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.	Case No. 8:21-cv-02429-SDM-TGW

DEFENDANTS' OPPOSITION TO PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER

Plaintiffs have filed an emergency motion asking the Court to prevent the U.S. Navy from removing purported Plaintiff Command Surface Warfare Officer from his command of a guided missile destroyer and the U.S. Marine Corps from withdrawing Plaintiff Lieutenant Colonel 2's command selection. Plaintiffs' motion fails to satisfy any of the requirements under law for such emergency relief. Most significantly, the Court should decline Plaintiffs' invitation to take command of armed services assignment decisions, which is a core constitutional responsibility entrusted to the President as Commander in Chief. Plaintiffs literally ask the Court to determine who is fit to command a U.S. Navy warship. And they also ask the Court to decide whether a Marine Corps officer should retain a command position. Such relief is well beyond the proper sphere of the courts. Plaintiffs' motion must be denied on this basis alone.

As explained in the attached declaration from the Vice Chief of Naval Operations, the second highest uniformed officer in the United States Navy, an order interfering with the military's ability to make judgments about officer assignments

would pose immediate and severe threats to both the success of the Navy's missions and the health of its service members. *See* Ex. 3 (Decl. of Admiral William Lescher).[1] Such an order would also be an extraordinary and unprecedented intrusion into the inner workings of the military, directly superintending senior military officials' operational judgments about service members' fitness to serve as commanding officers on some of the Nation's most sensitive and challenging military missions.

Plaintiffs' other claimed injuries relate to the outcome of future officer separation processes, which take, at a minimum, several months to complete, and are therefore neither imminent nor irreparable. Contrary to Plaintiffs' assertions that this matter presents an extraordinary emergency, justifying their failure to confer adequately and their astonishing suggestion that the military not even be allowed to respond to the motion,[2] nothing about the pending motion is proper or remotely justifies the entry of a temporary restraining order.

For these reasons, set forth further below, Plaintiffs' motion should be denied.

BACKGROUND

I. Procedural History

On October 15, 2021, eighteen service members, four government contractors, and one employer of federal contractors, all proceeding anonymously, filed their

[1] The Lescher Declaration was prepared and submitted in connection with separate litigation. Here, it provides essential background on the importance of vaccination for military readiness.

[2] Plaintiffs had five days' notice to get vaccinated or face adverse action, and they knew that subsequent disciplinary proceedings would take months to complete, and yet waited until the eve of their vaccination deadline to confer with Defendants' counsel and filed their motion on just one day's notice.

complaint challenging what they refer to as the "Federal COVID-19 vaccine mandate," which includes the two EOs governing federal employees and federal contractors and the DoD directive governing members of the Armed Forces. Compl. ¶¶ 50–57, ECF No. 1. Plaintiffs purported to bring a class action of "military servicemembers, civilian federal employees, and civilian federal contractors who have been denied religious exemption from the Federal COVID-19 Vaccine Mandate." *Id.* ¶ 157. Plaintiffs allege that the "Federal COVID-19 vaccine mandate" violates: (1) the FDCA, 21 U.S.C. § 360bbb-3, *id.* ¶¶ 166–193; (2) the First Amendment, *id.* ¶¶ 194–211; and (3) RFRA, 42 U.S.C. § 2000bb-1, *id.* ¶¶ 212–234. Plaintiffs seek a nationwide injunction against the President and the military that would prevent implementation of the EOs and the DoD directive, require the government to grant all religious exemption requests, and prevent the government from taking any adverse action or discipline against service members, Federal employees, and Federal contractors. *Id.* at 93–96; Plaintiffs filed an emergency motion for a temporary restraining order and preliminary injunction that same day. *See* ECF No. 2.

On October 18, 2021, the Court stated that Plaintiffs' motion for a temporary restraining order remains under advisement but "will likely not issue," and directed Plaintiffs' counsel to confer with defense counsel "in good faith" prior to seeking temporary injunctive relief for any individual Plaintiff. Order, ECF No. 9.

Defendants filed their opposition to Plaintiffs' motion for a temporary restraining order and preliminary injunction on November 3, 2021. ECF No. 23. Defendants incorporate by reference all arguments made in that opposition brief to

this brief.

Plaintiffs filed a motion to for class certification on November 15, 2021. ECF No. 35. Defendants opposed class certification, ECF No. 42, and that motion remains pending.

On January 20, 2022, Plaintiffs filed a motion for leave to amend their complaint, seeking, among other things, to add plaintiffs, including purported Plaintiff Command Surface Warfare Officer. *See* ECF No. 49. Defendants opposed that motion, ECF No. 57, and the motion remains pending.

On January 26, 2022, Plaintiffs, who had been proceeding anonymously for months without seeking leave to do so, filed a motion for leave to proceed via pseudonym. ECF No. 55. Defendants anticipate opposing that motion within the time provided by Local Rule 3.01(c). Plaintiffs have not provided all of their names to Defendants to allow Defendants to investigate the allegations in their complaint and motion for a preliminary injunction.

At 1:25 PM on Tuesday, February 1, Plaintiffs' counsel contacted defense counsel via email to seek defense counsel's position on an emergency motion for a temporary restraining order they planned to file that afternoon. Plaintiffs' counsel informed defense counsel that purported Plaintiff Command Surface Warfare Officer's religious accommodation appeal was denied on January 28, 2022, and that he had been ordered to get vaccinated by February 3 or he would be relieved of his command of a guided missile destroyer. Plaintiffs' counsel further informed defense counsel that named Plaintiff Lieutenant Colonel 2's religious accommodation appeal was denied

on January 26, 2022, and that she had been ordered to get vaccinated or would be placed on the Officer Disciplinary Notebook and her selection for command would be withdrawn on the next day, February 2. Plaintiffs' counsel asked for the Government's position on their motion to enjoin any adverse action, and defense counsel informed Plaintiffs that it would be difficult to provide a position without knowing the names of the Plaintiffs. Plaintiffs' counsel provided the names of the two Plaintiffs at 2:45 PM. At 5:21 PM defense counsel informed Plaintiffs' counsel that Defendants were still discussing Plaintiffs' request, but that they currently opposed the requested relief. Defense counsel further informed Plaintiffs' counsel that separating officers from the military usually took many months, so there was no need for an emergency motion, and that any individual assignment or command decision is non-justiciable. Plaintiffs' counsel did not respond and instead filed the emergency motion and, remarkably, urged that the military not even be allowed to respond – despite the fact they ask the Court to decide who may hold command positions in the United States military, including command of a warship. ECF No. 60.

That same evening, Defendants filed a notice of intent to respond, ECF No. 61, and the Court ordered Defendants to respond by 5:00 PM on February 2, ECF No. 62. On the afternoon of February 2, Plaintiffs filed a response to Defendants' notice with additional substantive arguments. ECF No. 64.

II. Plaintiffs' Background

A. Plaintiff Command Surface Warfare Officer

As the commanding officer of a guided-missile destroyer, Plaintiff commands a

crew of more than 300 sailors aboard a 510-foot long ship. Guided-missile destroyers are warships that provide multi-mission offensive and defensive capabilities.[3] They are equipped with missiles, torpedoes, and guns, and they carry helicopters that are also equipped with missiles and 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. Onboard, the crew of the ship and others, who may include helicopter aircrews or embarked special operations forces, sleep in confined berthing spaces, are in close proximity in passageways, and eat meals in a communal galley. Lescher Decl. ¶ 19; Decl. of Mery-Angela Sanabria Katson ¶ 15, ECF No. 42-4. There is no ability on a destroyer to care adequately or effectively for a service member with severe COVID symptoms. Lescher Decl. ¶ 13; Katson Decl. ¶ 13, ECF No. 42-4. 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. Lescher Decl. ¶¶ 13, 20; Katson Decl. ¶ 13, ECF No. 42-4. But a medical evacuation may not be a viable option due to the ship's location and the limited range of the ship's helicopter. Lescher Decl. ¶ 13; Katson Decl. ¶ 13, ECF No. 42-4. And 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. Lescher Decl. ¶ 21; Katson Decl. ¶ 13, ECF No. 42-4. Such a loss would have an adverse impact on employment of the

[3] *See* U.S. Navy, *Destroyers (DDG 51)* (Sept. 29, 2021), https://www.navy.mil/Resources/Fact-Files/Display-FactFiles/Article/2169871/destroyers-ddg-51/.

ship and the ability of the ship to execute its assigned missions. Lescher Decl. ¶ 21; Katson Decl. ¶ 13, ECF No. 42-4.

B. Plaintiff Lieutenant Colonel 2

As a logistics officer and material readiness officer assigned to United States Marine Forces Special Operations Command (MARSOC), Plaintiff Lieutenant Colonel 2 directly supports missions of special operations forces (i.e., the Marine Corps' version of Navy SEALs or Army Rangers). Logistics officers plan, coordinate, and execute and/or supervise the execution of all logistics functions to include functional areas of tactical logistics: supply, maintenance, transportation, general engineering, health services, and services. As a member of a deployable special operations unit, she must maintain her military readiness at all times; including medical readiness. *See* Ex. 2 (Assistant Commandant Appeal Mem.). Additionally, Plaintiff was due to permanently assume duties in Bahrain, but has been unable to do so because, while unvaccinated, she is not worldwide-deployable. *Id.* Her current duties require her to work indoors and in close proximity to others. *Id.* She is also required to stand Officer of the Deck duty, an in-person watch at the command.

LEGAL STANDARDS

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. NRDC, Inc.*, 555 U.S. 7, 24 (2008). To justify this "drastic remedy," the movants must "clearly establish[] the burden of persuasion" on the following four elements: (1) Plaintiffs have a substantial likelihood of success on the merits; (2) there is a substantial threat that Plaintiffs will suffer irreparable injury absent an injunction;

(3) the threatened injury to Plaintiffs outweighs the damage an injunction would cause to Defendants; and (4) the injunction would not be adverse to the public interest. *Davidoff & CIE, S.A. v. PLD Int'l Corp.*, 263 F.3d 1297, 1300 (11th Cir. 2001); *Ga. Advoc. Off. v. Jackson*, 4 F.4th 1200, 1208 (11th Cir. 2021); *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1223, 1225 (11th Cir. 2005) (same standard for a temporary restraining order). "Failure to show any of the four factors is fatal[.]" *ACLU of Fla., Inc. v. Miami-Dade Cty. Sch. Bd.*, 557 F.3d 1177, 1198 (11th Cir. 2009).

Aside from these traditional standards for any preliminary injunction, an injunction against the military involves an additional set of considerations and significant hurdles. Judicial review of claims involving the "complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force," *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973), is highly constrained. *Rostker v. Goldberg*, 453 U.S. 57, 66 (1981) (Because of the "healthy deference to legislative and executive judgments in the area of military affairs," courts employ a relaxed scrutiny in reviewing military policy.); *Aktepe v. United States,* 105 F.3d 1400, 1403 (11th Cir. 1997) ("[T]he political branches of government are accorded a particularly high degree of deference in the area of military affairs."); *see also Winck v. England*, 327 F.3d 1296, 1302–04 (11th Cir. 2003), *abrogated in part on other grounds by Santiago-Lugo v. Warden*, 785 F.3d 467, 471 (11th Cir. 2015). Such deference extends to constitutional claims and military decisions about the health and welfare of the troops. *E.g.*, *Solorio v. United States*, 483 U.S. 435, 448 (1987); *Mazares v. Dep't of Navy*, 302 F.3d 1382, 1385 (Fed.

Cir. 2002).

Moreover, and especially pertinent here, the Supreme Court and multiple Circuits have confirmed that courts should not interfere with military assignment decisions, even when they involve a constitutional challenge. *See, e.g.*, *Orloff v. Willoughby*, 345 U.S. 83 (1953) (declining to review service member challenge to a military assignment decision that was allegedly discriminatory punishment for his invocation of the constitutional right against self-incrimination)*; see also infra* pp. 16–17 (citing cases).

ARGUMENT

I. An Order Requiring The Department Of The Navy To Disregard Plaintiffs' Unvaccinated Status In Making Assignment And Reassignment Decisions Would Inflict Irreparable Damage On The Navy And The Public.

Plaintiffs invite this Court to begin judicial oversight of individual assignment, reassignment, and command decisions, asking this Court to enjoin the Navy from removing the commander of a warship and to stop withdrawal of another's command selection. Such unprecedented judicial action would damage the military's interests in readiness, health of service members, and good order and discipline, and the public interest in the national security of the United States.

The public has an exceptionally strong interest in national defense, *see Winter*, 555 U.S. at 7, and the military has a compelling interest in requiring its fighting forces to be vaccinated, healthy, and ready to deploy. 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.

The Stanley and Katson Declarations previously submitted in this case explained the severe and far-reaching impact that COVID-19 has had on the Navy. *See* ECF No. 23-19, ¶ 8; ECF No. 42-4 ¶¶ 13–16. Updated declarations of Major Scott Stanley and Colonel Tanya Rans and a declaration of Colonel James Poel, all recently prepared for another action, describe the continued threat from COVID-19 and the importance of vaccination as a defense. *See* Ex. 4 (Decl. of Colonel Tanya Rans) ¶¶ 5–39; Ex. 5 (Decl. of Major Scott Stanley) ¶¶ 3–20; Ex. 6 (Decl. of Colonel James Poel) ¶¶ 6, 10–36, 38. As Admiral Lescher further explains in his declaration, "[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. Indeed, the vast majority of active duty personnel whose COVID-19 symptoms required hospitalization were unvaccinated; only 12% had received a primary COVID-19 vaccine without a booster, and only 0.8% had received a booster. *Id*. ¶ 11; *see also* Stanley Decl. ¶ 18; Rans Decl. ¶ 39. 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. *See* Lescher Decl. ¶ 17.

The Navy's highest leaders have therefore made the judgment that "[f]ully vaccinated naval forces are required to ensure readiness to carry out Navy missions throughout the world and, if required, to engage in combat operations." *Id*.; *see id*. ¶ 11 ("The judgment of each of the Military Services is that vaccines 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."). And in particular, "[r]estriction of the Navy's ability to reassign unvaccinated personnel in order to mitigate COVID-19 related risks to units preparing to deploy, or that are deployed, will cause direct and immediate impact to mission execution," as well as to "[t]he health, readiness, and mission execution of broader conventional Navy units and personnel who support these personnel." *Id*. ¶ 2.

In the context of warship operations, the dangers are unique and the ability to mitigate the dangers limited. Katson Decl. ¶¶ 13–16, ECF No. 42-4; Lescher Decl. ¶¶ 13, 20, 21; Stanley Decl. ¶ 8; *see Garland v. N.Y.C. Fire Dep't*, 2021 WL 5771687, at *9 (E.D.N.Y. Dec. 6, 2021) (noting the city's "significant interest" in preventing the spread of COVID-19 among firefighters who work in "close proximity" with each other "while on duty [and] in their fire stations"); *Mass. Correction Officers Federated Union v. Baker*, No. 21-11599-TSH, 2021 WL 4822154, at *8 (D. Mass. Oct. 15, 2021) (noting the public interest in preventing the spread of COVID-19 in "congregate facilities"). "Navy ships have limited health care facilities," and if a sailor developed severe COVID-19 symptoms, his ship would be required to abandon its mission and "pull into port." Lescher Decl. ¶ 20; *see also* Katson Decl. ¶¶ 13–15, ECF No. 42-4.

Military leaders, in their professional judgment, have concluded that the risks of these potentially catastrophic outcomes 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" both of Plaintiffs' units and "of broader conventional Navy units and personnel who support these personnel." *Id.* ¶ 2.

The requested injunction would also undercut the maintenance of military good order and discipline. Lescher Decl. ¶ 16; Decl. of Vice Admiral William Merz ¶ 23, ECF No. 23-18; Decl. of Lieutenant General David Furness ¶ 23, ECF No. 23-19; *see also Miller v. United States*, 42 F.3d 297, 303 (5th Cir. 1995) (stating that the concern for preserving military discipline is "the most important consideration in any single case" (quoting *Scales v. United States*, 685 F.2d 970, 973 (5th Cir. 1982)). 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. *See Chappell v. Wallace*, 462 U.S. 296, 300 (1983) ("The inescapable demands of military discipline and obedience to orders cannot be taught on battlefields; the habit of immediate compliance with military procedures and orders must be virtually reflex with no time for debate or reflection."). 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 v.*

Orr, 747 F.2d 29, 33 (1st Cir. 1984) (noting the "strong judicial policy against interfering with the internal affairs of the armed forces"); *Shaw v. Austin*, 539 F. Supp. 3d 169, 184 (D.D.C. 2021) ("the public interest supports . . . limited intrusion in military affairs from civilian courts"); *Reinhard v. Johnson*, 209 F. Supp. 3d 207, 221 (D.D.C. 2016) (same). This is especially true here where both Plaintiffs are or would be in command positions, expected to set an example of obedience to orders and are charged with maintaining good order and discipline within the ranks.

The Court should decline Plaintiffs' invitation to take command of the U.S. Navy and Marine Corps both as a general matter and with respect to these two Plaintiffs. As another court found, "the public interest in the nation's military readiness may well be served by allowing military officials who are familiar with the unique challenges posed by the COVID-19 pandemic in a military setting to manage those challenges without this Court's intervention." Order at 6, *Robert v. Austin*, No. 1:21-cv-02228 (D. Colo. Sept. 1, 2021), ECF No. 12.

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

A. Plaintiffs 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*, 327 F.3d at 1302 (citing *Linfors v. United States*, 673 F.2d 332, 334 (11th Cir. 1982) (per curiam); *Von Hoffburg v. Alexander*, 615 F.2d 633, 637–38 (5th Cir.1980); *Hodges v. Callaway*, 499 F.2d 417, 420 (5th Cir. 1974); *Mindes v. Seaman*, 453 F.2d 197, 201 (5th Cir. 1971); *U.S. ex rel. Berry v. Commanding Gen., Third Corps, Fort Hood, Tex.*, 411 F.2d 822, 825 (5th Cir.

1969); *see, e.g., Layman v. Harvey*, No. 8:05-CV-2208-T24EAJ, 2007 WL 430678, at *5 (M.D. Fla. Feb. 5, 2007); *cf. Chappell*, 462 U.S. at 303 (service member complaints of a deprivation of constitutional rights can be addressed "within the framework of [] intramilitary administrative procedure").

