplish its assigned missions.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February, 2022.

ERIC N. THOMPSON

Exhibit 11

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

NAVY SEAL #1, *et al.* Plaintiffs, v. **JOSEPH R. BIDEN,** in his official capacity as President of the United States, *et al.* Defendants.	Case No. 8:21-cv-02429-SDM-TGW

DECLARATION OF FRANK BRANDON

[WITH REGARD TO PLAINTIFF NAVY COMMANDER]

I, Captain Frank Brandon, United States Navy, hereby state and declare as follows:

1. I am a Captain in the United States Navy, currently serving as Commodore of Destroyer Squadron TWO SIX, located in Norfolk, Virginia. I make this declaration in my official capacity, based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

2. I have been assigned to my current position since June 2021. Prior to my current assignment, I served as the Deputy Commodore of Destroyer Squadron TWO SIX from June of 2020 to June of 2021.

3. Select Navy tours include the following: Operations Officer onboard the USS LASSEN (DDG-82) transitioning the ship to the Forward Deployed Naval Forces - Yokosuka, Japan; Main Propulsion Assistant onboard the USS ENTERPRISE (CVN 65) deploying to the Arabian Gulf in support of Operations IRAQI FREEDOM and ENDURING FREEDOM

(OIF/OEF); Executive Officer onboard the USS MITSCHER (DDG-57); Commanding Officer onboard the USS MITSCHER executing a 5th Fleet Ballistic Missile Defense Deployment; and Reactor Officer onboard the USS EISENHOWER (CVN-69).

4. I have lost trust and confidence in Plaintiff, and I have determined that he should be removed immediately from his position as commander of a guided-missile destroyer. To be clear, I have not lost trust and confidence in Plaintiff because of his religious beliefs. Rather, once his religious accommodation appeal was denied, he was issued an order giving him five days to receive the COVID-19 vaccine, but he refused to do so. Therefore, Plaintiff is in violation of a lawful order. In the military, adherence to a lawful order is the most fundamental principle on which good order, discipline, and the success of military forces rests. Adherence to orders cannot be taught during a crisis or on the battlefield. Rather, a commanding officer is instilled with the responsibility to create a culture of immediate compliance to orders and military procedures that are reflexive for when such conditions arise. A commanding officer who cannot adhere to military orders has forever lost the ability to instill a culture of good order and discipline in their crew. This will inevitably lead to the breakdown of basic principles of training, safety and seamanship and could have tragic consequences at any moment but especially when the vessel is underway at sea.

5. I have reviewed the temporary restraining order (TRO), ECF No. 67, issued on February 2, 2022. Enjoining Navy leadership from relieving Plaintiff of his command of a destroyer creates a dangerous situation. *See* ECF 67 at 10. Specifically, the Navy is forced to leave an insubordinate officer with poor judgment and a lack of concern for the health and welfare of his crew of over 300 sailors in charge of a nearly 10,000-ton warship—armed with missiles, torpedoes, a mounted naval artillery gun, and other powerful ordnance—that could be

called to respond to a national security crisis. Under Navy regulations, "[t]he responsibility of the commanding officer for his or her command is absolute, except when and to the extent to which, he or she has been relieved therefrom by competent authority." With this awesome responsibility also comes accountability. Every commanding officer is accountable to a superior officer within the chain of command, up to and including the Commander-in-Chief, who is accountable to the American people. Navy Regulations 0802 ¶ 1. Because the Court has ordered that the Plaintiff cannot be removed from command, this result would give the Plaintiff the absolute responsibility and authority over his ship and crew but without any accountability to the chain of command. Providing Plaintiff with this authority and responsibility with no accountability is contrary to every principle of leadership in the 246-year history of the United States Navy and is anathema to the Constitution that every Naval Officer swears to defend.

6. In addition, this destroyer cannot deploy with the Plaintiff as the commanding officer. The TRO has rendered the Plaintiff's destroyer a non-worldwide deployable unit. The Plaintiff's unvaccinated status limits the destroyer's worldwide deployability—at this point in the ship's readiness cycle, she could be soon called upon to support military operations. The requirement to remove the plaintiff from command just prior to combat operations creates risk to the military mission, endangers the crew, and diminishes our national security. For example, vaccination for COVID-19 is required prior to deployment to the U.S. Central Command Area of Responsibility. Given current world events, sidelining a 1.8 billion dollar destroyer significantly reduces the capacity and readiness of my Destroyer Squadron to support national security objectives.

7. Navy policy and COVID-19 vaccination implementing guidance balances the safety, health and readiness of the Force with the ability of service members to seek medical

exemptions and religious accommodations to the vaccination requirement while—to the maximum extent possible—maintaining their current assignments and responsibilities. Specific to those in command, such as Plaintiff, commanding officers may be allowed to remain in command while unvaccinated with proper mitigation measures while their accommodation or exemption requests are pending. If a commanding officer has exhausted his or her exemption processes and is ultimately denied an exemption, he or she faces a choice: get vaccinated or be relieved of command:

> An unvaccinated senior leader without a pending or approved exemption calls into question the Navy's trust and confidence regarding their ability to ensure unit readiness or to maintain good order and discipline. These senior leaders must begin vaccination immediately. This constitutes a lawful order. The immediate superior in command (ISIC), commander, or commanding officer, as applicable, will notify in writing senior leaders refusing the vaccine that they have five (5) calendar days to initiate corrective action. If the senior leader does not begin a vaccination series or request an exemption within that five-day period, the ISIC, commander, or commanding officer will relieve the senior leader and initiate detachment for cause (DFC) [proceedings].

NAVADMIN 225/21 ¶ 6.a.

Plaintiff's religious accommodation appeal was denied, he was ordered to take the vaccine within five days, and he was about to be relieved from command before the TRO was issued. Plaintiff, now in violation of a lawful order, remains in command. The Plaintiff has issued the same or similar orders to members of his crew and has enforced the Navy's disposition guidance on members of his crew for refusing the vaccine—notwithstanding his refusal to obey the same order. The first member of his crew will be separated from the Navy on February 8, 2022 for refusing to get vaccinated.

8. Pursuant to Navy regulations, "[t]he commanding officer and his or her subordinates shall exercise leadership through personal example, moral responsibility and judicious attention to the welfare of persons under their control or supervision. Such leadership

shall be exercised in order to achieve a positive, dominant influence on the performance of persons in the Department of the Navy." Navy Regulations 0802 ¶ 4. The breadth of the TRO, which would arguably leave this officer in command with no accountability, will likely lead to a breakdown of good order and discipline on this ship. This authority without accountability could lead to tragic results. The TRO sets the conditions for over 300 personnel on this destroyer to not follow Plaintiff's orders because of his personal example. If Sailors disagree with an order issued by this commanding officer, the example they have from this Plaintiff is to refuse the order and, if needed, judicially challenge the order or assignment the commanding officer has issued.[1] A Navy warship cannot function under these conditions.

9. Men and women charged with the responsibility of command at sea understand that being at sea is fraught with hazards in normal operations. For example, in a span of approximately two months in 2017, two destroyers, USS FITZGERALD and USS JOHN S. MCCAIN, were involved in horrific collisions during routine transits resulting in the loss of 17 Sailors. The Navy determined that these incidents were, in part, based on a failure of leadership. Specifically the commands failed to create a culture that prioritized training, qualifications, and the flawless execution of the basics of seamanship. Because Plaintiff now refuses orders himself, I have lost confidence in his ability to create such a culture in his own command. To mitigate this risk, I have already placed extra supervision onboard the destroyer to ensure the safe handling and operations of this warship at sea.

10. In addition, the Court's order prohibits the Navy from removing the Plaintiff from his command "for any reason." On its literal terms, the order appears to mean that even if the

[1] The Navy waterfront is watching. Restricting my authority to enforce the orders from my Navy superiors sets a precedent across the Navy waterfront, and encourages Sailors to challenge the orders they are given when those Sailors disagree with the order.

Plaintiff were to cause a catastrophic event resulting in the loss of life or a tactical blunder with strategic consequences, such as a reckless maneuver in proximity to a hostile military aircraft or vessel, the Court's order appears to foreclose the Navy from removing Plaintiff from command or taking any other action against Plaintiff. Similarly, if Plaintiff issues a clearly unlawful order that endangers his entire crew, again, the Court's order seems to require that he be kept in place. For example, the Court's order purports to require the Navy to keep this officer in command even if he was responsible for a horrific accident similar to those that occurred on the USS FITZGERALD and USS JOHN S. MCCAIN. Even assuming the Plaintiff were to carry out his military duties without incident, the Court's order still would require the Navy to maintain in place a commanding officer who has lost the confidence of his superiors by defying a lawful order critical to ensuring the continued readiness of world-wide deployable Navy.