Plaintiffs have not exhausted their military remedies. Even though the two Plaintiffs' religious exemption requests have been denied, internal military procedures are available to them and should be completed before judicial review here. The Navy and Marine Corps have further administrative procedures that offer many opportunities for them to present their arguments and for the Navy to respond. *See* Merz Decl. ¶¶ 15–23, ECF No. 23-18; Furness Decl. ¶¶ 13–23, ECF No. 23-19. Service members subject to discipline can challenge the lawfulness of the vaccination requirement in those proceedings. *See United States v. Kisala*, 64 M.J. 50 (C.A.A.F. 2006). Should Plaintiffs face discharge for non-compliance with the directive, they may present their arguments before the discharge authority. *See* Merz Decl. ¶¶ 17–19, ECF No. 23-18; Furness Decl. ¶¶ 16–20, ECF No. 23-19. For officers, this process takes several months, and service members with more than six years of military service receive a formal administrative hearing over which a panel of no fewer than three senior service members preside in order to make findings with respect to the bases for separation, and recommendations with respect to retention or separation and character of service. Merz Decl. ¶¶ 17–19, ECF No. 23-18; Furness Decl. ¶¶ 17–18, ECF No. 23-19. If a service member is discharged, he or she can appeal to the Navy Discharge Review Board and Board for Correction of Naval Records ("BCNR"). Merz Decl. ¶

22, ECF No. 23-18; Furness Decl. ¶ 22, ECF No. 23-19. For adverse action less than discharge, the Navy has additional procedures that can provide relief. Merz Decl. ¶ 22, ECF No. 23-18; Furness Decl. ¶ 22, ECF No. 23-19.[4]

Courts have found that service members have failed to exhaust administrative remedies when even fewer steps in the administrative process remained. *See, e.g., Leicht v. McHugh*, No. 13-60015-CIV, 2013 WL 11971266, at *3 (S.D. Fla. May 24, 2013) (finding plaintiff failed to exhaust his administrative remedies before the Board of Correction for Military Records); *Layman v. Harvey*, No. 8:05-CV-2208-T24EAJ, 2007 WL 430678, at *6 (M.D. Fla. Feb. 5, 2007) (same); *Bickel v. Del. Air Nat'l Guard*, 2018 WL 2183296, at *6 (S.D. Ohio May 11, 2018) (concluding that "[g]iven all of the remaining steps in the military process, it is clear that [the plaintiff] has not yet exhausted his administrative remedies" as a board had not yet convened to determine whether plaintiff would be discharged, discharge would have to be approved by the Secretary of the Air Force, and plaintiff could appeal that decision); *Montgomery v. Sanders*, 2008 WL 4546262, at *5 (S.D. Ohio Aug. 18, 2008) (dismissing plaintiff's claims concerning an investigation and reassignment when he failed to exhaust internal military review processes); *Shuman v. Celeste*, 1989 WL 182617, at *1 (N.D. Ohio Apr. 2, 1989) ("A review of plaintiff's case in this instance would thrust the Court

[4] Plaintiff Commander Surface Warfare Officer in theory could be relieved of command due to loss of confidence, as he speculates may be the case. *See* ECF No. 60-1. That relief will only be characterized as "detachment for cause" (DFC) and entered into his record following a formal request from his leadership and Plaintiff will be afforded the opportunity to respond and submit matters to the DFC approval authority. *See generally* MILPERSMAN 1611-020, *available at* https://www.mynavyhr.navy.mil/Portals/55/Reference/MILPERSMAN/1000/1600Performance/1611-020.pdf.

deep into the internal decisionmaking of the military which is precisely what the doctrine of non-justiciability was formulated to prevent."); *Diraffael v. Cal. Mil. Dep't*, 2011 WL 13274364, at *3 (C.D. Cal. Mar. 21, 2011).

The exhaustion requirement is especially important in the military context because it serves the important purpose of allowing the military to apply its "specialized expertise" in the first instance. *Lawrence v. McCarthy*, 344 F.3d 467, 470 (5th Cir. 2003). If the service member is dissatisfied with the military's decision, that service member may seek judicial review only after exhausting military appeals, allowing the military to make its decision and fully articulate its interests. *Orloff*, 345 U.S. at 94 ("Orderly government requires that the judiciary be as scrupulous not to interfere with legitimate Army matters as the Army must be scrupulous not to intervene in judicial matters."); *Winck*, 327 F.3d at 1302–04 ("[W]e reaffirm the unflagging strength of the principles of comity and judicial noninterference with, and respect for, military operations."); *Seepe v. Dep't of Navy*, 518 F.2d 761, 764 (6th Cir. 1975) (recognizing that when the facts are "service-oriented" and the case involves a "mixed question of fact and law," "the service's development of a factual record and its interpretation of the law as applied to the facts may well prove of value to the reviewing court"); *Heidman v. United States*, 414 F. Supp. 47, 49 (N.D. Ohio 1976) (military's development of a record will avoid interruption of the administrative process and afford the court with a final application of the law and facts). As another court recently found in a similar context, review of service members' claims without first allowing the military's internal process to conclude "would undermine the

purpose of exhaustion and infringe on the military's expertise and interest in handling its own personnel matters." *Church*, 2021 WL 5179215, at *11 (citing *Orloff*, 345 U.S. at 94; *Hidalgo v. FBI*, 344 F.3d 1256, 1259 (D.C. Cir. 2003)); *see also Shaw*, 539 F. Supp. 3d at 183 ("Despite Plaintiff's skepticism about the show-cause process, the Court cannot so easily dismiss the possibility that he will have a fair opportunity to make his case to a Board of Inquiry.").

In sum, exhaustion procedures is the adequate remedy provided by law such that an exercise of the court's equity powers is premature. Because Plaintiffs have not exhausted their intra-military remedies, they thus fail to show a likelihood of success on the merits.

B. The Court Should Not Make Military Assignment Decisions Through Injunctive Relief.

Even if Plaintiffs' claims about their individual exemption denials were subject to judicial review, the relief sought with respect to their individual assignments should not be granted. Decisions about how to assign and deploy service members are for the military to make, under the supervision of the President as Commander in Chief, not civilian courts. For that reason, the Supreme Court and multiple Circuits have confirmed that courts should not review challenges to such assignment decisions, even when they involve a constitutional challenge. *See, e.g.*, *Orloff*, 345 U.S. at 83. Indeed, the Eleventh Circuit has observed that courts "have traditionally deferred to the superior experience of the military in matters of duty orders, promotions, demotions, and retentions." *Speigner v. Alexander*, 248 F.3d 1292, 1298 (11th Cir. 2001). In

Speigner, the Court found that a claim regarding injury from such orders was non-justiciable, despite the existence of constitutional claims, reasoning that "it is imperative to the military that only those officers determined to be competent to serve are retained" and that "[t]o dictate to the military which officers should be considered competent would be to interfere in just the way that *Feres* and its progeny preclude." *Id*. Courts in other circuits have reached the same conclusion. *See Harkness v. Secretary of Navy*, 858 F.3d 437, 443 (6th Cir. 2017) (noting in a case involving a First Amendment challenge to military assignment decisions that "courts are generally reluctant to review claims involving military duty assignments"); *Cargill v. Marsh*, 902 F.2d 1006, 1007 (D.C. Cir. 1990) (holding mandamus claim for reassignment is nonjusticiable); *Schlanger v. United States*, 586 F.2d 667, 671 (9th Cir. 1978) ("[C]ourts should not review internal military decisions such as duty order or duty assignments."); *Sebra v. Neville*, 801 F.2d 1135, 1141 (9th Cir. 1986) (same); *Wilson v. Walker*, 777 F.2d 427, 429 (8th Cir. 1985) (same); *Cortright v. Resor*, 447 F.2d 245, 254 (2d Cir. 1971) (same); *Antonellis v. United States*, 723 F.3d 1328, 1332 (Fed. Cir. 2013) ("Courts are in no position to determine the 'best qualified Officer' or the 'best match' for a particular billet.").

Plaintiffs argue that the Government's position is that their underlying RFRA and First Amendment claims are non-justiciable. *See generally* Pls.' Resp., ECF No. 64. But Plaintiffs misstate Defendants position. Defendants have not argued that Plaintiffs' underlying RFRA and First Amendment claims or subsequent military discharge claims are non-justiciable. Indeed, in many circumstances such claims are

reviewable. However, as far as the Court's review of Plaintiffs' claims extend to a review of military assignment decisions and specifically Plaintiffs' fitness for command, or Plaintiffs' requested relief pertaining to such claims, judicial review would impermissibly intrude into the Constitutional purview of the Executive and Legislative Branches. *Gilligan*, 413 U.S. at 10 ("The complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force are essentially professional military judgments, subject *always* to civilian control of the Legislative and Executive Branches."); *Orloff*, 345 U.S. at 94–95; *Chappell*, 462 U.S. at 301 ("[J]udges are not given the task of running the [military].").

The ultimate relief sought in the proposed amended complaint is an injunction against enforcement of the vaccinate mandate across the armed services, including a prohibition on related discipline. *See* ECF No. 49-1. That is extraordinary in itself, but the relief sought in this emergency motion is even more extraordinary – ongoing judicial oversight of assignment and duty decisions, as a preliminary matter. Plaintiffs, through a purported "emergency" motion, invite the Court to take command of the armed services assignment decisions. But these are core constitutional responsibilities entrusted to the President as Commander in Chief and, through him, to military commanders. However the Court may rule on the underlying merits of this case, it should not purport to determine who may presently be assigned to command a U.S. Navy warship—today, tomorrow, next week, or at any point, nor should the Court determine who may hold a command position in the United States Marine Corps. This is especially so where the military has judged that doing so would

risk harm to the health and readiness of the military force and, thus, harm to the national security of the United States as the Navy and the Marine Corps carry out their vital missions.

C. Plaintiffs' RFRA and First Amendment Claims Are Unlikely To Succeed.

"Under RFRA, the Federal Government may not . . . substantially burden a person's exercise of religion, 'even if the burden results from a rule of general applicability.'" *Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 424 (2006) (quoting 42 U.S.C. § 2000bb–1(a)). "The only exception recognized by the statute requires the Government to satisfy the compelling interest test—to 'demonstrat[e] that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.'" *Id.* (quoting 42 U.S.C. § 2000bb–1(b)).

Here, senior military commanders have reasonably assessed the Government's compelling interest in vaccinating both Plaintiffs and the lack of less restrictive alternatives, taking into consideration current military needs, and Plaintiffs' unique circumstances. Without the benefit of a full administrative record, the Court should not, on emergency briefing, conclude that Plaintiffs have a strong likelihood of success on the merits of their RFRA and First Amendment claims such that a temporary restraining order is warranted.[5] Even the limited record before the Court

[5] There is no reason to address Plaintiffs' First Amendment claim separately. If Plaintiffs prevail on their RFRA claim there is no need to reach their separate First Amendment theory, as the Court would

shows they do not.

1. The COVID-19 Vaccination Requirement Furthers the Government's Compelling Interest in Military Readiness.

The Supreme Court has recognized that "[s]temming the spread of COVID–19 is unquestionably a compelling interest." *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020). In addition, "when evaluating whether military needs justify a particular restriction on religiously motivated conduct, courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest."[6] *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986). After consulting with "medical experts and military leadership," ECF No. 23-3, including the "Chairman of the Joint Chiefs of Staff, the Secretaries of the Military Departments, [and] the Service Chiefs," and considering the rise in infection rates due to the Delta variant, ECF No. 23-2, the Secretary of Defense "determined that mandatory vaccination against [COVID-19] is necessary to protect the Force and defend the American people," ECF No. 23-3 ("To defend this Nation, we need a healthy and ready Force"). The Secretary of the Navy likewise found that COVID-19 vaccination is necessary to ensure military readiness and the health and safety of

already have concluded that Plaintiffs are likely to succeed on their challenge to the vaccination requirement. Conversely, if the Government prevails under RFRA, it would necessarily prevail under Plaintiffs' First Amendment theory as well.

[6] Congress intended for courts to continue to apply principles of military deference in RFRA cases. *See* S. REP. 103-111, 12, *reprinted in* 1993 U.S.C.C.A.N. 1892, 1901 ("The courts have always recognized the compelling nature of the military's interest in [good order, discipline, and security] in the regulations of our armed services. Likewise, the courts have always extended to military authorities significant deference in effectuating these interests. The committee intends and expects that such deference will continue under this bill.").

sailors and marines. ECF No. 23-8. The Court must "give great deference" to the "professional military judgments" of these leaders when it comes to what is needed to ensure military readiness and the welfare of service members.[7] *See Winter*, 555 U.S. at 24–25; *Goldman*, 475 U.S. at 507.

These professional military judgments are supported by the evidence showing COVID-19's harmful impact on the military. *See Church*, 2021 WL 5179215, at *18 (requiring vaccination is "supported by a lengthy record replete with data demonstrating the necessity of a general vaccine mandate"). COVID-19 has "impacted exercises, deployments, redeployments, and other global force management activities," Stanley Decl. ¶ 6; caused the cancellation of "19 major training events, many of which involved preparedness and readiness training with our foreign partners," *id.* ¶ 9; and "required significant operational oversight" by the most senior military leaders, *id.* ¶ 4. Further, vaccination requirements of other nations restrict the ability of unvaccinated service members to participate in joint training exercises, which are "vital to the preservation of national security and the protection of our foreign interests." *Id.* ¶¶ 10–11. And because health care providers have had to care for COVID-19 patients, certain service members have not been able to "address non-emergency conditions and undergo routine medical and health assessments that

[7] In finding that the Navy had no compelling interest in vaccinating the 35 Navy SEALs and members of the Navy's Special Warfare Community, the court in *Navy SEALs 1–26* ignored Supreme Court precedent such as *Goldman*, 475 U.S. at 507, and *Winter*, 555 U.S. at 24–25, and failed to consider either the Secretary of Defense's or the Secretary of the Navy's determinations that vaccination is necessary for military readiness, or the declarations from military leaders concerning the military's interest in vaccination. *See Navy SEALs 1–26 v. Biden*, 2022 WL 34443, at *9–11 (N.D. Tex. Jan. 3, 2022).

are required under military directives to maintain medical readiness." *Id.* ¶¶ 12–13.

Vaccinations have promoted readiness by reducing the risk of infections, hospitalizations, and deaths of service members. *Id.* ¶ 20. Since the onset of the COVID-19 pandemic, hundreds of thousands of service members have been infected, thousands have been hospitalized, and 92 have died. *Id.* ¶ 3. None of the service members who died had both doses of an mRNA vaccine. *See id.* In addition, "[b]etween 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," "[i]n December 2021 unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults," *id.* ¶ 18, and "the hospitalization rate during Omicron dominance in the unvaccinated active duty population was 65 times higher than the hospitalization rate in those fully vaccinated," Rans Decl. ¶ 39. "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." Stanley Decl. ¶ 20. Not only have vaccinations reduced the risk of infections, hospitalizations, and deaths of service members, they have reduced the number of service members required to quarantine, permitted the military to return to higher levels of occupancy in DoD facilities and hold in-person training, and allowed service members to participate in joint training exercises with countries that have vaccine requirements. *Id.* ¶ 14.

Upon review of Plaintiffs' religious exemption request packages, the appeal

authorities concluded that the Navy and the Marine Corps have compelling interests in vaccinating Plaintiffs. With regard to Plaintiff Command Surface Warfare Officer, the Chief of Naval Operations (CNO) took into account that Plaintiff is the "command[er] [of] an operational warship," and found that the Navy had a compelling interest in "preventing the spread of disease" on that ship to ensure "military readiness and [the] health of the force." Ex. 1 (CNO Appeal Mem.). The Navy further concluded that waiving the vaccine requirement "would have a predictable and detrimental effect on the readiness of [Plaintiff] and the Sailors who serve alongside [Plaintiff]." *Id.* Indeed, "[s]pread of communicable diseases among Sailors who live and work in confined quarters aboard ships . . . has the potential to cause mission failure if one or more personnel become too sick to perform their jobs." Katson Decl. ¶ 13, ECF No. 42-4. This is because

> [l]ogistical challenges inherent in moving personnel to and from deployed ships and other deployed environments makes it difficult, if not impossible, to quickly evacuate sick personnel and replace them with healthy personnel. Navy ships have limited medical and long-term placement capabilities. If even one Sailor infected with a communicable disease requires treatment beyond the capabilities of a ship's medical department, or if multiple Sailors must be placed in critical care, a decision will have to be made whether the ship may have to abandon its mission and transit to a location that offers more adequate treatment. Transit time is not instantaneous and depends on factors such as ship location, current mission requirements, and port access or availability. That time variable creates additional health risk for infected Sailors and the potential for disease transmission to the remaining crew.

Id. In sum, "[t]here is little ability on ship to care for a service member with severe COVID symptoms" and severe illness "would require a return to port or an emergency medical evacuation by helicopter," which is "not always viable due to the location of

the ship and the limited range of helicopters." Lescher Decl. ¶ 13.

With regard to Plaintiff Lieutenant Colonel 2, the appeal authority was skeptical that a sincere belief was substantially burdened in light of her past practice of taking vaccines, but found that even if it was, vaccination served the Marine Corps' compelling "interests in military readiness and in the health and safety of the force." Ex. 2. The Assistant Commandant of the Marine Corps found that personnel who have gotten ill from COVID-19 have "undermine[d] a unit's effective functioning and negatively impact[ed] their unit's ability to accomplish the mission." *Id.* The Assistant Commandant further found that the Delta and Omicron variants were "highly transmissible," that the "greatest risk of transmission is from and among unvaccinated people," and that while fully vaccinated people can have breakthrough infections, "they appear to spread the virus for shorter periods of time." *Id.* Accordingly, "personnel who are unvaccinated do not just put themselves at risk, they also risk the health and medical readiness of other persons within their unit, which in turn decreases the military readiness of the unit and the Marine Corps as a whole." *Id.* The Assistant Commandant determined that waiving immunization for Plaintiff Lieutenant Colonel 2 would harm readiness because she "work[s] primarily indoors and cannot perform all of [her] duties remotely." *Id.* Indeed, the Assistant Commandant found that Plaintiff Lieutenant Colonel's failure to get vaccinated had already harmed the Marine Corps' interest in readiness, as she had been unable to travel to Bahrain to complete her duty assignment. *Id.* ("[Y]our orders to Bahrain have been delayed several times due to your failure to be fully medically ready to travel overseas as a result of your

vaccination status."). Finally, the Assistant Commandant found that Plaintiff Lieutenant Colonel 2 is "attached to a deployable unit, and [she] must be prepared to deploy at a moment's notice." *Id.*

2. **Vaccination is the Least Restrictive Means of Furthering the Government's Compelling Interest in Military Readiness.**

As other courts have found, in non-military settings, vaccination is the least restrictive means in fully accomplishing the government's interest in preventing the spread of infectious diseases in the workforce. *See, e.g.*, *Does 1-6 v. Mills*, No. 1:21-CV-00242-JDL, 2021 WL 4783626, at *14 (D. Me. Oct. 13, 2021), *aff'd*, 16 F.4th 20 (1st Cir. 2021); *see also F.F. ex rel. Y.F. v. New York*, 65 Misc. 3d 616, 634 (N.Y. Sup. Ct. 2019) (concluding same in schools); *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 733 (2014) ("Other coverage requirements, such as immunizations, may be supported by different interests (for example, the need to combat the spread of infectious diseases) and may involve different arguments about the least restrictive means of providing them."). This reasoning has even greater force in the military setting, where health of service members is paramount to military readiness.