11. The TRO will also result in decreased morale and a breakdown of discipline within the unit and likely other units as well. The order creates a bifurcated system for leading, assigning, disciplining, and employing Navy personnel. The lack of uniformity and disparate treatment necessitated by the TRO significantly corrodes good order and discipline beyond this officer's destroyer.

12. As the commanding officer of a guided-missile destroyer, Plaintiff commands a crew of more than 300 Sailors aboard a 510-foot long ship. Generally, the Arleigh Burke Class Guided Missile Destroyers are warships that provide multi-mission offensive and defensive capabilities. These modern warfighting platforms cost approximately $1.8 billion to build. Destroyers can operate independently or as part of Carrier Strike Groups, Surface Action Groups, and Expeditionary Strike Groups. Guided-missile destroyers are multi-mission surface combatants capable of conducting Anti-Air Warfare, Anti-Submarine Warfare, and Anti-Surface

Warfare. The destroyer's armament has greatly expanded the role of the ship in strike warfare utilizing the MK-41 Vertical Launching System. The class's armament includes Standard Missile; Vertical Launch ASROC missiles; Tomahawk; six MK-46 torpedoes (from two triple tube mounts); Close In Weapon System, 5-in. MK 45 Gun, and Evolved Sea Sparrow Missile (ESSM). Aircraft include two LAMPS MK III MH-60 B/R helicopters with Penguin/Hellfire missiles and MK 46/MK 50 torpedoes. Because a destroyer can fill several mission sets and deploy independently, it is one of the most dynamic and versatile assets within the Navy.[2] Readiness to deploy is paramount. Onboard, the crew of the ship and others, who may include helicopter air crews or embarked special operations forces, sleep in confined berthing spaces, are in close proximity in passageways, and eat meals in a communal galley. There is no ability to social distance on a destroyer. There is no ability on a destroyer to provide appropriate care for a service member with severe COVID-19 symptoms. Accordingly, if a service member were to develop severe symptoms on a destroyer, it would require the ship to return to port (and abandon its present mission) or arrange for an emergency medical evacuation using a helicopter. Often a medical evacuation may not be a viable option due to the ship's location and the limited range of the ship's helicopter. Even where a medical evacuation is an option, it may involve the long-term loss of the ship's helicopter and members of the ship's crew to accompany the sick service member. Such a loss would have an adverse impact on employment of the ship and the ability of the ship to execute its assigned missions. Because of the risks to unvaccinated personnel, the crew, and the mission, unvaccinated personnel cannot be assigned to operational units.[3]

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[2] For instance, the Commander of U.S. Central Command, Gen McKenzie, stated the following regarding destroyers in his 2021 posture statement: "As Iran's ballistic missile force is the most formidable in the region, USCENTCOM's missile defense assets incorporate Patriots, Sentinel and Avenger systems, and ***Navy cruisers/destroyers*** to form a layered defense, augmented by Theater High-Altitude Air Defense when ordered."

[3] "[A]ll operational Navy units are assumed to be 100 percent vaccinated. Unvaccinated uniformed personnel should only include those with an approved waiver, those awaiting waiver disposition, or those processing for separation." NAVADMIN 077/22 ¶5.b.1. "Operational" units refer to the Navy's warfighting units, like a guided-missile destroyer,

NAVADMIN 007/22.

13. The destroyer that Plaintiff currently commands is in her "basic phase." The "basic phase" means the ship is in training in preparation for future deployment, conducting measures such as live-fire events, helicopter operations, handling of munitions and ordnance, small-craft boarding team evolutions, and others, to prepare for future deployment certification. In other words, the ship is preparing for deployment. This preparation involves qualifications and certification events that require the ship to be underway (at sea) for several short periods of time. Units that have completed the basic phase may be tasked with independent contingency operations as directed by the President and Secretary of Defense, in addition performing homeland security, humanitarian assistance (HA) and disaster relief (DR), or other specific, focused operations. It should also be noted that this ship is homeported on the east coast. Geopolitical events and national security crises are unpredictable but some are foreseeable. This ship could be called into foreseeable contingency operations in very short order. If this occurs, the Navy would have to deploy a destroyer with a commander for whom I have lost confidence in his ability to follow orders, faithfully execute his duties as assigned, and who could compromise the health and effectiveness of the ship. The Navy's discretion to choose commanders of its destroyers for deployments is paramount for national security.