After careful consideration of Plaintiffs' requests for a religious exemption and their appeals, the Navy and Marine Corps concluded that there are no lesser restrictive means than vaccination to further the military's compelling interests in readiness and ensuring the health and safety of service members. The Chief of Naval Operations found that vaccination "reduce[s] an individual's risk of contracting the disease and generally reduce[s] the severity of disease for those who do contract the illness" and

that other mitigation measures, such as "personal hygiene, mask wearing, and social distancing," "are not as effective as vaccination in maintaining military readiness and the health of the force." Ex. 1. This is especially true on ships, such as the destroyer Plaintiff Command Surface Warfare Officer currently commands. *See id.* As Admiral Lescher states, "The environment in which Navy personnel operate -- in close quarters for extended periods of time -- make them particularly susceptible to contagious respiratory diseases such as COVID-19 and renders mitigation measures such as social distancing unrealistic." Lescher Decl. ¶ 12; *see also* Katson Decl. ¶ 13, ECF No. 42-4.

The Assistant Commandant of the Marine Corps likewise found that mitigation measures such as "masking, social distancing, hygiene, teleworking, and other similar measures, individually or in combination," are "not as effective as vaccination" and "are often incompatible with the demands of military life, where Marines and Sailors must live, work, realistically train, and, if necessary, fight in close quarters." Ex. 2. The Assistant Commandant further rejected Plaintiff Lieutenant Colonel 2's claim that "natural immunity" was as effective as vaccination. *See id.*

Although Plaintiffs argue that the mitigation measures the Navy and Marine Corps utilized from the start of the pandemic worked equally well as vaccination, *see* Pl. Decl. ¶¶ 12–14, ECF No. 60-1, Pl. Decl. ¶¶ 19–21, ECF No. 60-2, the record shows otherwise. The effectiveness of mitigation measures such as sanitizing workspaces, hand washing, mask wearing, and maintaining 6-foot social distancing "is extremely limited on ships, where Sailors must live, work, eat, and sleep in close proximity to other Sailors." Katson Decl. ¶¶ 14–15, ECF No. 42-4; *see also* Lescher Decl. ¶ 12; Rans

Decl. ¶ 10; Stanley Decl. ¶ 8. Indeed, as Captain Katson, a Surface Warfare Officer like Plaintiff, states,

> On board a ship, Sailors must navigate narrow passageways that do not permit sufficient social distancing. Ships have almost no windows, and fresh air circulation is intentionally limited, as ships are designed to be able to seal off compartments to protect against water intrusion or chemical, biological, or radiological weapons attacks. Though Sailors work to keep their ships clean, safe transit up and down ladders and through watertight doors requires everyone to touch all of the same handrails and handles frequently. Ships typically have limited space to quarantine Sailors from the rest of the crew, if such facilities exist at all. Frequent handwashing is not generally feasible because Sailors have to transit up and down ladders, using those shared handrails, to get between their workspaces and the restrooms ("heads") in which they can wash their hands. Almost all enlisted berthing compartments feature three-foot by six-foot bunks ("racks") that are generally stacked three high with narrow passages between rows. Enlisted berthing compartments have as few as 12 and as many 210 personnel sleeping in the same space. Sailors in larger berthing compartments are typically never alone in the head when they use the facilities, shower, or brush their teeth, because the head is a shared space used by 200 or more personnel.

Katson Decl. ¶ 15, ECF No. 42-4. Because in these circumstances, many mitigation measures, such as social distancing, are "unrealistic," Lescher Decl. ¶ 12, they cannot possibly be equally as effective as vaccination in serving the military's interest in readiness, *see Burwell*, 573 U.S. at 731 (examining whether alternative served interest "equally well").

The same is true even outside of the ship environment. Many mitigation measures, such as masks, temperature checks, testing, social distancing, isolating, handwashing, and sanitizing workspaces, are limited to controlling the spread of the virus; they provide no protection from severe illness, hospitalization, or death if a service member contracts the disease. *See* Poel Decl. ¶¶ 15, 21, 26, 36.

Plaintiff Command Surface Warfare Officer argues that because 93% of sailors on his ship are vaccinated (leaving 24 out of 294 sailors unvaccinated), he has a reduced risk of infection and there is a reduced risk the disease will spread through the ship. Pl. Decl. ¶ 15, ECF No. 60-1. As in initial matter, the premise of this "herd immunity" argument is flawed. "Even with approximately 97% of the Navy vaccinated, the COVID-19 virus can degrade units and impact mission[s]." Lescher Decl. ¶ 13. Indeed, even with a fully vaccinated crew, the USS Milwaukee, a 100-person ship, had to remain in port one week beyond its schedule because several members tested positive for COVID-19." *Id.* However, "[b]ecause the full crew was vaccinated, infected personnel were asymptomatic or had mild symptoms and the impact to mission accomplishment was substantially mitigated compared to the [aircraft carrier] USS THEODORE ROOSEVELT's experience of more than 4,000 crew removed from the ship and a 51-day loss of mission." *Id.* "Given the hospitalizations and death statistics" for unvaccinated individuals, "the MILWAUKEE's minor deployment delay would likely have been far worse with unvaccinated personnel." *Id.* The Navy's experience with the USS Milwaukee as compared to the USS Theodore Roosevelt underscores that the Navy's interest in vaccination is not just limited to mitigating the spread of disease, but also in mitigating the severity of illness for those who do contract the virus.

Even if herd immunity had been achieved, it is not as effective as vaccination at protecting a member from infection, spreading the disease, or combatting the disease. Poel Decl. ¶¶ 28, 32; Rans Decl. ¶ 23. Unvaccinated service members are at an

increased risk of infection and may spread the virus (particularly new variants) to other service members, and thus still pose a risk of significant harm to maintaining a healthy force. Poel Decl. ¶¶ 31–32. For these reasons, the military has not set any benchmark to cease any of its immunization requirements based on herd immunity. *See* Rans Decl. ¶¶ 23–27. The military has determined that maximum vaccination for all of the mandatory ten vaccines minimizes the risk to service members of illness and outbreaks. *See id.*; *see also* Lescher Decl. ¶ 11 ("[O]rdering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions" would not "maximiz[e] the crew's odds of success."). The Court should defer to the military regarding its assessment of the acceptable level of risk. *See Gilligan*, 413 U.S. at 10.

Next, although Plaintiff Lieutenant Colonel 2 asserted that her prior COVID-19 infection was a lesser restrictive means to vaccination, *see* Ex. 2, "there is no 'recognized, long standing, natural immunity' against COVID-19," Poel Decl. ¶ 22; *see also* Rans Decl. ¶ 28 (noting that "[t]he body of evidence for infection-induced immunity is more limited than that for vaccine-induced immunity in terms of the quality of evidence . . . and types of studies"). Individuals who have been infected with the virus have had "diverse or varying immune responses which, when compared to the subsequent response of those receiving the COVID-19 vaccine, are not as reliable or consistent." Rans Decl. ¶ 20; Poel Decl. ¶ 23. "Conversely, the immune response following COVID-19 vaccination is more reliable, consistent, and predictable." Rans Decl. ¶ 20. Furthermore, "[n]umerous 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." *Id.* For these reasons, Plaintiff Lieutenant Colonel 2's assertion that she previously had COVID-19 is irrelevant.

In sum, the military's vaccine policy is narrowly tailored to serve compelling military interests. The military is best situated to assess whether a specific unvaccinated individual puts the military mission at risk, or whether feasible, less restrictive alternatives are available. *See Orloff*, 345 U.S. at 94; *Bryant v. Gates*, 532 F.3d 888, 899 (D.C. Cir. 2008) (Kavanaugh, J., concurring) ("[T]he Supreme Court has indicated" that "military decisions and assessments of morale, discipline, and unit cohesion . . . are well beyond the competence of judges."). The Navy and Marine Corps have considered whether there are any lesser restrictive means of achieving their interest in military readiness and concluded that there are none. RFRA does not compel the military to adopt a measure that is inferior in the military context to requiring the use of safe and effective vaccines. Therefore, Plaintiffs has not shown a likelihood of success on their RFRA claims to warrant the extraordinary injunctive relief they seek.

III. Plaintiffs Do Not Face 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 v. City of Jacksonville, Fla.*, 896 F.2d 1283, 1285 (11th Cir. 1990). "Mere injuries, however substantial, in terms of money, time and energy necessarily expended in the absence of a stay, are not enough." *Id.* (quoting *Sampson v. Murray*, 415 U.S. 61, 90 (1974)). "The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm." *Sampson*, 415 U.S. at 90. "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*, 539 F. Supp. 3d at 183; *Spadone v. McHugh*, 842 F. Supp. 2d 295, 301 (D.D.C. 2012) ("When plaintiffs have requested an injunction preventing a military discharge, some courts have determined that plaintiffs must make a 'much stronger showing of irreparable harm than [must be made under] the ordinary standard for injunctive relief,' due to the "magnitude of the interests weighing against judicial interference with the internal affairs of the armed forces.'" (quoting *Veitch v. Danzig*, 135 F.Supp.2d 32, 37 (D.D.C. 2001)).

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. If a process is initiated soon, such processes would take months for officers, like Plaintiffs, who are entitled to a Board if they request a hearing. *See* ECF No. 23-18, ¶ 17, 19 (Navy); ECF No. 23-19, ¶¶ 17–18 (Marines). Even if these 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 could later be reinstated and provided back pay if he prevailed on his claim. *See, e.g.*, *Hartikka v. United States*, 754 F.2d 1516, 1518 (9th Cir. 1985); *Chilcott*, 747 F.2d at 34; *Guitard v. Sec'y of Navy*, 967 F.2d 737, 742 (2d Cir. 1992); *Church*, 2021 WL 5179215, at *17. Placement on the Officer Disciplinary Notebook, as Plaintiff Lieutenant Colonel claims will happen to her, likewise does not constitute irreparable harm; it is not even a disciplinary measure.[8] Even a court martial, unlikely here, would not constitute irreparable injury. *See Schlesinger v. Councilman*, 420 U.S. 738, 755 (1975). If even the most severe and unlikely penalty available is not irreparable harm, then assignment to other job duties in which their

[8] Plaintiff Lieutenant Colonel 2's declaration misunderstands the next steps and likely outcomes of the process available to her. For example, placement on the Officer Disciplinary Notebook, "a database used to track officer misconduct and substandard performance in the Marine Corps," is not itself a disciplinary measure, and ODN entries are not included in an officer's personnel file. *See* MCO 5800.016.104. If she did proceed to a Board of Inquiry, the Board has a range of options available. *See generally* Secretary of the Navy Instruction (SECNAVINST) 1920.6D, encl. (11), ¶ 13. It could find that she had not committed the misconduct alleged, *see* SECNAVINST 1920.6D, encl. (11), ¶ 13a (providing that only court-martial findings of guilty or civilian criminal convictions are binding on Board), or if it finds misconduct, the Board could nevertheless recommend her retention, which would be binding on the Secretary, *see* 10 U.S.C. § 1182(d)(1); SECNAVINST 1920.6D, encl. (11), ¶ 13a(2)–(3); *id.* ¶ 17b. Even if she is involuntarily retired, there is no reason to think she would be retired in a lesser grade. *See* SECNAVINST 1920.6D, encl. (9), ¶ 2a–b; *id.*, encl. (11), ¶¶ 13b, 17b(3). And it is unlikely that her service would be characterized as anything but honorable. *Id.* encl. (7), ¶ 4c.

vaccination status will pose less of a threat to their units is certainly not irreparable harm. For this reason alone, there is no basis for emergency injunctive relief, let alone relief directing the military's command assignment decisions, where Plaintiffs' alleged injuries are fully reparable.

IV. The Court Should Not Grant Relief For a Non-Party.

Finally, Plaintiffs cannot seek relief for an individual who has not yet been added as a party to the case. *See Piambino v. Bailey*, 757 F.2d 1112, 1137 n.62 (11th Cir. 1985) (stating that a non-party could not seek an injunction); *Jones v. Arnold*, No. 3:09-CV-1170-J-34JRK, 2010 WL 11507773, at *1 (M.D. Fla. May 7, 2010) ("An unnamed 'class member' in an uncertified class, Haddad is not a party to this case and lacks standing here to seek the relief requested in the Motion for Preliminary Injunction"). Plaintiffs filed their motion for leave to amend their complaint on January 20, 2022, in which they sought to, among other things, add Commander Surface Warfare Officer as a party. *See* ECF Nos. 49, 49-1. Because the motion is still pending, that individual is not a party to the case. Nor has the Court certified as class. Accordingly, the Court should not grant any relief whatsoever, but especially not to Commander Surface Warfare Officer.

CONCLUSION

The religious accommodation requests of the two plaintiffs seeking emergency relief have been denied based on the Navy's and Marine Corps' considered military judgment that vaccination is the only way to meet the Navy's and Marine Corps' needs with respect to these two individuals. The Court should defer to that judgment, which

is amply supported in the record. While the Court evaluates this matter, these plaintiffs face no imminent irreparable harm that this court can redress, but they do pose an ongoing threat to their units and the Navy as a whole. The Court in no event should purport to determine where officers may serve in the military, nor dictate to the military that these two plaintiffs must remain in their command positions, including command of a U.S. Navy warship, contrary to the judgement of military officials. For all of these reasons, Plaintiffs' motion for a temporary restraining order should be denied.

Dated: February 2, 2022

Respectfully submitted,

BRIAN M. BOYNTON
Acting Assistant Attorney General

ALEXANDER K. HAAS
Director, Federal Programs Branch

ANTHONY J. COPPOLINO
Deputy Director

/s/ Amy E. Powell

ANDREW E. CARMICHAEL
AMY E. POWELL
Senior Trial Counsel
ZACHARY A. AVALLONE
COURTNEY D. ENLOW
R. CHARLIE MERRITT
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
1100 L Street, N.W.
Washington, DC 20005
Tel: (919) 856-4013
Email: amy.powell@usdoj.gov
Counsel for Defendants

Table of Exhibits

Exhibit Number	Exhibit Description
1.	Mem. from the Chief of Naval Operations regarding Commander Surface Warfare Officer (Jan. 23, 2022)
2.	Mem. from the Assistant Commandant of the Marine Corps regarding Marine Lieutenant Colonel 2 (Jan. 24, 2022)
3.	Declaration of Admiral William K. Lescher (Jan. 19, 2022)
4.	Declaration of Colonel Tonya Rans (Jan. 31, 2022)
5.	Declaration of Major Scott Stanley (Jan. 28, 2022)
6.	Declaration of Colonel James R. Poel (Jan. 31, 2022)

Exhibit 1

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

1730
N00
23 Jan 22

From: Chief of Naval Operations
To: [redacted]
Via: Commander, Destroyer Squadron [redacted]

Subj: APPEAL OF RELIGIOUS ACCOMMODATION FOR IMMUNIZATION REQUIREMENT

Ref: (a) DCNO (N1) ltr 1730 Ser N1/114357 of 22 Oct 21
(b) DoD Instruction 1300.17 of 1 Sep 2020
(c) SECNAVINST 1730.8B
(d) ASN (M&RA) memo of 6 Jun 13
(e) BUPERSINST 1730.11A
(f) CHBUMED 6320 Ser M44/21UM40540 of 13 Oct 21
(g) NAVADMIN 190/21

1. Your appeal of reference (a) is disapproved. I am disapproving your appeal due to the Navy's compelling governmental interest in preventing spread of diseases to support mission accomplishment, including military readiness, unit cohesion, good order and discipline, and health and safety, at the individual, unit, and organizational levels. A waiver of immunizations would have a predictable and detrimental effect on the readiness of you and the Sailors who serve alongside you. Granting your request will have a direct and foreseeable negative impact on the compelling governmental interest in military readiness and health of the force. I further find that there are no less restrictive means to achieve the Navy's compelling governmental interest.

2. References (b) through (e) designate me as the final appeal authority for requests for religious accommodation.

3. I considered your original request, your appeal, and the endorsements on your correspondence. In reviewing your appeal, I evaluated the request under the assumption that your religious beliefs are sincere and would be substantially burdened. Your status as a Surface Warfare Officer commanding an operational warship was taken into account in making my determination. As explained in reference (f), while no vaccine is 100 percent effective, vaccines with lower effectiveness still reduce disease incidence in the population, reduce an individual's risk of contracting the disease, and generally reduce the severity of disease for those who do contract the illness. In addition, the current coronavirus disease 2019 (COVID-19) pandemic further highlights the importance of vaccination in both individual and unit force health protection.

4. Vaccination of Navy personnel can impact both individual and unit mission accomplishment. It reduces the risk to the individual for disease-related performance impairment, and it reduces the risk to the unit for disease outbreaks of contagious diseases such as COVID-19. While non-

pharmacologic measures such as personal hygiene, mask wearing, and social distancing can also reduce the risk of disease outbreaks, they too are not 100 percent effective and must be implemented in conjunction with immunization to reduce the risk of mission failure. As explained in reference (f), these measures are not as effective as vaccination in maintaining military readiness and the health of the force.

5. You must now become fully vaccinated against COVID-19 in accordance with reference (g). You are free to choose which authorized COVID-19 vaccine to take, but you must receive a vaccine within five calendar days upon receipt of this letter. If you choose a COVID-19 vaccine that requires two doses, you must complete the series as prescribed.

6. The Navy welcomes people of all faiths and no faith to join our ranks in patriotic service. Our greater mission sometimes requires reasonable restrictions. You have my sincere best wishes for your continued success in your Navy career.

M. M. GILDAY

Copy to:
ASN (M&RA)
OPNAV (N131)
BUMED

Exhibit 2

DEPARTMENT OF THE NAVY
HEADQUARTERS UNITED STATES MARINE CORPS
3000 MARINE CORPS PENTAGON
WASHINGTON, DC 20350-3000

IN REPLY REFER TO:
1020
ACMC
JAN 2 4 2022

From: Assistant Commandant of the Marine Corps
To: Lieutenant Colonel [redacted] USMC

Subj: APPEAL FROM DENIAL OF RELIGIOUS ACCOMMODATION REQUEST IN THE CASE OF LIEUTENANT COLONEL [redacted] /0402 USMC

Ref: (a) 42 U.S.C. § 2000bb et seq., Religious Freedom Restoration Act of 1993 (RFRA)
(b) DoD Instruction 1300.17
(c) SECNAVINST 1730.8B CH 1
(d) DoD Instruction 6205.02
(e) MCO 1730.9
(f) MARADMIN 462/21
(g) Assistant Secretary of Defense for Health Affairs Memo of 14 Sep 21, "Mandatory Vaccination of Service Members using the Pfizer-BioNTech COVID-19 and Comirnaty COVID-19 Vaccines"
(h) ASN M&RA Memo of 8 Sep 21, "Use of Pfizer-BioNTech Vaccine for Mandatory Vaccination"

Encl: (1) LtCol [redacted] Appeal 1000[redacted] of 3 Nov 21
(2) DC M&RA ltr 1730 MRA of 13 Oct 21
(3) LtCol [redacted] AA Form of 7 Sep 21
(4) Religious Accommodation Review Board Recommendation Worksheet
(5) Applicant Information Form
(6) 3270 Data (BIR, BTR, Awards)

1. After careful consideration of the references and enclosures, I have decided to disapprove your appeal.

2. In your original request, you ask for a religious accommodation for an immunization exemption. Your request indicates that you are specifically requesting exemption from receiving the COVID-19 vaccine and influenza vaccine. Your request is based on a concern regarding the use of aborted fetal cell tissue and cell lines in the development, confirmation testing, or production of the vaccines. You state your religious beliefs prohibit you from defiling your body, which is the temple of the Holy Spirit. You also assert that forcing another person to accept a vaccine is unconscionable and violates the Laws of nature and of Nature's God. In response, the Deputy Commandant for Manpower and Reserve Affairs (DC M&RA) denied your request. You have appealed DC M&RA's decision.

Subj: APPEAL FROM DENIAL OF RELIGIOUS ACCOMMODATION REQUEST IN THE CASE OF LIEUTENANT COLONEL [redacted] USMC

3. In your appeal, you assert that your chain of command mischaracterized the nature of your request by suggesting that your religious beliefs have not precluded you from receiving other required vaccines. You further assert that your initial request should be approved because the government failed to demonstrate a sufficient compelling interest in requiring the vaccine.

4. Pursuant to reference (e), I am the appeal authority. In reaching a decision on your appeal, I considered the denial letter issued by DC M&RA on 13 October 2021, your appeal dated 3 November 2021 and its enclosures, your initial request dated 7 September 2021, and the endorsements and exhibits attached to your initial request. Additionally, I considered the applicant information form, your basic individual record, basic training record, and your awards page. I further considered your right to the free exercise of your religion, and the government's compelling interest in mission accomplishment at the individual, unit, and organizational levels. Specifically, I considered such necessary elements of mission accomplishment as (1) military readiness, (2) unit cohesion, (3) good order and discipline, and (4) the health and safety of the force. I also considered whether the DC M&RA's previous decision constitutes the least restrictive means of furthering the government's compelling interests. Finally, I consulted with legal counsel.

5. I have determined that the COVID-19 vaccination requirement does not substantially burden your sincerely held religious belief because fetal stem cells are neither used in the manufacture of the Pfizer COVID-19 vaccine nor are they present in the vaccine itself. Furthermore, you assert that your body is a temple that you cannot defile by receiving the COVID-19 vaccine. The same argument could be made for every FDA approved vaccine you have received during your twenty-five years in service; therefore, this requirement does not substantially burden your sincerely held religious belief.

6. Nonetheless, even assuming that the COVID-19 vaccination substantially burdens your religious beliefs, I have considered, in accordance with references (b) and (e), your assertions concerning your beliefs and weighed them against the government's compelling interests in military readiness and in the health and safety of the force. The Delta variant of the novel coronavirus is highly transmissible and causes more severe illness, hospitalization, and death than previous variants. The greatest risk of transmission is from and among unvaccinated people. And, while fully vaccinated people with Delta variant breakthrough infections can spread the virus, they appear to spread the virus for a shorter period of time. Other emerging variants, such as the Omicron variant, which

is highly transmissible, pose further concerns. Personnel who have fallen ill due to a failure to be vaccinated against COVID-19 undermine a unit's effective functioning and negatively impact their unit's ability to accomplish the mission. Moreover, personnel who are unvaccinated do not just put themselves at risk, they also risk the health and medical readiness of other persons within their unit, which in turn decreases the military readiness of the unit and the Marine Corps as a whole. For a unit to function effectively, either in garrison, in field training, or in combat, all personnel must be able to perform their individually assigned duties, which ensures military readiness, another of the government's compelling interests. As a result, an exemption from the COVID-19 vaccination poses a significant risk to military readiness, and the health and safety of the force, particularly in your case where you work primarily indoors and cannot perform all of your duties remotely. Additionally, your orders to Bahrain have been delayed several times due to your failure to be fully medically ready to travel overseas as a result of your vaccination status. Finally, you are currently attached to a deployable unit, and you must be prepared to deploy at a moment's notice.

7. Your claims that your natural immunity is a less restrictive means to vaccination is not supportable because these means are less effective than vaccination and they do not achieve the Marine Corps' compelling government interests in readiness, and health and safety. While masking, social distancing, hygiene, teleworking, and other similar measures, individually or in combination, have been shown to help slow the spread of the virus, they are simply not as effective as vaccination. Moreover, these measures are often incompatible with the demands of military life, where Marines and Sailors must live, work, realistically train, and, if necessary, fight in close quarters. The demands of military life render these less restrictive means of furthering the government's compelling interests in military readiness and the health and safety of the force even less effective than such measures among the civilian community. Accordingly, because there are no less restrictive means to ensure these compelling government interests, your appeal is disapproved.

8. I urge you to consult your military health care provider regarding your medical concerns about the COVID-19 and influenza vaccines. These vaccines are critical to saving lives and ensuring military readiness. My point of contact on this matter is Mr.

Subj: APPEAL FROM DENIAL OF RELIGIOUS ACCOMMODATION REQUEST IN THE CASE OF LIEUTENANT COLONEL [redacted] USMC

Michael D. Graham, Judge Advocate Division (JCA), (703) 614-2510, or email michael.d.graham@usmc.mil.

E. M. SMITH
Assistant Commandant
of the Marine Corps

Copy to:
DC M&RA
CO MRSG MARSOC
CO MARSOC

Exhibit 3

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

DECLARATION OF WILLIAM K. LESCHER

I, William K. Lescher, hereby state and declare as follows:

1. I am an admiral[1] in the United States Navy, currently serving as the Vice Chief of Naval Operations (VCNO), located in Arlington, Virginia at the Pentagon. The position of VCNO is appointed by the President, with the advice and consent of the Senate, and is the second highest uniformed Officer in the Navy. I have served in this position since May 29, 2020. I make this declaration in support of the Government's motion for a stay of this Court's preliminary injunction pending appeal. The statements made in this declaration are based on my

[1] The rank of "admiral" is the highest military rank in the Navy. The term "admirals" is also frequently referred to as "flag officers." Flag officers include the ranks of rear admiral (lower half), rear admiral (upper half), vice admiral and admiral. Flag officers comprise the most senior levels of uniformed leadership in the Navy.

personal knowledge, my military judgment and experience, and on information that has been provided to me in the course of my official duties.

Preliminary Statement

2. I have reviewed the preliminary injunction order issued by this Court on January 3, 2022. I believe the Court's injunction will cause immediate harm to the Navy, and in particular to the operations of Naval Special Warfare (NSW) and Special Operations Forces (SOF), and to the national security of the United States. Operationally, in 2021, the Navy executed more than 30,000 steaming days and one million flying hours to protect America, deter conflict and keep the sea lanes open and free. The Court's injunction directly impacts the Navy's ability to carry out its responsibilities to protect and maintain the health and safety of our Force, in particular our ability to halt the spread of COVID-19 through a mandatory vaccination requirement. Unvaccinated 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. Vaccination against COVID-19 has proven to be essential in keeping Navy units on mission by mitigating the impact of COVID-19. Fully vaccinated naval forces are required to ensure readiness to carry out Navy missions throughout the world and, if required, to engage in combat operations. Restriction of the Navy's ability to reassign unvaccinated personnel in order to mitigate COVID-19 related risks to units preparing to deploy, or that are deployed, will cause direct and immediate impact to mission execution. Further, the harm caused by this injunction is not limited to 35 unvaccinated Plaintiffs. The heath, readiness, and mission execution of broader conventional Navy units and personnel who support these personnel are threatened as well.

Naval Background and Experience

3. As the Vice Chief of Naval Operations,[2] I work in coordination with the Chief of Naval Operations (CNO), the senior admiral in the U.S. Navy, [3] in the execution of his statutory duties and responsibilities as they pertain to the employment of the Navy. Those duties include recruiting, organizing, supplying, equipping, training, servicing, mobilizing, demobilizing, administering, and maintaining the Navy, as will assist in the execution of any power, duty, or function of the Secretary of the Navy or the Chief of Naval Operations. Additionally, the CNO delegated several specific responsibilities to me. I oversee programs and policies that impact Sailors and their families, including health affairs, and monitor and enact polices that promote good order and discipline in the Navy.

4. I have served in the United States Navy for nearly 42 years. A 1980 graduate of the United States Naval Academy, my experience includes command of the Vipers of Helicopter Anti-Submarine Light (HSL) Squadron-48, the Airwolves of HSL-40 and the Maritime Strike Wing Atlantic. As Commanding Officer, HSL-48, my responsibilities included training, preparing, and executing Seahawk helicopter detachment deployments on Navy ships deploying worldwide. As Commanding Officer, HSL-40, I was responsible for the training, evaluation, and maintenance of the Seahawk helicopter squadron that trains all East Coast Seahawk pilots in employment of this weapon system. As Commander, Maritime Strike Wing Atlantic, I was responsible for the material readiness and training of eight Helicopter Maritime Strike (HSM)

---

[2] "The [VCNO] has such authority and duties with respect to the Department of the Navy as the Chief of Naval Operations, with the approval of the Secretary of the Navy, may delegate to or prescribe for him. Orders issued by the [VCNO] in performing such duties have the same effect as those issued by the Chief of Naval Operations." 10 U.S.C. § 8035(c).

[3] The CNO is the senior uniformed officer in the United States Navy. *See* 10 U.S.C. § 8033(b) ("The Chief of Naval Operations, while so serving, has the grade of admiral without vacating his permanent grade. In the performance of his duties within the Department of the Navy, the Chief of Naval Operations takes precedence above all other officers of the naval service.").

squadrons, the Weapons School, Fleet Replacement Squadron, and a total of 42 detachments deploying on Atlantic Fleet aircraft carriers and air capable ships, encompassing 68 aircraft and 1,900 personnel. Between command of the Vipers and Airwolves, I was the executive officer of Mine Countermeasures Command and Control Ship USS Inchon (MCS 12), a 20,000 ton vessel with a crew of 700. As the second in command, I was responsible for the supervision, training and development of the crew and the daily execution of the command mission, which included training and preparing the crew for deployment, maintaining and improving operational readiness and material condition of the ship. As a flag officer, I commanded Expeditionary Strike Group 5 (ESG-5) and Task Forces 51/59 (CTF 51/59) in Bahrain, leading multiple Amphibious Ready Groups, Marine Expeditionary Units and the afloat forward staging base USS Ponce (AFSB(I)-15) in execution of theater security events, combat operations, and emergent national taskings spanning the Middle East/Central Command region. My responsibilities as ESG-5 and CTF 51/59 included multiple events working with NSW forces embarked on my ships and interoperability exercises with partner countries. I also served as Joint Staff deputy director for resources and acquisition, deputy assistant Secretary of the Navy for budget, and Deputy Chief of Naval Operations for integration of capabilities and resources.

Specific Functions of the United States Navy

5. The United States Navy and Marine Corps comprise the Nation's principal maritime forces. Their missions are to provide globally deployable forces in order to "secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests." *See*

Department of Defense Directive (DoDD) 5100.01, Change 1, 09/17/2020, Encl. 6, ¶ 5.a. –b (attached hereto). Effective execution of all of these discrete functions is vital to the national security of the United States, and is accomplished by providing fully trained and qualified naval forces to joint commanders[4] to deter aggression and, if required, engage in combat operations and win decisively.

Naval Special Warfare (NSW) and Special Operations Forces (SOF)

6. Naval Special Warfare (NSW) and Special Operations Forces (SOF) are composed of Navy SEALs[5] and Special Warfare Combatant-Craft Crewmen (SWCC). The NSW team is a multipurpose combat force organized and trained to conduct a variety of special operations missions in all environments. Navy SEALs conduct clandestine missions infiltrating their objective areas by fixed and rotary-wing aircraft, Navy surface ships, combatant craft, submarines and ground mobility vehicles. Service members designated as Navy SEALs consist of officers and enlisted members who have been designated pursuant to Navy and NSW policies. SWCC focus on infiltration and exfiltration of SEALs and other SOF to include from other Services, and they provide dedicated rapid mobility in maritime environments, as well as the ability to deliver combat craft via parachute drop. SWCC operate and maintain state-of-the-art surface craft to conduct special operations.

7. In addition to SEALs and SWCC, combat support (CS) and combat service support (CSS) personnel are assigned to NSW units to support the mission. CS/CSS personnel

[4] Joint commanders are the combatant vested with authority and responsibility 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.

[5] The term "SEAL" refers to "Sea, Air, Land."

include officers and enlisted service members identified in Plaintiffs' complaint (i.e., Explosive Ordinance Disposal (EOD) personnel and Navy Divers), in addition to other officers and enlisted service members performing a variety of military functions (e.g., chaplains, medical personnel, mobile communications teams, tactical cryptologic support, etc.). Navy EOD personnel perform missions neutralizing explosive weapons, including various weapons of mass destruction. Their duties include detonating or demolishing hazardous munitions, neutralizing various ordnance, including sea mines, torpedoes or depth charges, performing parachute or helicopter insertion operations, and clearing waterways of mines in support of our military operations. Navy Divers perform a variety of military functions, including wreckage salvage operations and underwater repairs, harbor and waterway clearance operations, assisting in construction and demolition projects, executing search and rescue missions, performing deep submergence operations, and serving as technical experts for diving operations for numerous military special operations units.

8. Service members in the NSW force are responsible for performing special operations. Special operations require unique tactics, techniques, procedures and equipment. They are often conducted in hostile, austere or diplomatically sensitive environments, and are characterized by one or more of the following: time-sensitivity, clandestine nature, low visibility, working with or through host-nation forces, greater requirements for regional orientation and cultural expertise, and a higher degree of risk. These missions often require members of the NSW force to work in close quarters where social distancing is not possible. Small NSW teams may travel for an extended duration on boats, submersibles, helicopters, aircraft, or other vehicles that are less than six feet across, and/or which have limited ventilation. Service members may be in such close quarters while traveling that they must sit shoulder-to-shoulder.

Additionally, members may be required to operate in subsea environments and may have to share diving rebreather devices and inhale one another's exhalation.

Mandatory Vaccination Requirements in Response to COVID-19 Pandemic

9. On August 24, 2021, the Secretary of Defense directed the Secretaries of the Military Departments to immediately begin full vaccination of all members of the Armed Forces on active duty or in the Ready Reserve. The Secretary of Defense determined that mandatory COVID-19 vaccinations are necessary to protect the health and military readiness of the force. The Secretary of the Navy directed implementation of Secretary of Defense's COVID-19 vaccination mandate[6] via a Department-wide administrative message (ALNAV) on August 30, 2021. The ALNAV applies to both Services within the Department of the Navy (DON), the United States Navy and the United States Marine Corps. The ALNAV required all active duty DON Service members, who were not already vaccinated, exempted, or currently seeking an exemption, to be fully vaccinated with an FDA-approved COVID-19 vaccine within 90 days of the ALNAV, and all Reserve Component personnel to be fully vaccinated within 120 days. ALNAV 062/21 ¶ 4. Active duty Sailors and Marines were required to become fully vaccinated[7] by November 28, 2021, and Reserve Component Sailors and Marines by December 28, 2021. The requirement to obtain full vaccination constitutes a lawful order under Article 92 of the Uniform Code of Military Justice (UCMJ), and failure to comply may result in punitive or adverse administrative action, or both. ALNAV 062/21 ¶ 5.

[6] Secretary of Defense Memorandum, "Memorandum for Senior Pentagon Leadership, Commanders of the Combatant Commands, Defense Agency, and DoD Field Activity Directors," (August 24, 2021).
[7] Although refusal to receive the vaccine may subject a member to adverse administrative or disciplinary action, the vaccine will not be forcibly administered to any member who refuses.

10. The United States Navy issued service-specific guidance via a separate administrative message ("NAVADMIN") on September 1, 2021. NAVADMIN 190/21 outlines Navy policy concerning the mandatory vaccination of Navy service members, vaccination administration and reporting requirements, and general guidance related to logistics and distribution of vaccines. The policy reiterates that COVID-19 vaccination "is mandatory for all DoD service members who are not medically or administratively exempt" under existing Navy policy. NAVADMIN 190/21 ¶ 2, 3.a. Refusal to become fully vaccinated against COVID-19 without an approved or pending exemption constitutes a failure to obey a lawful order and is punishable under Article 92, UCMJ.

The COVID-19 Pandemic Threat to Naval Forces

11. The judgment of each of the Military Services is that vaccines 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. 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 who were required to be hospitalized because of COVID-19, 0.8% received a booster shot prior to hospitalization. Separately, there have only been six active duty personnel who have received a booster and had a breakthrough COVID-19 infection that required hospitalization. Among the active duty force, 12% of those required to be hospitalized have received a primary COVID-19 vaccine without the booster. Among Reserve and National Guard service members, 97% of those hospitalized with COVID were unvaccinated or partially vaccinated; 3% of hospitalized members received primary vaccination but no booster shot; 0.2% hospitalized members had received a booster shot.

Sending ships into combat without maximizing the crew's odds of success, such as would be the case with ship deficiencies in ordnance, radar, working weapons or the means to reliably accomplish the mission, is dereliction of duty. The same applies to ordering unvaccinated personnel into an environment in which they endanger their lives, the lives of others and compromise accomplishment of essential missions.

12. The environment in which Navy personnel operate -- in close quarters for extended periods of time -- make them particularly susceptible to contagious respiratory diseases such as COVID-19 and renders mitigation measures such as social distancing unrealistic. In mid-March 2020, the aircraft carrier USS THEODORE ROOSEVELT (CVN 71) was deployed to the Western Pacific Ocean, a vital geo-political center of gravity encompassing several of the world's largest militaries and five nations allied with the U.S. through mutual defense treaties. The leadership of USS THEODORE ROOSEVELT began to see several COVID-19 cases among the crew. By April 1, 2020, USS THEODORE ROOSEVELT had been pulled off mission and into Guam with approximately 1,000 crew removed from the ship, with a reduced crew remaining to maintain the nuclear reactor and other essential systems. By April 20, 2020, 4,069 Sailors had been removed from the ship out of a crew of approximately 4,800. The ship was unavailable for 51 days to maintain presence in a strategically important area which includes the world's busiest sea lanes, creating a national security vulnerability in an area vital to our national interests. When USS THEODORE ROOSEVELT finally got underway on May 21, 2020, approximately 1,800 Sailors remained in Guam. Tragically, one Sailor succumbed to the COVID-19 virus and died.