14. In addition to refusing to obey a lawful order, after exhausting the religious accommodation process, on February 1, 2022, Plaintiff then submitted a "new" request in an effort to remain in an indefinite "exemption request pending" status to avoid adverse administrative action and accountability. Plaintiff's religious accommodation appeal was denied

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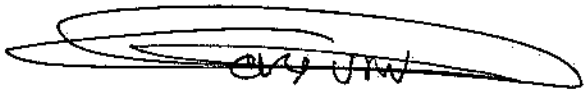
which are required to be worldwide deployable at all times to ensure our national security. The assumption is that, to ensure mission readiness, unvaccinated personnel will only remain assigned to these types of units temporarily until such time as they are vaccinated, reassigned, or separated.

on January 23, 2022. Plaintiff's "new" religious accommodation request seeks the identical accommodation that was the subject of his appeal. However, Plaintiff contends that there are significant changes in the physical environment by referencing the number of personnel vaccinated, infections with the Omicron variant, and the fact that he was inconvenienced during the holiday period when his executive officer became infected with COVID-19, requiring Plaintiff to be aboard the ship—of which his responsibility for is "absolute"—for more than he would have preferred.[4] In response, the Chief of Navy Personnel, the adjudication authority for religious accommodation requests, denied the renewed request, finding that there was no significant change in the environment and no change in the compelling government interest in Plaintiff being vaccinated. Exhibit B. In the short time since his religious accommodation appeal was denied and through his actions and words, Plaintiff has demonstrated that he will remain personally unvaccinated to the detriment of the readiness of his crew and unit.

15. In conclusion, the COVID-19 vaccine is the best defense the military has against a virus which can significantly degrade the health and welfare of service members and compromise the mission. The Court's order barring the implementation of this lawful order, and requiring the Navy to leave an insubordinate officer in command, has undermined the good order and discipline onboard this destroyer. As long as this order remains in place, this TRO will continue to severely undermine the military readiness of this destroyer. Due to its overall impact on good order and discipline it is also likely to affect the military readiness of other ships and the Navy. Finally, sidelining a 1.8 billion dollar destroyer is an unnecessary risk to national security.

[4] "Of note, my holiday stand down was limited/non-existent because my XO (fully vaccinated) contracted COVID-19 and remained away from his duties to execute required ROM [restriction of movement] protocols." Exhibit A at 2.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 4th day of February, 2022.



Frank Brandon

Exhibit A

1 Feb 22

From: [redacted] USN
To: Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N1)
Via: Commander, Destroyer Squadron TWO SIX

Subj: REQUEST FOR WAIVER OF POLICY IN SUPPORT OF RELIGIOUS PRACTICE

Ref: (a) DOD Instruction 1300.17
(b) SECNAVINST 1730.8
(c) BUPERSINST 1730.11A

Encl: (1) APPEAL OF RELIGIOUS ACCOMMODATION FOR IMMUNIZATION REQUIREMENT, dated 23 January 2022
(2) APPEAL OF DISAPPROVED REQUEST FOR WAIVER OF POLICY IN SUPPORT OF RELIGIOUS PRACTICE IN CONSIDERATION OF COMMANDER [redacted]
(3) Email from CDR [redacted] to ISIC requesting missing information from RA disapproval, dated 29 December 2021
(4) Email from CDR [redacted] to OPNAV requesting missing information from RA disapproval, dated 04 January 2022
(5) Email from ISIC providing the missing documentation, dated 24 January
(6) REQUEST FOR RELIGIOUS ACCOMMODATION THROUGH WAIVER OF IMMUNIZATION REQUIREMENTS ICO CDR [redacted] USN, dated 13 October 2021 (BUMED letter)
(7) https://www.washingtonpost.com/national-security/2022/01/03/uss-milwaukee-covid-outbreak/
(8) https://news.usni.org/2022/01/04/uss-milwaukee-back-in-sea-after-covid-19-outbreak
(9) https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1
(10) https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00258-1/fulltext
(11) https://www.news-medical.net/news/20210608/No-point-vaccinating-those-whoe28099ve-had-COVID-19-Findings-of-Cleveland-Clinic-study.aspx
(12) https://www.nih.gov/news-events/nih-research-matters/lasting-immunity-found-after-recovery-covid-19