13. Even with approximately 97% of the Navy vaccinated, the COVID-19 virus can degrade units and impact mission. Last month, USS MILWAUKEE (LCS 5), with a 100%

vaccinated 100-person crew, remained in port one week beyond its schedule because several members tested positive for COVID-19. Because the full crew was vaccinated, infected personnel were asymptomatic or had mild symptoms and the impact to mission accomplishment was substantially mitigated compared to the USS THEODORE ROOSEVELT's experience of more than 4,000 crew removed from the ship and a 51-day loss of mission. Given the hospitalizations and death statistics cited above, the MILWAUKEE's minor deployment delay would likely have been far worse with unvaccinated personnel. The MILWAUKEE is one example of a Navy manning model where each individual crew member has a high level of responsibility with little redundancy. The medical staff of the MILWAUKEE consists of only two Navy Hospital Corpsman, comparable to an Emergency Medical Technician in the civilian setting. There is little ability on ship to care for a service member with severe COVID symptoms. If a service member were to develop severe symptoms on this type of ship, it would require a return to port or an emergency medical evacuation by helicopter. Helicopter medical evacuation is not always viable due to the location of the ship and the limited range of helicopters. At the deployable unit level, NSW, EOD, and diver personnel operate in units that can be as small as a squad of four personnel. Medical evacuations in these small units can be even less practical and significantly more damaging than the loss of an equal number of crew on a ship the size of the MILWAUKEE.

14. The types of missions conducted by SEALs, SWCC, EOD and divers cannot be conducted remotely. A SEAL assigned to perform a counterterrorism mission in a foreign country cannot perform that task from home; a SWCC cannot drive a combatant craft and transport SEALs in a telework status; an explosive ordnance disposal technician—whose job it is to disarm and dispose of explosives—cannot perform that task remotely. Similarly, the arduous

training necessary to prepare NSW personnel for these missions cannot be performed remotely. It is not possible for a Navy Diver to remotely prepare compressed air and oxygen tanks for personnel to complete their training dives. A safety diver must be physically present during a high-risk training evolution that may require rescue divers or oxygen technicians. In particular, Navy Divers assigned to NSW must be able to operate a diving recompression chamber – a small confined space where the Navy Diver must be in the chamber to assist with the personnel casualty – which cannot be done remotely. SEAL trainers cannot oversee dangerous swim or survival training from a physically distanced location. NSW personnel also routinely interact with the greater Navy population, on ships and aircraft, and in dining facilities and office environments across the globe. They are required to deploy with no-notice. NSW, EOD and diver training and operations necessitate our service members interact in close-quarters, confined spaces, and under conditions where telework, social distancing, and mask-wearing are not reliable mitigation options.

Immediate Harm to Readiness and Mission Accomplishment

15. The preliminary injunction forbids the Navy from applying MANMED § 15-105(3)(n)(9), NAVADMIN 225/21, NAVADMIN 256/21 and Trident Order #12. Order 26, ECF No. 66. MANMED § 15-105(3)(n)(9) states that personnel who choose not to receive required vaccinations will be disqualified from special operations duty. NAVADMIN 225/21 provides guidance for disposition of offenses involving Navy service members who are not fully vaccinated by the required deadlines. Navy Service members who refuse the COVID-19 vaccine, absent a pending or approved exemption, are required to be processed for administrative separation.[8] NAVADMIN 225/21 ¶ 2. A Navy Service member is considered to be "refusing the

[8] Although processing for separation is required, this does not automatically result in a member actually being separated. Members processed for separation may ultimately be retained in the service.

vaccine, if: (1) the individual has received a lawful order to be fully vaccinated, (2) is not or will not be fully vaccinated by the date required, and (3) does not have a pending or approved exemption request." *Id.* ¶ 3.c. The policy designates the Chief of Navy Personnel, a 3-star admiral, as the COVID-19 Consolidated Disposition Authority to ensure fair and consistent administrative processing across the service. *Id.* at ¶ 5.b. For disciplinary matters, authority to initiate disciplinary proceedings, either non-judicial punishment or court-martial, is withheld to the Vice Chief of Naval Operations. *Id.* NAVADMIN 256/21 provides additional guidance on administrative separation processing for those refusing the vaccine, as well as guidance on other applicable administrative actions. These other applicable administrative actions include: cancellation of government travel for training or other official purposes; temporary reassignment within the local area for unvaccinated personnel (with or without a medical exemption or religious accommodation); adverse fitness reports and evaluations; prohibition on executing permanent change of station orders; potential termination of special duty and incentive pays; potential recoupment of unearned bonuses; termination of and potential reimbursement for Navy-funded education and training; promotion and advancement delays; and removal of additional qualification designations or Navy Enlisted Classifications.[9] *See* NAVADMIN 256/21 ¶¶ 4.b.through 13. Trident Order # 12, which is directed to the NSW force, does not create any new requirements or adverse administrative actions. It consolidates and restates previously promulgated Navy implementing guidance.

16. The preliminary injunction forbids the Navy from "[t]aking any adverse

[9] Navy Enlisted Classifications define the work performed by Navy enlisted members and the requirements to perform specific "ratings" (i.e., occupations). *See generally*, MANUAL OF NAVY ENLISTED MANPOWER AND PERSONNEL CLASSIFICATIONS AND OCCUPATIONAL STANDARDS, VOL II NAVY ENLISTED CLASSIFICATIONS (NAVPERS 18068F), April 21, 2021 (supplementing the enlisted rating structure in identifying personnel and billets [i.e., jobs] and skills, knowledge, aptitude, or qualifications that must be documented to identify both people and billets for management purposes).

action against Plaintiffs on the basis of Plaintiffs' requests for religious accommodation." Order 26, ECF No. 66. The order specifically references actions that Plaintiffs allege are being taken against them while they await a decision on their religious accommodation requests, actions such as restrictions on travel, access to non-work activities, unpleasant assignments, and being relieved of leadership duties. Order 26, ECF No. 66. This aspect of the order is intrusive and harmful to Navy operations, including deployment decisions. In the Navy, "adverse action" refers to an action that is punitive or the action itself has a direct adverse impact on one's career such as a court martial or discharge. The Court's order, however, indicates that routine personnel actions, such as assignment, official travel and specific duties, are adverse decisions. Contrary to the Court's apparent understanding, temporarily reassigning personnel to other units because they are unvaccinated, regardless of the reason they are unvaccinated (e.g., medical exemption, religious accommodation, or pending exemption request) is not an adverse action but a step to protect the health of the whole unit and maintain mission readiness. The Court's injunction appears to require the Navy to leave unvaccinated NSW, EOD, and diver personnel in their units, performing their same duties and deploying on missions regardless of the known risk to personnel and mission. Such an injunction will degrade NSW, EOD, and diver mission readiness, breakdown good order and discipline within the NSW force, unnecessarily limit the Navy's ability to conduct daily operations and operational missions, and could clearly result in mission failure in contingencies and crises that cause harm to national security.

17. NSW personnel must be fully medically ready and at peak fitness given that their training and missions are physically demanding and arduous. It is vital that all members of the NSW force be medically fit to perform daily operations and to train or deploy on short notice. Regardless of their current assignment, all naval forces, NSW in particular, must be ready to

respond to contingencies and crises around the world. All NSW personnel are expected to meet this requirement, whether in a training status, on instructional duty, or at a headquarters, as the mission of NSW is to be ready to provide maritime SOF to conduct full spectrum operations to support national objectives. The Navy could easily require Navy Special Warfare Command to mobilize personnel outside from any unit, regardless of the planned deployment cycles of a unit or the currently assigned duties of NSW personnel to respond to the full range of contingencies and crises. Medical conditions or illness create risk, both medical and operational, not only for the service member afflicted, but for other members of the unit. As a result, unvaccinated 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. The following publicly available mission event illustrates how rapidly a NSW unit can go from steady state in the United States to deploying forward on a mission of the highest difficulty, requiring peak medical, physical and mental readiness. This example illustrates the rapid manner in which a contingency or crisis could unfold, and although more than a decade old, is used due to the unclassified classification of my declaration.

18. On April 8, 2009, armed Somali pirates boarded the U.S.-flagged container ship, *Maersk Alabama* in the Indian Ocean, taking the crew, composed of U.S. citizens, hostage and making ransom demands. USS BAINBRIDGE (DDG-96) was the first ship of the international counter-piracy task force to respond. BAINBRIDGE's commanding officer realized he needed additional capabilities beyond what he had available on the ship. In response, on short notice, a SEAL team flew 8,000 miles from the United States to USS BAINBRIDGE and were recovered onboard. By the evening of April 12, 2009, the situation escalated and SEALs on BAINBRIDGE eliminated the threat to the remaining hostage, *Maersk Alabama* Captain

Phillips, who was subsequently rescued. This is but one example, using a well-publicized mission, that illustrates how an unvaccinated member would put himself, his teammates, the conventional forces and the mission at great risk. While NSW personnel may be assigned to various units with various mission-sets, all naval forces must be ready to respond to global contingencies and crises on short notice.

19. If this type of crisis or contingency occurred today, with the Court's preliminary injunction in place, the Navy could be required to deploy a SEAL team with one or more unvaccinated members, risking a COVID-19 outbreak within that unit or on the host Navy destroyer. Destroyer crews, and others embarked aboard, sleep in confined shared berthing spaces, are in close proximity in passageways, and eat meals in a communal galley. An unvaccinated service member is not only more likely to contract COVID-19, but to experience significant disease symptoms, impact the mission and spread the disease to others.

20. Navy ships have limited health care facilities. A Sailor experiencing severe COVID symptoms would require the ship to pull into port instead of executing its mission. NSW forces often deploy in countries with little or no healthcare support structure and in remote areas where healthcare is scarce. This is why there has been a long-standing requirement for all members of the NSW force to be fully medically ready to deploy. A small number of SOF medical personnel provide limited medical support and patient movement; therefore, any encumbrance placed on that limited capability unnecessarily puts the mission and the force at-risk. While some SEALs are trained to perform emergency, life-saving procedures in remote and hostile environments, those personnel are not physicians or nurses. Unlike doctors and nurses, formal civilian medical licenses are not required for them. They do not generally have the capability, capacity or training to use a ventilator. Additionally, they do not have access to this

equipment in the types of austere environments in which the NSW units operate. If a deployed team member contracts COVID-19, there is a strong possibility that the necessary equipment or treatment would not be readily available. Further, if medical evacuation is necessary for a member of the unit, this creates additional risk not only to the mission, but places those service members executing medical evacuation at a risk of harm to themselves such as when the member requires transport from a hostile, remote or diplomatically sensitive areas.

21. Redirecting these assets and their crew to perform preventable evacuations results in a degradation of the Navy's ability to accomplish its primary missions and incurs collateral impacts. Medical evacuations often require one or more member from the service member's unit to accompany the evacuated service member. The loss of even one member can degrade the effectiveness of small NSW units and may compromise the mission. This is similarly the case for SWCC personnel, who routinely operate with a crew of as little as four personnel on a combatant craft. Every member of a SEAL team is vital.

22. Unvaccinated NSW personnel put conventional Navy forces at risk as well. Navy SEALs are one of the most versatile elements of the SOF across all branches of the military services, in part, because the Navy can deliver them to their mission locations through a variety of conventional means (*e.g.*, fixed-wing aircraft, helicopters, surface ships and submarines). All of these means of delivery are confined spaces in which social distancing is impractical. Because NSW personnel rely on conventional Navy forces to support their missions, any unvaccinated NSW personnel will put the crew of those conventional forces at unnecessary risk as well. The Navy must balance the risk to unvaccinated individuals and vaccinated personnel alike. That risk calculation led to the mandatory vaccination mandate and associated personnel policies pertaining to the COVID-19 pandemic. It is imperative for the entire force, including

every member of NSW, to be vaccinated and ready to deploy and execute assigned missions on short notice.

23. The capabilities NSW personnel provide include crisis response, support to forward presence operations, support to conventional Naval forces at sea and in training, support to Law Enforcement agencies and clandestine insertion operations. EOD personnel provide critical safety and response to units using live ordnance; Navy divers, EOD and SEALs support underwater surveys and route clearances. SEALs conduct insertions and extractions by sea, air or land; they capture high-value enemy personnel and terrorists around the world, carry out small-unit direct-action missions against military targets and perform underwater reconnaissance and strategic sabotage. SEALs, SWCC, EOD and divers frequently deploy to foreign countries to train partners and allies and participate in exercises. Reducing the Navy's ability to apply long-standing, proven medical readiness principles to this small, elite community will clearly negatively impact the NSW force's ability to conduct their operations and could have significant negative effects to the NSW force's ability to respond to large-scale contingencies or crises. This would damage the national security interests of the United States and our foreign allies and partners.

24. These concerns apply if the injunction requires the Navy to maintain these 35 Plaintiffs in their current status while an appeal is pending. Of the 35 Plaintiffs, 18 are assigned to nine different parent commands and may deploy anywhere in the world in the immediate future to perform the type of missions described. 15 Plaintiffs are assigned to the NSW Center or a NSW Center subordinate command, with 14 of them assigned to NSW Advanced Training

Command (ATC);[10] some as instructors who necessarily have close contact with ATC students in courses to prepare them for NSW operations and some as students attending an advanced training course before returning to their current or prospective assignment. Two Plaintiffs are currently assigned to non-NSW training commands. Because the court's order prohibits them from being temporarily reassigned, the 14 unvaccinated personnel at NSW ATC have close contact with fellow instructors and students. These students then circulate among the larger NSW community as soon as their courses at ATC end. Simply put, close quarters contact during training creates the opportunity to contract COVID-19 from the unvaccinated instructors at ATC detachments. The unvaccinated instructors can spread COVID-19 to dozens of candidates in training, and qualified SEALs, SWCCs, and other personnel, including fellow instructors, at NSW ATC training courses who will promptly return to their primary units or interact with additional training classes.

25. In summary, the Navy's judgment is that COVID-19 vaccines are a critical defense against COVID-19 and mitigate risk both to our force and to our mission. This judgment takes 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. The COVID-19 virus has had a proven substantial impact on Navy unit readiness. The Court's order, which bars implementation of the vaccine requirement and requires the Navy to keep service members it has determined are not medically fit for deployment in a ready to deploy status, will undermine military readiness through the spread of disease and cause

[10] ATC's mission is to provide standardized and accredited individual training and education for qualified NSW and support personnel, U.S. SOF (i.e., from other Services), partner nation SOF and other personnel, as required for NSW Operations. There are several ATC detachments. The largest detachment in Coronado, California provides a course of instruction to candidates (i.e., those seeking to obtain their SEAL or SWCC designation). It also provides training to those already designated as SEALs, SWCC or combat support personnel. Other ATC detachments provide training in specialized areas to NSW personnel, other SOF and partner nation SOF.

significant harm to military operations by allowing unvaccinated service members to remain in an unvaccinated status.

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.

W. K. LESCHER

ENCLOSURE 6

FUNCTIONS OF THE MILITARY DEPARTMENTS

1. COMMON MILITARY DEPARTMENT FUNCTIONS. For purposes other than the operational direction of the Combatant Commands, the chain of command runs from the President to the Secretary of Defense to the Secretaries of the Military Departments and, as prescribed by the Secretaries, to the commanders of Military Service forces.

a. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are responsible for, and have the authority necessary to conduct, all affairs of their respective Departments, including:

(1) Recruiting.

(2) Organizing.

(3) Supplying.

(4) Equipping (including research and development).

(5) Training.

(6) Servicing.

(7) Mobilizing.

(8) Demobilizing.

(9) Administering (including the morale and welfare of personnel).

(10) Maintaining.

(11) Construction, outfitting, and repairs of military equipment.

(12) Construction, maintenance, and repair of buildings, structures, and utilities as well as the acquisition, management, and disposal of real property and natural resources.

b. Subject to the authority, direction, and control of the Secretary of Defense, the Secretaries of the Military Departments are also responsible to the Secretary of Defense for ensuring that their respective Departments:

(1) Operate effectively, efficiently, and responsively.

(2) Formulate policies and programs that are fully consistent with national security objectives and policies established by the President and the Secretary of Defense.

(3) Implement, in a timely and effective manner, policy, program, and budget decisions and instructions of the President or Secretary of Defense.

(4) Present and justify positions on the plans, programs, and policies of the Department of Defense.

(5) Prepare, submit, and justify budgets before Congress, in coordination with other USG departments and agencies, as applicable; and administer the funds made available for maintaining, equipping, and training the forces of their respective departments, including those assigned to the Combatant Commands. Among other things, budget submissions shall be informed by the recommendations of the Military Service Chiefs, Commanders of the Combatant Commands, and of Military Service component commanders of forces assigned to the Combatant Commands.

(6) Establish and maintain reserves of manpower, equipment, and supplies for the effective prosecution of the range of military operations and submit, in coordination with the other Military Departments, mobilization information to the Joint Chiefs of Staff.

(7) Develop integrated mobilization plans for the expansion of peacetime components to meet the needs of war.

(8) Perform Military Department functions necessary to fulfill the current and future operational requirements of the Combatant Commands, including the recruitment, organization, training, and equipping of interoperable forces.

(9) Provide forces to enhance military engagement, conduct security cooperation, build the security capacity of partner states, and deter adversaries to prevent conflict. These actions shall be coordinated with the other Military Departments, Combatant Commands, USG departments and agencies, and international partners, as required.

(10) Provide forces, military missions, and detachments for service in foreign countries as may be required to support the national interests of the United States, and provide, as directed, assistance in training, equipping, and advising the military forces of foreign nations.

(11) Coordinate with the other Military Departments and all of the other DoD Components to provide for more effective, efficient, and economical administration; eliminate duplication; and assist other DoD Components in the accomplishment of their respective functions by providing personnel, intelligence, training, facilities, equipment, supplies, and services, as may be required.

(12) Develop, garrison, supply, equip, and maintain bases and other installations, including lines of communication, and provide administrative and logistical support for all assigned forces and bases, unless otherwise directed by the Secretary of Defense.

(13) Provide, as directed, administrative and logistical support to the headquarters of the Combatant Commands, to include direct support of the development and acquisition of the command and control systems of such headquarters.

(14) Supervise and control Military Department intelligence activities, including the collection, production, and dissemination of military and military-related foreign intelligence and counterintelligence as required for execution of Military Department responsibilities.

(15) Afford the Assistant Secretary of Defense for Special Operations and Low-Intensity Conflict; the Commander, USSOCOM; the PCA; and the Commander, USCYBERCOM, an opportunity to coordinate on Military Department and Military Service personnel management policy and plans as they relate to accessions, assignments, compensation, promotions, professional development, readiness, retention, sustainment, and training of all SOF (for USSOCOM) and all cyber operations forces (for USCYBERCOM) personnel. This coordination shall not interfere with the title 10 authorities of the Military Departments or Military Services.

(16) Engage in such other activities as are prescribed by law, the President, or the Secretary of Defense.