1. Per references (a) and (b), the Department of the Navy (DON) recognizes that religion can be as integral to a person's identity as one's race or sex. To that extent, DON promotes a culture of diversity, tolerance, and excellence by **making every effort** to accommodate religious practices **absent a compelling operational reason** to the contrary. Religious medical practices include traditional objections to receiving immunizations. It is DON policy to accommodate the traditional observances of the religious faith practiced by individual members when these doctrines or observances **will not** have an adverse impact on military readiness, individual or unit readiness, unit cohesion, health, safety, discipline, or mission accomplishment. Immunizations requirements may be waived when requested by the member based on religious objection.

2. Per enclosure (1), I received denial of my Religious Accommodation (RA) appeal request from the CNO dated 23 Jan 2022. I am submitting a new RA request per reference (c) which states as follows:

> *5f(2) When a religious accommodation request is denied, the requestor may renew the request upon change in **physical**, operational or geographical environment, or at any time in which there is a change to pertinent policy.*

Since my original request for RA submitted 13 September 2021 and appeal submitted 3 November 2021, my physical environment has changed significantly as follows:

1. About 300 sailors at my command have become vaccinated or natural infected and recovered from the COVID-19 virus;
2. I contracted the COVID-19 virus on 10 November 2021 with mild symptoms associated with the Omicron variant and have natural immunity that I did not have previously;
3. Over 160 Sailors have contracted the COVID-19 virus despite being fully vaccinated. Of note, my holiday stand down was limited/non-existent because my XO (fully vaccinated) contracted COVID-19 and remained away from his duties to execute required ROM protocols.
4. Over 5500 COVID-19 positive reports on surface ships under USFFC have demonstrated the primary COVID-19 infections are in vaccinated sailors, clearly indicating current COVID-19 vaccinations do not prevent contraction or spread of the COVID-19 virus;
5. The Omicron variant (as opposed to the original virus and subsequent variants), though more transmissible, has significantly lower instances leading to hospitalization and almost non-existent instances of death directly relating to COVID-19 infection; and
6. [redacted] is increasing its operational status with fewer and fewer days ashore, naturally limiting myself and crew to additional, outside COVID-19 virus exposure.

3. Additionally, after I submitted my RA appeal in November 2021 per enclosure (2), I was made aware by my PERSREP JAG that I had not received all of the information utilized by N1 to deny my Sep 2021 RA request. Specifically, in consult with my JAG, I had the right to view documents and/or recommendations made by other agencies and individuals which should have been provided along with the CNP denial letter dated 22 Oct 2021, contained in enclosure (2). I requested this information from my ISIC on 29 Dec 2021 (see enclosure (3)) and formally requested this information from OPNAV N1 via email on 04 Jan 2022, see enclosure (4). In my email request, I asked the following information to be provided:

a. Reference (h) of CNP's denial letter: BUMED ltr 6320 Ser M44/21UM40540 of 13 Oct 21 which CNP states in paragraph 5 he relied upon in making his determination.

b. Any documents, notes, or additional material submitted to CNP for evaluation and consideration of my 13 September 2021 request for religious accommodation.

After receiving some of the requested documentation from N1 on 24 Jan 2022 via email from my ISIC (see enclosure (5)), it was clear that **I had not had the opportunity to fully address the issues I would have raised in my appeal had I been provided the original denial's supporting documents**.

4. Upon reading the BUMED letter dated 13 Oct 2021, see enclosure (6), I would like to proactively address some of the information that is contained therein as follows:

a. Per para 2, vaccines required for individual medical readiness have met the safety requirements of the FDA. Of note, vaccines that are required for individual medical readiness have been approved by the FDA. The only COVID-19 vaccines that are currently approved by the FDA are "COMIRNATY" by BioNTech Manufacturing GmbH (Mainz, Germany) and "SPIKEVAX" by Moderna, neither of which are available in the United States presently as stated in the 31 Jan 2022 letter to ModernaTX, Inc. which states:

*"Although SPIKEVAX (COVID-19 Vaccine, mRNA) and Comirnaty (COVID-19 Vaccine, mRNA) are approved to prevent COVID-19 in certain individuals, within the scope of the Moderna COVID-19 Vaccine authorization, there is **not sufficient approved vaccine** available for distribution to this population in its entirety at the time of reissuance of this **EUA**."*

b. Currently, all other COVID-19 vaccinations that are available to servicemembers are only authorized by the FDA for Emergency Use Authorization (EUA) only. Per 21 USC Sec. 360bbb-3, vaccinations under EUA are voluntary, unless waived by POTUS per 10 USC Sec. 1107a, DoDI 1300.17 and DoDI 6200.02.

c. The BUMED letter states that vaccinations have demonstrated effectiveness in disease prevention. That statement may apply to other vaccinations; however, it does not apply to any of the current COVID-19 vaccines available. The efficacy of the current COVID-19 vaccinations is based on reducing symptoms if exposed and preventing severe illness or death. None of the COVID-19 vaccinations prevent contracting the predominant Omicron variant virus, or transmission of the virus as evidenced by world wide reports and current Navy COVID-19 virus positivity tracking data.

d. Per para 3, the letter states that active duty personnel will be up to date on routine vaccinations. COVID-19 is not a routine vaccination.

e. Per para 4, the BUMED letter states that a waiver of immunization requirements would have a **detrimental** effects on readiness of myself and my fellow service members. The letter does not explain **how** this is detrimental. The letter continues to state that primary prevention of disease is through immunization. It is still common knowledge that COVID-19 vaccination does not prevent the contraction or spread of COVID-19. Studies have shown natural immunity is an effective guard against contraction, spread and symptoms that would cause hospitalization or death, see enclosures (9) through (12).

f. The BUMED letter further cites the case of USS THEODORE ROOSEVELT that had a COVID outbreak in March 2021 as an example of how an outbreak of COVID can degrade the individual unit readiness. This case is used by BUMED to "highlight the importance of vaccination to both individual and unit force health protection. A similar outbreak happened to the USS MILWAULKEE (LCS 5) in December 2021 with a crew that was 100% vaccinated, see enclosures (7) and (8). One third of the crew tested positive for COVID. This ship had just deployed, and had

to be isolated inport, removing the unit from executing its mission capabilities for about two weeks. This demonstrates that unit and mission readiness could be negatively impacted **regardless** of COVID vaccination status.

g. Per para 5, the BUMED letter states that unvaccinated individuals remain at risk for developing COVID-19 and propagating new variants that impact the force. This statement is inaccurate in that both vaccinated and unvaccinated individuals can develop COVID-19. Also, studies show that vaccinated individuals are just as likely to transmit COVID and propagate variants, see enclosure (9). Specifically, researchers found that "those who were fully vaccinated with the Pfizer-BioNTech Covid-19 vaccine had a 13.06-fold increased risk of developing COVID-19 from the delta variant than those who had previously contracted and recovered from a COVID-19. The study also found that those who previously contrac ted and recovered from COVID-19 had increased protection against reinfection from a single dose of Pfizer's COVID-19 vaccine compared to those who had had a prior infection and remained unvaccinated. Researchers calculated the 13-fold increased risk of infection based on just 238 infections among about 16,000 vaccinated people—accounting for less than 1.5% of that group—versus 19 reinfections among roughly 16,000 study participants who had been previously infected." According to the CDC website, "High viral loads suggest an increased risk of transmission and raised concern that, unlike with other variants, vaccinated people infected with Delta can transmit the virus," CDC Director Rochelle Walensky said in a statement. "This finding is concerning and was a pivotal discovery leading to CDC's updated mask recommendation. The masking recommendation was updated to ensure the vaccinated public would not unknowingly transmit virus to others, including their unvaccinated or immunocompromised loved ones." **The BUMED letter is not up to date with the CDC** comments on vaccinated individuals being susceptible to transmitting COVID. Therefore, it should not be used against unvaccinated personnel who are no different.