2. COMMON MILITARY SERVICE FUNCTIONS. The Army, the Navy, the Air Force, the Marine Corps, and the Space Force, and the Coast Guard, when transferred to the Department of the Navy in accordance with sections 2, 3, and 145 of Reference (h), to include the Active and Reserve Components of each, under their respective Secretaries, shall provide conventional, strategic, and SOF to conduct the range of operations as defined by the President and the Secretary of Defense. Further, they shall perform the following common functions:

a. Develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip, and provide land, naval, air, space, and cyberspace forces, in coordination with the other Military Services, Combatant Commands, USG departments and agencies, and international partners, as required, that enable joint force commanders to conduct decisive operations across the spectrum of conflict in order to achieve the desired end state.

b. Determine Military Service force requirements and make recommendations concerning force requirements to support national security objectives and strategy and to meet the operational requirements of the Combatant Commands.

c. Recommend to the Joint Chiefs of Staff the assignment and deployment of forces to the Combatant Commands established by the President through the Secretary of Defense.

d. Monitor and assess Military Service operational readiness and capabilities of forces for assignment to the Combatant Commands and plan for the use of the intrinsic capabilities of the other Military Services, USSOCOM, and USCYBERCOM that may be made available.

e. Develop doctrine, tactics, techniques, and procedures for employment by Military Service forces and:

(1) Assist the Chairman of the Joint Chiefs of Staff in the development of joint doctrine.

(2) Coordinate with the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the other Military Services, USG departments and agencies, partner security forces, and non-governmental organizations, in the development of the doctrine, tactics, techniques, and procedures necessary for participation in and/or command of joint, interagency, and multinational operations.

(3) Coordinate with the Commanders, USSOCOM and USCYBERCOM, in the development of the doctrine, tactics, techniques, and procedures employed by Military Service forces when related to special operations and cyber operations, respectively.

f. Provide for training for joint operations and joint exercises in support of Combatant Command operational requirements, including the development of Military Service joint training requirements, policies, procedures, and publications.

g. Provide logistical support for Military Service and all forces assigned to joint commands, including procurement, distribution, supply, equipment, and maintenance, unless otherwise directed by the Secretary of Defense.

h. Organize, train, and equip forces to contribute unique service capabilities to the joint force commander to conduct the following functions across all domains, including land, maritime, air, space, and cyberspace:

(1) Intelligence, surveillance, reconnaissance, and information operations, to include electronic warfare and MISO in order to provide situational awareness and enable decision superiority across the range of military operations.

(2) Offensive and defensive cyberspace operations to achieve cyberspace superiority in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(3) Special and cyber operations in coordination with USSOCOM, USCYBERCOM, and other Combatant Commands, the Military Services, and other DoD Components.

(4) Personnel recovery operations in coordination with USSOCOM and other Combatant Commands, the Military Services, and other DoD Components.

(5) Counter weapons of mass destruction.

(6) Building partnership capacity/security force assistance operations.

(7) Forcible entry operations.

(8) Missile Defense.

(9) Other functions as assigned, such as Presidential support and antiterrorism.

i. Organize, train, and equip forces to conduct support to civil authorities in the United States and abroad, to include support for disaster relief, consequence management, mass migration, disease eradication, law enforcement, counter-narcotics, critical infrastructure protection, and response to terrorist attack, in coordination with the other Military Services, Combatant Commands, National Guard, and USG departments and agencies.

j. Operate organic land vehicles, aircraft, cyber assets, spacecraft or space systems, and ships or craft.

k. Conduct operational testing and evaluation.

l. Provide command and control.

m. Provide force protection.

n. Consult and coordinate with the other Military Services on all matters of joint concern.

3. INDIVIDUAL MILITARY DEPARTMENT FUNCTIONS. The forces developed and trained to perform the primary functions set forth in sections 4 through 6 of this enclosure shall be employed to support and supplement the other Military Service, USSOCOM, and USCYBERCOM forces in carrying out their primary functions, wherever and whenever such participation shall result in increased effectiveness and shall contribute to the accomplishment of overall military objectives.

4. FUNCTIONS OF THE DEPARTMENT OF THE ARMY

a. The Department of the Army includes land combat, and service forces, and such aviation, water transport, and space and cyberspace forces as may be organic therein, and shall be organized, trained, and equipped primarily for prompt and sustained combat incident to operations on land, and to support the other Military Services and joint forces. The Army is responsible for the preparation of land forces necessary for the effective prosecution of war and military operations short of war, except as otherwise assigned. The Army is the Nation's principal land force and promotes national values and interests by conducting military engagement and security cooperation; deterring aggression and violence; and should deterrence fail, compelling enemy behavioral change or compliance. The Army shall contribute forces through a rotational, cyclical readiness model that provides a predictable and sustainable supply of modular forces to the Combatant Commands, and a surge capacity for unexpected contingencies.

b. The Functions of the Army. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Army, within the Department of the Army, shall develop concepts, doctrine, tactics, techniques, and procedures, and organize, train, equip,

and provide forces with expeditionary and campaign qualities to perform the following specific functions:

(1) Conduct prompt and sustained combined arms combat operations on land in all environments and types of terrain, including complex urban environments, in order to defeat enemy ground forces, and seize, occupy, and defend land areas.

(2) Conduct air and missile defense to support joint campaigns and assist in achieving air superiority.

(3) Conduct airborne and air assault, and amphibious operations. The Army has primary responsibility for the development of airborne doctrine, tactics, techniques, and equipment.

(4) Conduct CAO.

(5) Conduct riverine operations.

(6) Occupy territories abroad and provide for the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Interdict enemy sea, space, air power, and communications through operations on or from the land.

(8) Provide logistics to joint operations and campaigns, including joint over-the-shore and intra-theater transport of time-sensitive, mission-critical personnel and materiel.

(9) Provide support for space operations to enhance joint campaigns, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(l0) Conduct authorized civil works programs, to include projects for improvement of navigation, flood control, beach erosion control, and other water resource developments in the United States, its territories, and its possessions, and conduct other civil activities prescribed by law.

(11) Provide intra-theater aeromedical evacuation.

(12) Conduct reconnaissance, surveillance, and target acquisition.

(13) Operate land lines of communication.

5. FUNCTIONS OF THE DEPARTMENT OF THE NAVY

a. The Department of the Navy is composed of naval, land, air, space, and cyberspace forces, both combat and support, not otherwise assigned, to include those organic forces and capabilities necessary to operate, and support the Navy and Marine Corps, the other Military Services, and joint forces. The Navy and Marine Corps comprise the Nation’s principal maritime force. They

employ the global reach, persistent presence through forward-stationed and rotationally-based forces, and operational flexibility to secure the Nation from direct attack; secure strategic access and retain global freedom of action; strengthen existing and emerging alliances and partnerships; establish favorable security conditions; deter aggression and violence by state, non-state, and individual actors and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Navy. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Navy, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct offensive and defensive operations associated with the maritime domain including achieving and maintaining sea control, to include subsurface, surface, land, air, space, and cyberspace.

(2) Provide power projection through sea-based global strike, to include nuclear and conventional capabilities; interdiction and interception capabilities; maritime and/or littoral fires, to include naval surface fires; and close air support for ground forces.

(3) Conduct ballistic missile defense.

(4) Conduct ocean, hydro, and river survey and reconstruction.

(5) Conduct riverine operations.

(6) Establish, maintain, and defend sea bases in support of naval, amphibious, land, air, or other joint operations as directed.

(7) Provide naval expeditionary logistics to enhance the deployment, sustainment, and redeployment of naval forces and other forces operating within the maritime domain, to include joint sea bases, and provide sea transport for the Armed Forces other than that which is organic to the individual Military Services, USSOCOM, and USCYBERCOM.

(8) Provide support for joint space operations to enhance naval operations, in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(9) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

c. The Functions of the Marine Corps. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, and pursuant to section 8063 of Reference (e), the Marine Corps, within the Department of the Navy, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces, normally

employed as combined arms air ground task forces, to serve as an expeditionary force-in-readiness, and perform the following specific functions:

(1) Seize and defend advanced naval bases or lodgments to facilitate subsequent joint operations.

(2) Provide close air support for ground forces.

(3) Conduct land and air operations essential to the prosecution of a naval campaign or as directed.

(4) Conduct complex expeditionary operations in the urban littorals and other challenging environments.

(5) Conduct amphibious operations, including engagement, crisis response, and power projection operations to assure access. The Marine Corps has primary responsibility for the development of amphibious doctrine, tactics, techniques, and equipment.

(6) Conduct security and stability operations and assist with the initial establishment of a military government pending transfer of this responsibility to other authority.

(7) Provide security detachments and units for service on armed vessels of the Navy, provide protection of naval property at naval stations and bases, provide security at designated U.S. embassies and consulates, and perform other such duties as the President or the Secretary of Defense may direct. These additional duties may not detract from or interfere with the operations for which the Marine Corps is primarily organized.

d. The Functions of the Coast Guard. The Coast Guard is a unique Military Service residing within the Department of Homeland Security while simultaneously providing direct support to the Department of Defense under its inherent authorities under References (e) and (h). In addressing the Coast Guard when it is not operating in the [Department of the] Navy, this issuance is descriptive in nature and does not purport to be either directive or regulatory. As directed by the President, and in accordance with Memorandum of Agreement between the Department of Defense and Department of Homeland Security on the use of Coast Guard Capabilities and Resources in Support of the National Military Strategy (Reference (ab)), the Department of the Navy shall coordinate with the Department of Homeland Security regarding Coast Guard military functions in time of limited war or defense contingency, without transfer of Coast Guard authority to the Secretary of the Navy. As directed, the Department of the Navy will provide intelligence, logistical support, and specialized units to the Coast Guard, including designated ships and aircraft, for overseas deployment required by naval component commanders, maritime search and rescue, integrated port security, and coastal defense of the United States. The Coast Guard shall maintain a state of readiness to function as a specialized Military Service in the Department of the Navy in time of war or national emergency. If specified in a declaration of war by Congress or if directed by the President, the Coast Guard shall operate as a Military Service in the Department of the Navy, and shall continue to do so

until the President transfers the Coast Guard back to the Department of Homeland Security by Executive order pursuant to section 3 of Reference (h).

(1) The Coast Guard shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions when providing direct or cooperative support to the Department of Defense:

(a) Conduct coastal sea control and maritime and air interception and interdiction operations.

(b) Conduct maritime homeland security and counterterrorism operations.

(c) Provide for port operations, security, and defense.

(d) Provide maritime operational threat response.

(e) Conduct counter-illicit trafficking operations.

(f) Conduct military environmental response operations.

(g) Conduct theater security cooperation operations.

(h) Conduct search and rescue operations.

(i) Conduct ice operations.

(j) Provide for marine safety, including aids to navigation.

(2) The Coast Guard will coordinate with the Department of Defense, including the Department, of the Navy to provide specialized Coast Guard units, or obtain Navy units, including designated ships and aircraft, for deployment as requested by Military Service component or joint commanders.

6. FUNCTIONS OF THE DEPARTMENT OF THE AIR FORCE

a. The Department of the Air Force is composed of air, space, and cyberspace forces, both combat and support, not otherwise assigned. The Air Force and Space Force are the Nation's principal air and space forces, and are responsible for the preparation of forces necessary for the effective prosecution of war. The Department of the Air Force shall organize, train, equip, and provide air, space, and cyberspace forces for the conduct of prompt and sustained combat operations, military engagement, and security cooperation in defense of the Nation, and to support the other Military Services and joint forces. The Air Force and Space Force will provide the Nation with global vigilance, global reach, and global power in the form of in-place, forward-based, and expeditionary forces possessing the capacity to deter aggression and violence by state, non-state, and individual actors to prevent conflict, and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests.

b. The Functions of the Air Force. In addition to the common military service functions listed in paragraphs 2.a. through 2.n. of this enclosure, the Air Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Conduct nuclear operations in support of strategic deterrence, to include providing and maintaining nuclear surety and capabilities.

(2) Conduct offensive and defensive operations, to include appropriate air and missile defense, to gain and maintain air superiority, and air supremacy as required, to enable, the conduct of operations by U.S. and allied land, sea, air, space, and special operations forces.

(3) Conduct global precision attack, to include strategic attack, interdiction, close air support, and prompt global strike.

(4) Provide timely, global integrated intelligence, surveillance, and reconnaissance capability and capacity from forward deployed locations and globally distributed centers to support world-wide operations.

(5) Provide rapid global mobility to employ and sustain organic air and space forces and other Military Service and USSOCOM forces, as directed, to include airlift forces for airborne operations, air logistical support, tanker forces for in-flight refueling, and assets for aeromedical evacuation.

(6) Provide agile combat support to enhance the air and space campaign and the deployment, employment, sustainment, and redeployment of air and space forces and other forces operating within the air and space domains, to include joint air and space bases, and for the Armed Forces other than which is organic to the individual Military Services and USSOCOM in coordination with the other Military Services, Combatant Commands, and USG departments and agencies.

(7) Conduct global personnel recovery operations including theater-wide combat and civil search and rescue, in coordination with the other Military Services, USJFCOM, USSOCOM, and DoD Components.

(8) Conduct global integrated command and control for air and space operations.

c. The Functions of the Space Force. In addition to the common military service functions listed in Paragraphs 2.a. through 2.n. of this enclosure, the Space Force, within the Department of the Air Force, shall develop concepts, doctrine, tactics, techniques, and procedures and organize, train, equip, and provide forces to perform the following specific functions:

(1) Provide freedom of operation for the United States in, from, and to space.

(2) Provide prompt and sustained space operations.

(3) Protect the interests of the United States in space.

(4) Deter aggression in, from, and to space.

(5) Conduct space operations.

7. DEPARTMENT OF THE ARMY AND DEPARTMENT OF THE AIR FORCE: THE NGB. The NGB is a joint activity of the Department of Defense. The NGB performs certain Military Service-specific functions and unique functions on matters involving non-federalized National Guard forces as set forth in Reference (i).

Exhibit 4

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
DAYTON DIVISION

MICHAEL POFFENBARGER,

Plaintiff,

v.

FRANK KENDALL, *et al.*,

Defendants.

No. 3:22-cv-1-TMR-SLO

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.

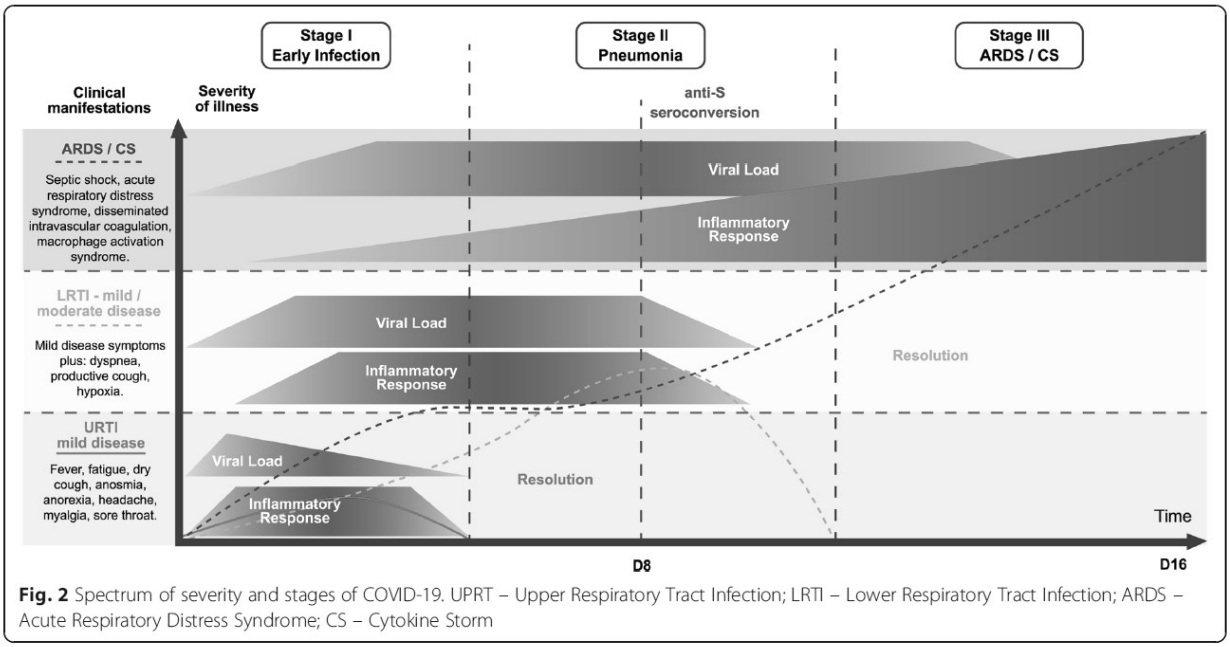


Fig. 2 Spectrum of severity and stages of COVID-19. UPRT – Upper Respiratory Tract Infection; LRTI – Lower Respiratory Tract Infection; ARDS – Acute Respiratory Distress Syndrome; CS – Cytokine Storm

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 with a COVID-19 case. Therefore, upon exposure, these individuals may be at higher risk to be

[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.

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.

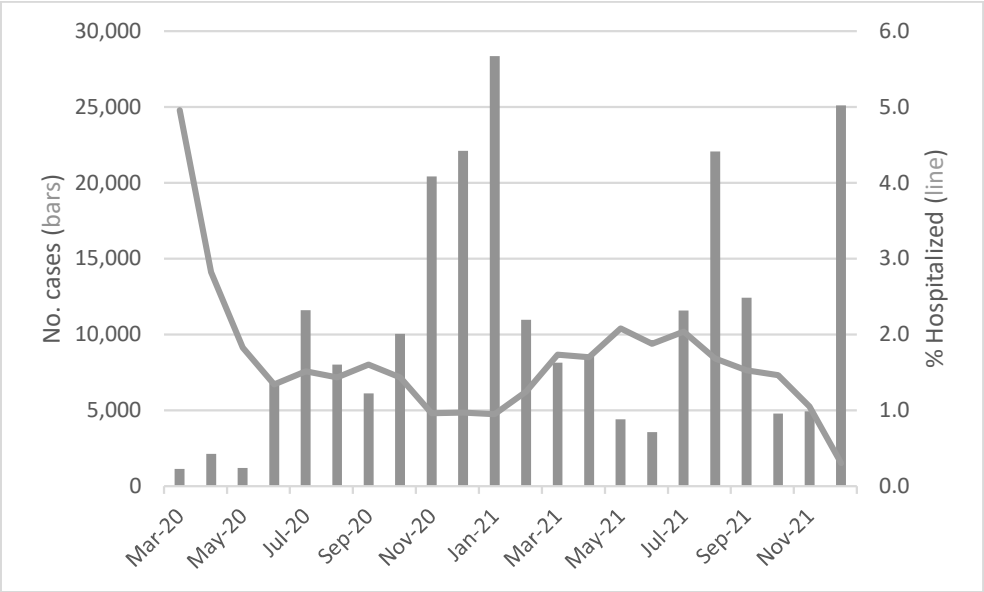
Table. COVID-19 cases, hospitalizations, and deaths among active duty service members, February 2020 - December 2021

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

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

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

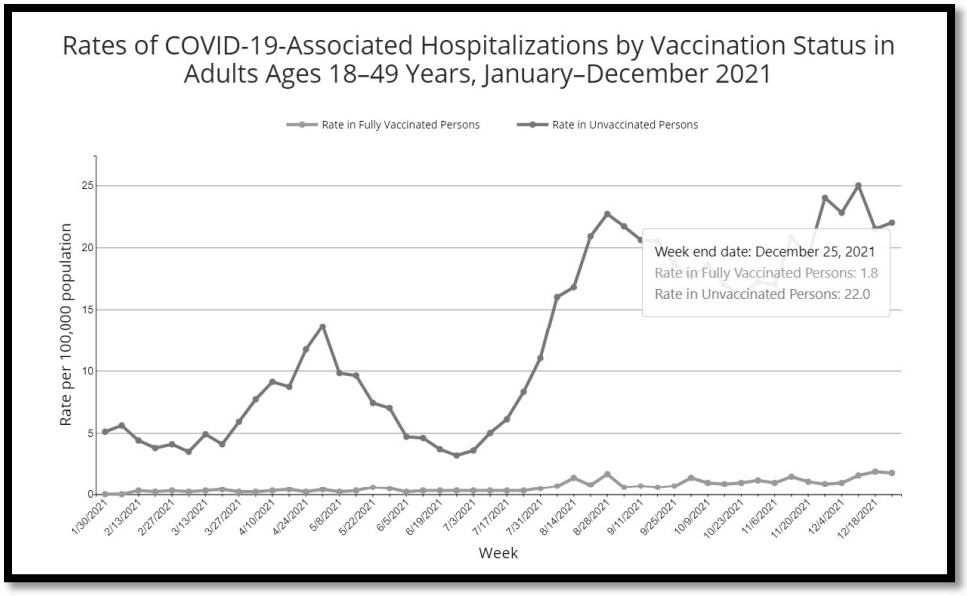
prevention through immunization also mitigates the need for pharmacologic treatment (antibiotics for sepsis, etc.), reducing the risk of drug-resistant pathogen development.