h. Per para 6, the BUMED letter states that vaccination remains the most effective means to prevent COVID-19. However, studies show that vaccination does not prevent one from contracting or spreading COVID. The letter does state that efficacy was tied to **preventing symptomatic** COVID. This matches up with my previous statement; it should be restated that the efficacy is NOT tied to preventing the contraction or transmission of COVID. Additionally, the BUMED letter refers to the FDA approved vaccine. The FDA has only approved two of the five COVID-19 vaccine products, COMIRNATY on 23 Aud 2021 and SPIKEVAX on 31 Jan 2022. Of note, the other three COVID vaccine products (Pfizer-BioNTech, Moderna, and Johnson&Johnson remain under EUA). This statement by BUMED implies that the FDA approved vaccine is and has been available to servicemembers. Based upon my personal attempts to locate an FDA licensed vaccine at my local MTFs, I have been unsuccessful to locate any.

i. Per para 7, the BUMED letter states that my religious objects must be balanced against the medical risk to me and my unit. Subsequent to my original RA request and RA denial appeal, I have already contracted COVID-19 and have natural immunity to the virus. I am not at risk for severe illness. All personnel (vaccinated or unvaccinated) are susceptible to COVID transmission; vaccination status does not prevent that fact. Per enclosure (10), there is increasing evidence that vaccinated individuals are more likely to transmit COVID than unvaccinated individuals. Regardless, it has already been shown that mission accomplishment can still be done despite vaccination status. And we already know that complete vaccination can still be impacted by COVID, which could affect unit readiness. Not receiving the vaccine has no measurable effect to

the opinion that BUMED states in their letter, and should not be held against service members that have a sincerely held belief or religious objection.

5. Per reference (c), when a religious accommodations is denied, the request or may renew the request upon a change in physical, operational or geographical environment. Physical environment includes your work environment on the ship, on the job. Since my initial RA request of 13 Sep 2021, and the subsequent appeal on 03 Nov 2021, I contracted & recovered from COVID-19 (with a positive test dated 10 Nov 2021). Natural immunity reduces the risk of additional covid infection and effects, see enclosures (9) through (12). Lasting immunity is found up to 8 months post COVID infection. It can be concluded that "This study demonstrated that natural immunity confers longer lasting and stronger protection against infection, symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity."

6. The Religious Freedom Restoration Act of 1993 (RFRA) states the Government may substantially burden an individual's exercise of religion only if it demonstrates that the application of the burden to the person is: (1) in furtherance of a compelling governmental interest, and (2) is the least restrictive means of furthering that interest. The burden rests with the government to demonstrate both factors in their entirety, not the individual requesting the exemption per DoDI 1300.17, September 1, 2020. All requests for accommodation of religious practices are to be assessed on a case-by-case basis. My original RA request, subsequent appeal, and this change to RA request demonstrate facts that the government's vaccination mandate is NOT the least restrictive means to further the interest of mission accomplishment and unit readiness. The original disapproval from CNP and subsequent Appeal disapproval from CNO **do not** explain how vaccination outweighs my sincerely held beliefs to accomplish the mission and promote good order and discipline, nor do they explain how this would detrimentally affect me and my unit's readiness. Using the information provided, I have demonstrated how the COVID-19 vaccination is not the least restrictive means available to preserve military readiness, mission accomplishment and the health and safety of military service members. Natural immunity also confers the same benefits and offers better protection. The government must show it cannot accommodate the religious adherent while achieving its interest through a viable alternative, which is available.

7. Unit cohesion and good order and discipline are not affected by my vaccination status at the command. The medical status of individuals is a private matter that is not disclosed to the command at large. All military members may wear a mask for personal protection even if fully vaccinated in light of personal health protection. It is well-established that even individuals who have been fully vaccinated against COVID-19 may still contract and spread the virus. Individuals who chose to receive a COVID-19 vaccination did so to protect their individual health and have put their confidence in the efficacy and effectiveness of the vaccine to protect them from contracting the virus or reducing the effects of the virus if contracted. The vaccination status of co-workers is not an issue within our command.

8. On 3 Jan 2022, Judge Reed O'Connor issued a preliminary injunction for plaintiffs in U.S. NAVY SEALS 1-26, et al, v. JOSEPH R. BIDEN, JR., et al. Plaintiffs had submitted RA requests but were not provided the legal review required in evaluating their submissions. The Court noted that the Navy utilized a "six-phase, fifty step process" that at Phase 1 the administrator is instructed to update a prepared disapproval template with the requestor's name and rank. Based upon the

boilerplate rejection template, it appears the RA review process is pre-determined and sidesteps an individualized review process as required by law. The Judge called the Navy RA review process "theater" and that it "merely rubber stamps each denial." Based upon the documents presented to the Court and the Judge's acknowledgement of the blanket denial process of all RA requests, I am submitting a new RA request for an individualized case-by-case review as required under the law.

9. As I discussed in my initial religious accommodation request, I believe that my natural God-given immunity, in conjunction with my healthy diet/lifestyle, is better than the artificial immunity created by the COVID-19 vaccine. Studies support the conclusion that natural immunity derived from prior COVID-19 infection confers longer lasting and stronger protection against infection, symptomatic disease, and hospitalization caused by the Delta variant of SARS-CoV-2 compared to the Pfizer two-dose vaccine induced immunity. In comparison, vaccines had over 13-fold increased risk of breakthrough infection with the Delta variant compared to those individuals previously infected. Proof of recovery from a prior COVID-19 infection is a less restrictive means of furtherance of a compelling government interest as opposed to an additional unnecessary and less effective vaccination that substantially burdens my religious freedoms. Other mitigations still remain in place, such as: mask wear, social distancing, frequent sanitization, weekly testing, etc.

10. As stated in my previous request, I cannot do something that I know to be wrong for my body. Being mandated to take the COVID-19 vaccine would negatively impact my spiritual, mental, and emotional readiness, and cause significant anguish due to my sincerely held beliefs. I have served honorably for nearly 18 years. I can continue in my capacity with current mitigations that is backed by research, science, and opinions of leading medical experts.

11. In closing, the Founders envisioned a nation where religious people are free to practice their faith without fear of discrimination or retaliation by the federal government. For that reason, the Constitution enshrines and protects the fundamental right to religious liberty as Americans' first freedom. Federal law protects this freedom without undue interference by the federal government. James Madison said the free exercise of religion is "in its nature an unalienable right because the duty owed to one's creator is precedent both in order of time and in degree of obligation to the claims of Civil Society." Except in the narrowest circumstances, no one should be forced to choose between living out his or her faith and complying with the law.

12. Based upon the above supplement to my appeal request and enclosures in support, I respectfully request another review of my religious accommodation request and appeal. As stated by Judge O'Connor:

> *"The COVID-19 pandemic provides the government no license to abrogate those [religious] freedoms. There is no COVID-19 exception to the First Amendment. There is no military exclusion from our Constitution.*

[redacted]

Exhibit B

DEPARTMENT OF THE NAVY
OFFICE OF THE CHIEF OF NAVAL OPERATIONS
2000 NAVY PENTAGON
WASHINGTON DC 20350-2000

1730
Ser N1/117995
2 Feb 22

From: Deputy Chief of Naval Operations (Manpower, Personnel, Training and Education) (N1)
To: [redacted] USN
Via: Commander, Destroyer Squadron TWO SIX

Subj: REQUEST FOR RELIGIOUS ACCOMMODATION THROUGH WAIVER OF IMMUNIZATION REQUIREMENTS

Ref: (a) [redacted] USN ltr of 1 Feb 22 w/ends
(b) BUPERSINST 1730.11A
(c) DCNO/N1 RA Response ltr of 22 Oct 21
(d) CNO Appeal RAl Response ltr of 23 Jan 22

1. Your request at reference (a) is denied. Contrary to your assertion, there have been no substantive changes to the physical environment since your original request and appeal. The compelling government interest in ensuring mission accomplishment, to include military readiness, unit cohesion, good order and discipline, health and safety, on both individual and unit levels remains the same.

2. As provided in reference (b), members are afforded the opportunity to renew requests when the physical, operational, or geographical environment in which they work or operate has changed. In your case, the environment has not materially changed. Specifically, and as already noted in references (c) and (d), you remain a Surface Warfare Officer commanding an operational warship, where you live and work in close proximity with your shipmates. Further, a waiver of the COVID-19 immunization would continue to have a predictable and detrimental effect on your readiness and the readiness of the Sailors who serve alongside you in both operational and non-operational environments. Granting your request would still have a direct and foreseeable negative impact on the compelling government interests of military readiness and health of the force. Finally, while no vaccine is completely effective, vaccines reduce disease incidence and disease severity.

JOHN B. NOWELL, JR

Copy to:
OPNAV (N131, N0975)
BUMED