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]

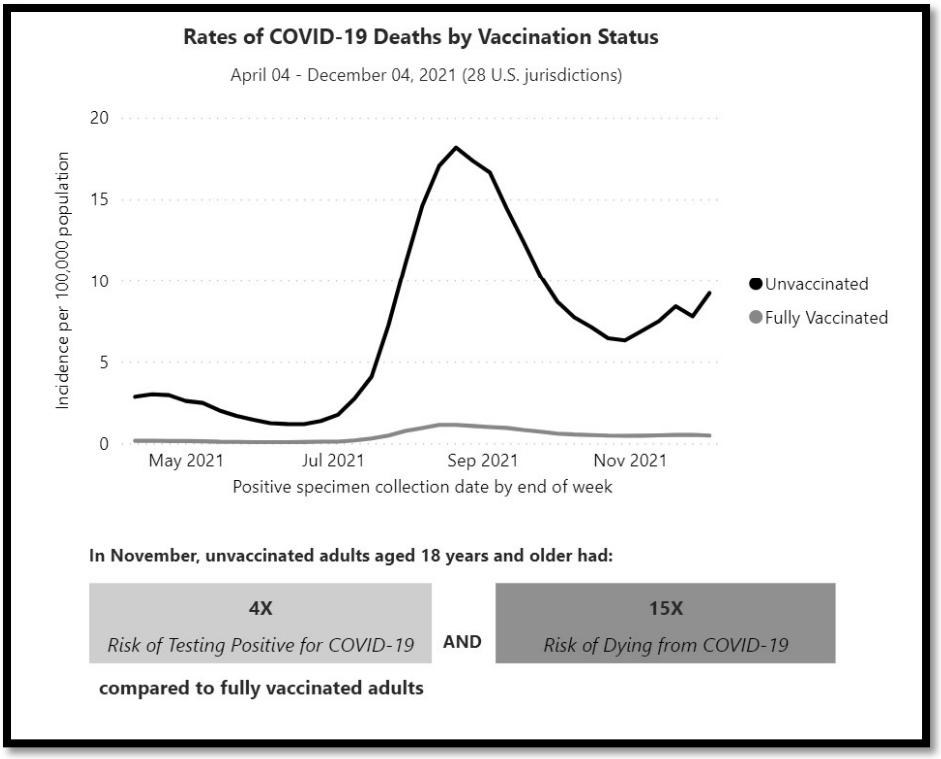
[14] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html, last accessed January 24, 2022.

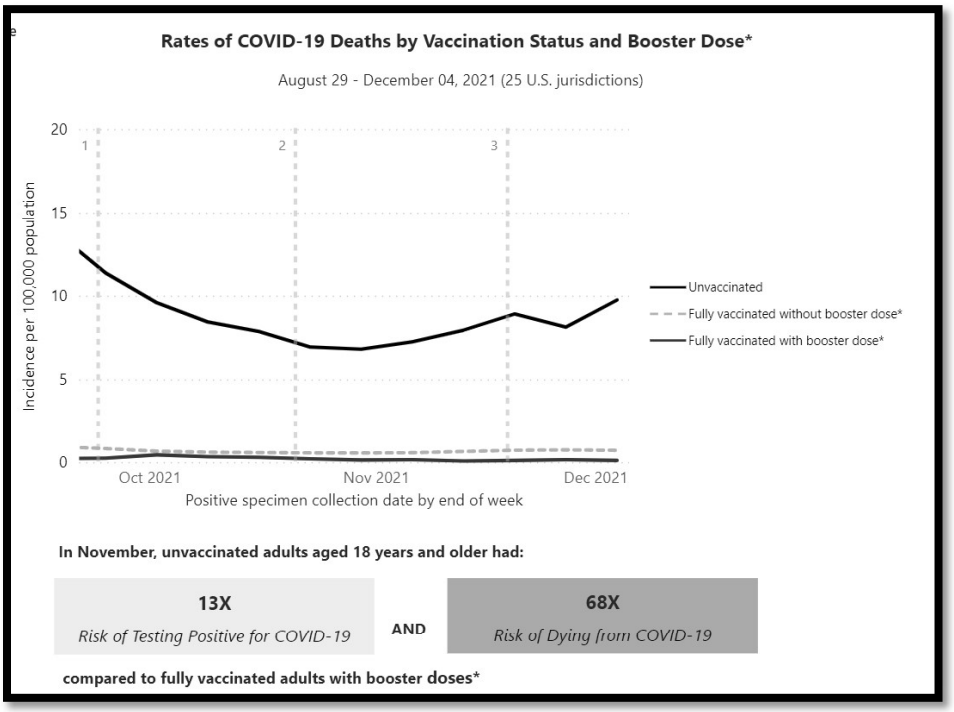
[11] https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, last accessed January 24, 2022.



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. 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 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

[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.

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.

19. 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]

20. 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 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] 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.

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]

21. 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.

22. 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.

23. "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.

---

[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

24. 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]

25. 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.

26. 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.

27. 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.

28. 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%).

[18] 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.

29. 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.

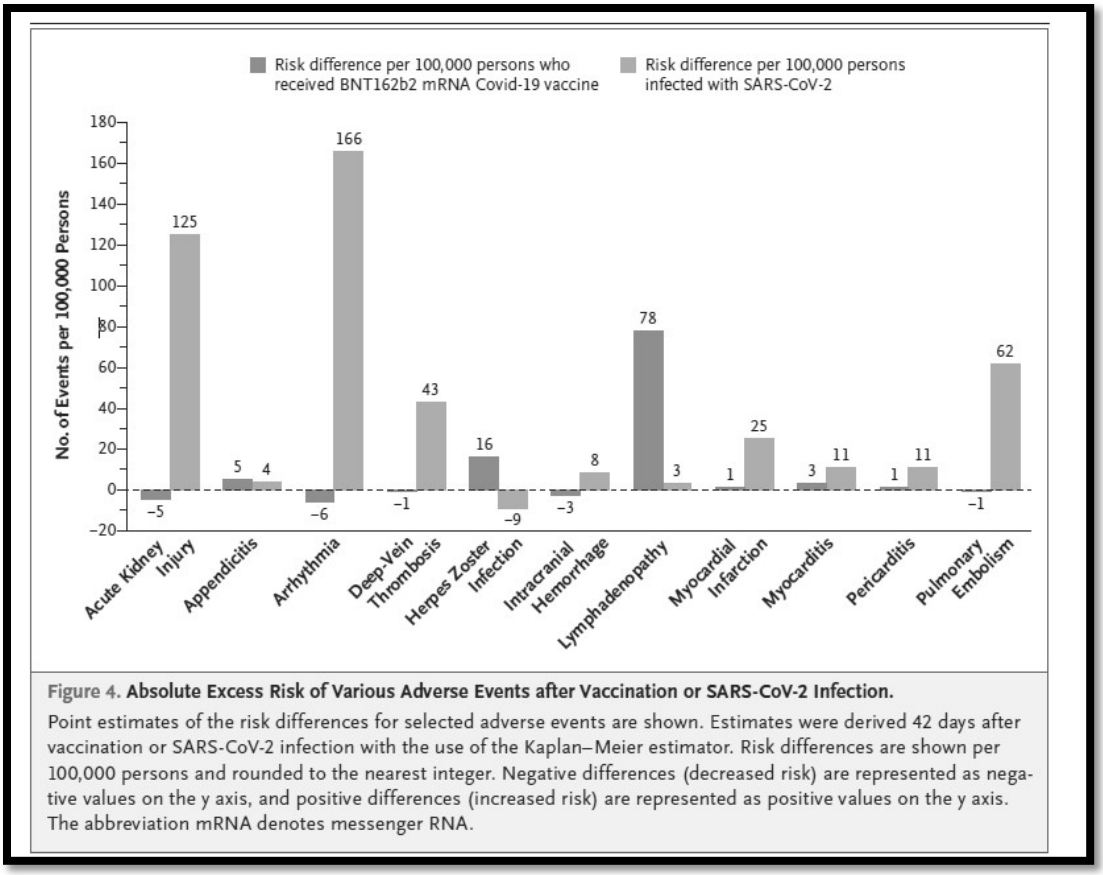


Figure 4. Absolute Excess Risk of Various Adverse Events after Vaccination or SARS-CoV-2 Infection.

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

30. 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]

31. 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]

32. 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.

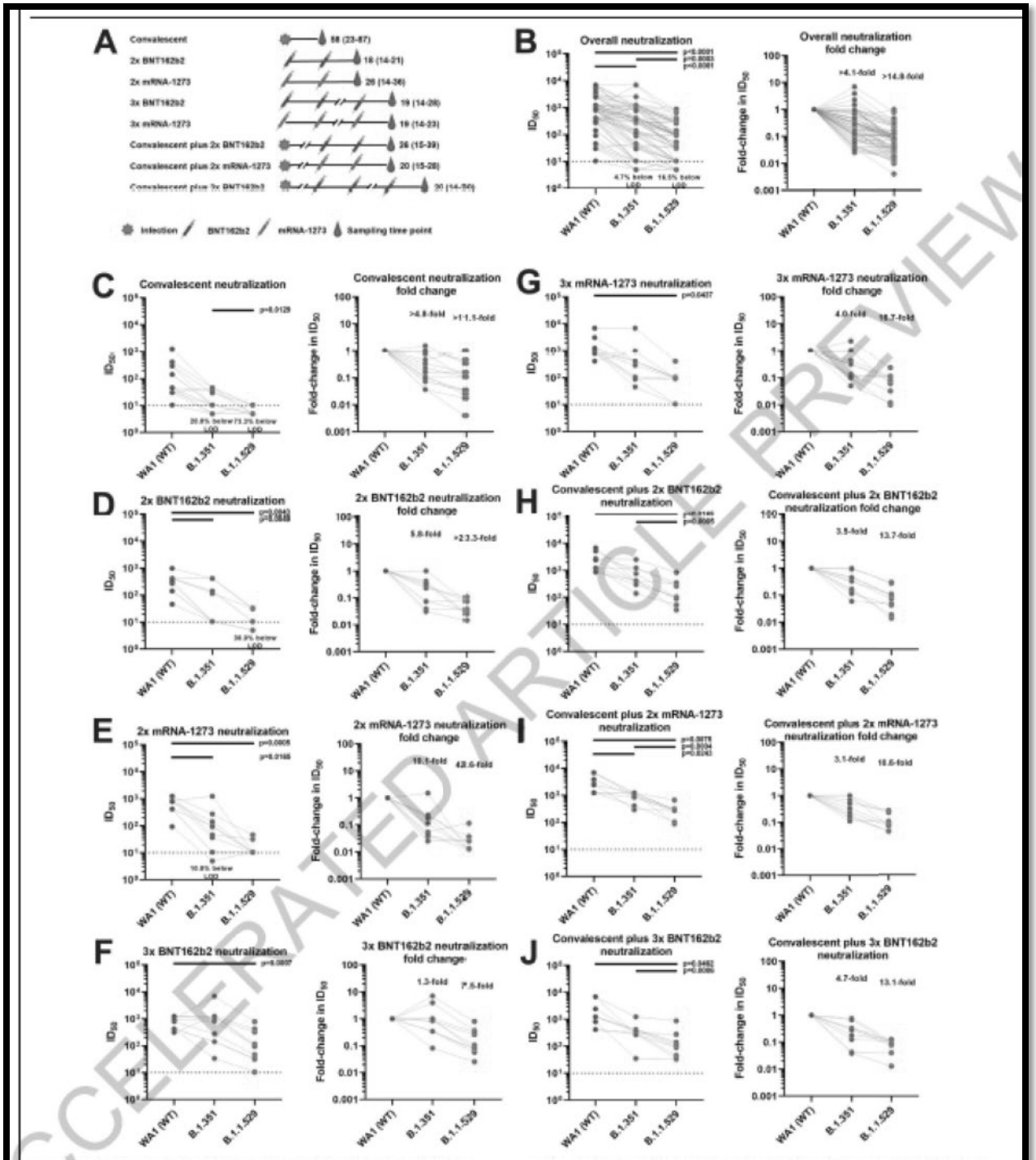
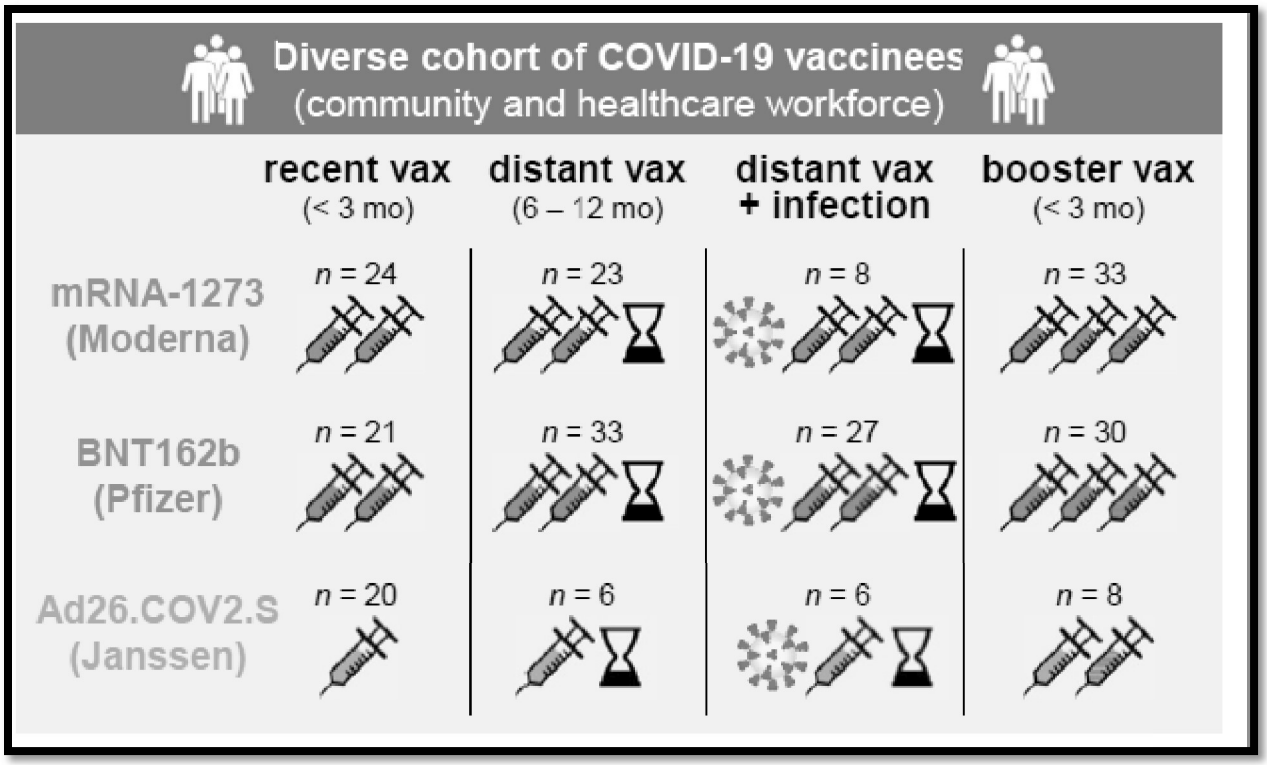


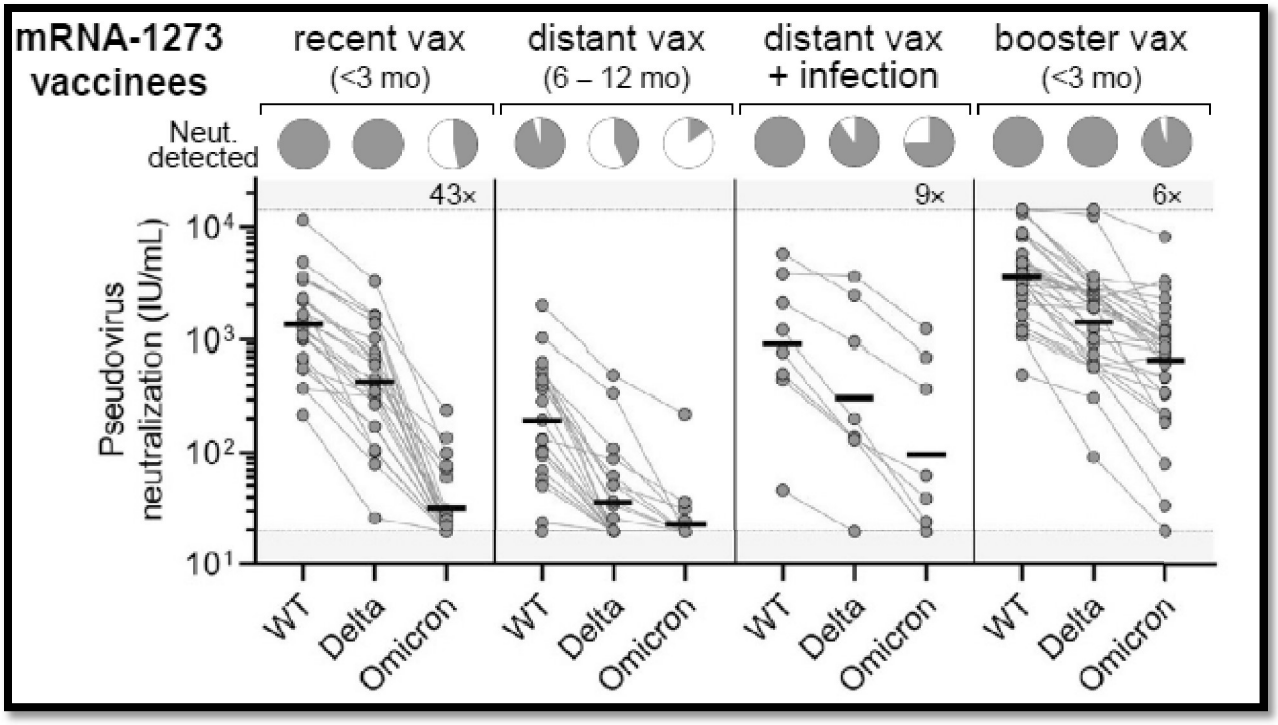
Fig. 1 | Sera of convalescent and vaccinated individuals have strongly reduced neutralizing activity against Omicron as compared to wild type SARS-CoV-2. A Overview of different exposure groups from whom samples were obtained. Further details are provided in Supplemental Table 1 and 2. **B** shows absolute 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.

33. 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.

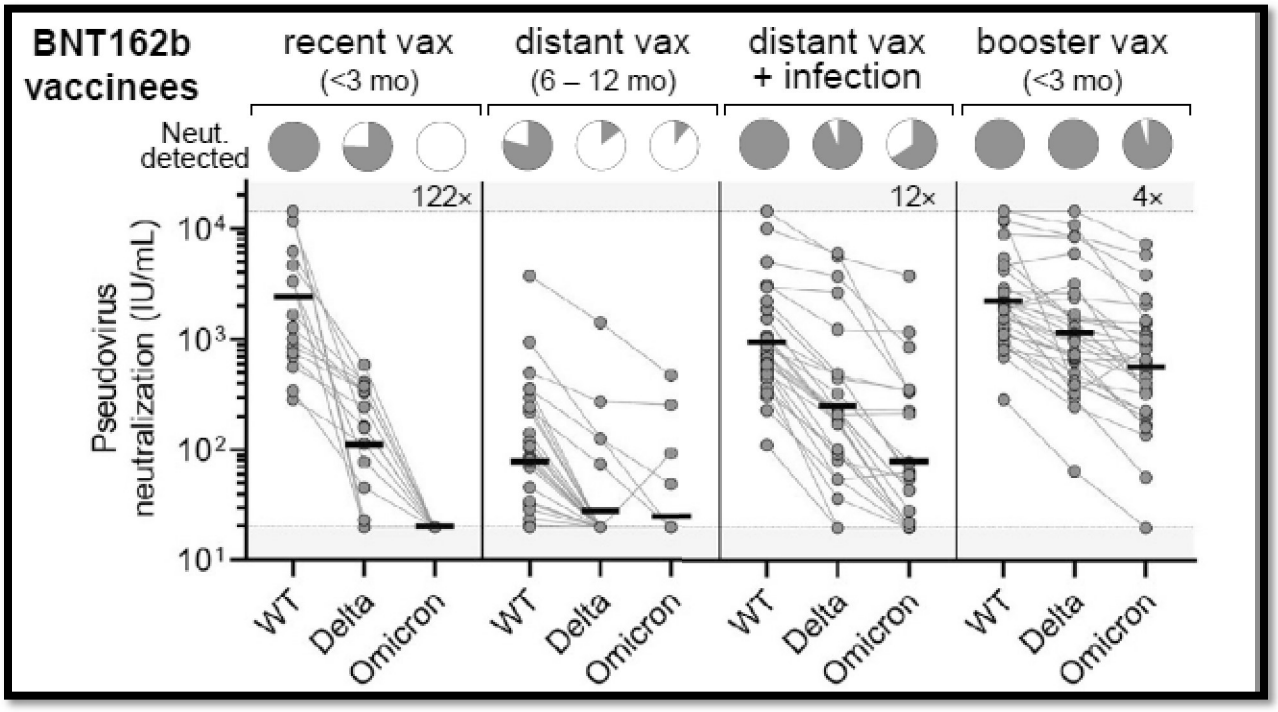


34. Against the Omicron variant, recent (< 3 months) vaccine recipients exhibited a 43-fold lower neutralization than the wild type (WT). Those with a history of vaccination and infection had a 9-fold decrease in neutralization than WT, whereas those who received a booster dose less than 3 months ago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

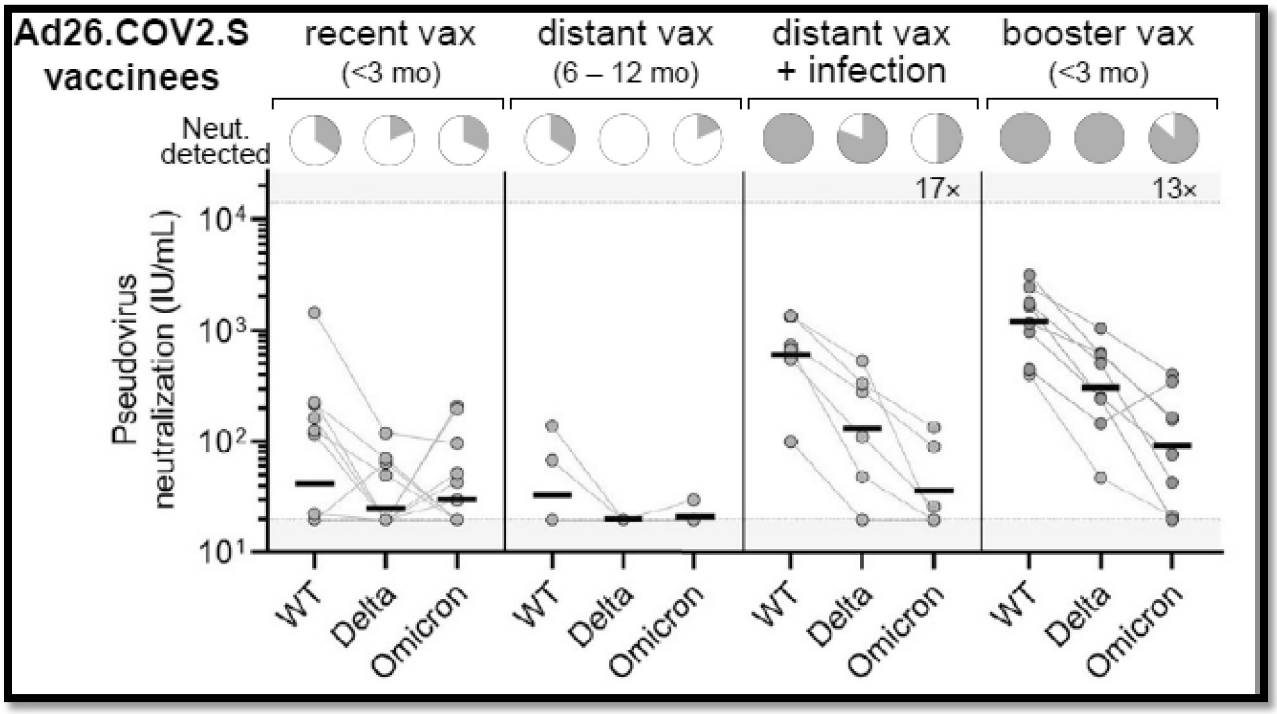
[36]Garcia-Beltran WF, et al mRNA-based COVID-19 vaccine boosters induce neutralizing immunity against SARS-CoV-2 Omicron variant. Cell 185, 1-10, accessed January 29, 2022



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



36. 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.



37. 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."

38. 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.

39. 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

40. 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.

41. 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

42. 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.

****

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 January 31, 2022, in Falls Church, Virginia

RANS.TONYA.SUE.1081263031
Digitally signed by RANS.TONYA.SUE.1081263031
Date: 2022.01.31 12:45:28 -05'00'

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

Exhibit 5

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
DAYTON DIVISION

MICHAEL POFFENBARGER,

Plaintiff,

v.

FRANK KENDALL, *et al.*,

Defendants.

No. 3:22-cv-1-TMR-SLO

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 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.

****

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

Executed on January 28, 2022 in Washington, DC.

STANLEY.SCOTT.E.1169637659 Digitally signed by STANLEY.SCOTT.E.1169637659 Date: 2022.01.28 11:45:37 -05'00'

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

Exhibit 6

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

MICHAEL POFFENBARGER,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 3:22-cv-00001
	)	
FRANK KENDALL, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF COLONEL JAMES R. POEL

I, James R. Poel, hereby state and declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as the Chief of Public Health at the Air Force Medical Readiness Agency (AFMRA). I have been in this position since July 31, 2018. As a part of my duties, I am responsible for developing and directing Department of the Air Force (DAF) Public Health and Preventive Medicine policy, directing accessions and assignments for DAF Public Health Officers, and advising the DAF Surgeon General on Public Health matters.[1] I also develop DAF policy for force health protection, immunization recommendations and community health programs to ensure they are consistent with national medical standards and guidelines, improve the health of Airmen and Guardians, and enhance the mission.

[1] The Department of the Air Force includes the U.S. Air Force (including the Air National Guard and the Air Force Reserve) and the U.S. Space Force.

2. I make this declaration in my official capacity as the Chief of Public Health and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. The Air Force depends on healthy personnel to complete its mission to "fly, fight and win . . . airpower anytime, anywhere."[2] When service members become ill, are hospitalized, or die from an infectious disease, they are unable to fulfill their role in achieving the Air Force's mission. Just as important, an infected service member can spread disease to other service members, further undermining the Air Force's ability to accomplish its mission. Any treatment of infected service members impacts the Air Force's ability to meet the medical needs of other service members. The Air Force relies on its vaccine program to protect service members from potential health risks, including infectious disease threats.

4. The Air Force requires vaccination because vaccines are the most effective way of mitigating the risk of spreading infectious diseases to other members, both in non-deployed and deployed environments, and preventing service members from becoming ill and dying. Vaccination has been ranked among the top 10 "Great Public Health Achievements" since 1900[3,4] and has dramatically decreased the number of infectious diseases world-wide over the last century. The main causes of death in the early 1900s were infectious diseases.[5] However,

---

[2] U.S. Air Force, *Air Force unveils new mission statement* (Apr. 8, 2021), https://www.af.mil/News/Article-Display/Article/2565837/air-force-unveils-new-mission-statement/. "Airmen work to support all aspects of airpower, which includes five core missions: air superiority; global strike; rapid global mobility; intelligence, surveillance and reconnaissance; and command and control."

[3] Centers for Disease Control and Prevention (CDC), *Ten Great Public Health Achievements – United States, 1900 – 1999*, Morbidity and Mortality Weekly Report (MMWR), Vol. 48 (12), pages 241–243 (Apr. 2, 1999), *available at* https://www.cdc.gov/mmwr/pdf/wk/mm4812.pdf;

[4] CDC, *Ten Great Public Health Achievements – United States, 2001 – 2010*, Morbidity and Mortality Weekly Report, (MMWR), Vol. 60 (19), pages 619–623 (May 20, 2011), *available at* https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm.

[5] CDC, *Achievements in Public Health, 1900-1999: Control of Infectious Diseases*, MMWR, Vol. 48(29), pages 621-629 (July 30, 1999), *available at* https://www.cdc.gov/mmwr/preview/mmwrhtml/mm4829a1.htm.

since the introduction of vaccines, many previously deadly diseases are rarely seen today. Cases of measles and polio, for example, have been dramatically reduced by 80–99%.[6,7] But these diseases have not been entirely eradicated, so continued vaccination is necessary. For example, 159 cases of measles were reported in the United States over an eight month period in 2013, and 11% of those cases required hospitalization. The majority of those cases (82%) were unvaccinated individuals.[8] Vaccines are therefore crucial to keeping diseases at bay. As the number of unvaccinated people increases, the risk of resurgence of such diseases and their associated morbidity and mortality, increases.

5. Vaccines prevent infectious disease and have long been a cornerstone of military strategy. Disease and non-battle injury have historically been a greater threat to military personnel than battle injuries. There are numerous examples where the use of vaccines has enhanced the U.S. military mission by drastically curtailing morbidity and mortality among U.S. military personnel.[9, 10] "Influenza vaccine development was a high priority for the U.S. military after the deaths of approximately 1 in every 67 soldiers from influenza during the 1918-1919 pandemic."[11] The first influenza vaccine was first adopted for use by the Army in 1943, but out of fear for a winter outbreak of influenza, the Army directed influenza vaccination for all Army personnel on September 3, 1945.[12] Today, all active duty and reserve component personnel are

[6] World Health Organization (WHO), *10 Facts on Polio Eradication* (Apr. 1, 2017), https://www.who.int/news-room/photo-story/photo-story-detail/10-facts-on-polio-eradication.
[7] Centers for Disease Control and Prevention (CDC), *Measles Data and Statistics* (Apr. 16, 2019), https://www.cdc.gov/measles/downloads/measlesdataandstatsslideset.pdf.
[8] CDC, *Measles – United States, January 1 - August 24, 2013*, MMWR, Vol. 62(36), pages 741-43 (Sept. 13, 2013), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6236a2.htm.
[9] Gaberstein J, Pittman P, Greenwood J, Engler R, Immunization to Protect the US Armed Forces: Heritage, Current Practice and Prospects. *Epidemiologic Reviews*, Vol 28, 2006, pgs. 3-26.
[10] Lemon S, Thaul S, Fisseha S, O'Maonaigh H, editors, Protecting Our Forces: Improving Vaccine Acquisition and Availability in the US Military, National Academies Press, 2002.
[11] College of Physicians of Philadelphia; The History of Vaccines: Influenza, https://www.historyofvaccines.org/content/articles/influenza; last updated 25 Jan 2018.
[12] War Department Circular No. 267, Influenza – Vaccination of Army Personnel, 5 September 1945.

required to receive the annual seasonal influenza immunization or obtain an exemption. AFI 48-110, ¶ 4–7(a).

6. Vaccines are vital to ensuring the health and safety of the force, maintaining mission readiness, and essential to protecting the individual from infectious diseases and preventing transmission to other military members with whom he or she interacts. This is even more important for those military duties and positions that require interacting with others in close quarters on a regular basis.

7. Vaccinations are also important in providing protection for Service members who are unable to receive one or more vaccines due to medical issues. Those issues can be temporary (e.g., during pregnancy) or permanent (e.g., allergic or severe adverse reaction to ingredients in a vaccine).[13] Medical exemptions are provided in those situations. 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.

8. Second Lieutenant (2d Lt) Michael Poffenbarger's request for a religious accommodation to be exempt from the COVID-19 vaccine is based on his stated opposition to the use of aborted fetal cells in the "design, production, [or] testing phases"[14] of vaccine development. He also states that he opposes the use of mRNA vaccines (i.e., the Pfizer-BioNTech and Moderna COVID-19 vaccines) because they use "the recipient's cells to manufacture the S1 spike protein"[15] and the Johnson & Johnson/Janssen vaccine because it uses "a viral vector instead of

[13] The Department of the Air Force only granted temporary medical exemptions from the COVID-19 vaccine. This allows individuals who have a temporary medical condition (e.g., pregnancy) to get vaccinated after that temporary condition has resolved. This also allows the Air Force to reassess individuals with allergies or severe adverse reactions to determine whether a vaccine has been approved which constitutes the member can safely take.
[14] 2d Lt Poffenbarger memorandum, *Appeal of Religious Accommodation Request Denial*, dated October 30, 2021.
[15] Id.

mRNA to enter the recipient's body to produce the protein spike."[16] He states that he believes "using these technologies to force our bodies to manufacture this pathogenic protein is not a part of God's plan for our bodies."[17] The nature of his objections potentially would exclude the use of many vaccines in the future.

9. Other proposed means of accommodating 2d Lt Poffenbarger's request for an exemption from the COVID-19 vaccine would not be as effective and would hinder the Air Force mission. Evaluating his request entails evaluating whether practices, other than immunizations, to reduce the member's risk of infectious diseases and transmission can meet an equivalent level as if he were fully immunized. Unfortunately, short of fully isolating the member in a role that prevents contact with others – which is not practicable – I am not aware of any way to reduce the risks of contracting, transmitting, and physically combatting COVID-19 to the same level as if he were fully immunized.

10. Vaccinated members clear the virus faster and therefore are contagious for fewer days than those unvaccinated.[18,19,20] Transmission of COVID-19 can occur in vaccinated individuals,[21] but vaccinated individuals are much less likely to develop severe disease, be

[16] Id.
[17] Id.
[18] Singanayagam, A., et al., "Community transmission and viral load kinetics of the SARS-CoV-2 delta (B. 1.617. 2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study," *The Lancet Infectious Diseases* (2021).
[19] Chia, PY., et al., "Virological and serological kinetics of SARS-CoV-2 delta variant vaccine-breakthrough infections: a multi-center cohort study," *medRxiv* 2021 (July 31,2021), https://doi.org/10.1101/2021.07.28.21261295 (preprint).
[20] Kissler, SM., et al., "Viral Dynamics of SARS-CoV-2 Variants in Vaccinated and Unvaccinated Individuals," *medRxiv* 2021 (Aug. 25, 2021), https://doi.org/10.1101/2021.02.16.21251535.
[21] One study found that the infection rate among vaccinated people from a family member or roommate infected with the Delta variant was 25% with prolonged, close contacts. *See* Singanayagam, Anika, et al., "Community transmission and viral load kinetics of the SARS-CoV-2 delta (B. 1.617. 2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study," *The Lancet Infectious Diseases* (2021).

hospitalized, or die.[22,23] With the Delta variant (which was the primary variant in the United States when 2d Lieutenant Poffenbarger's request was denied), fully-vaccinated individuals had a 5-fold decreased risk of infection, a 13-fold decreased risk of hospitalization, and a 14-fold decreased risk of death compared to unvaccinated individuals.[24] Early studies from South Africa of vaccine effectiveness against the Omicron variant indicated the Pfizer vaccine was effective, although at a reduced level, against hospital admissions for COVID-19.[25] Similarly, the United Kingdom Security Agency published a recent technical report, indicating reduced efficacy against symptomatic disease from the Omicron variant after 2 doses of Pfizer or Moderna COVID-19 vaccines; however, vaccine efficacy increased to levels comparable to the Delta variant effectiveness after a third or booster dose.[26] Protection against hospitalization is much greater, in particular after a booster dose. In summary, a fully vaccinated service member is less likely to contract COVID-19 than an unvaccinated Service member and, if infected, is more likely to recover quicker and get back to the fight, minimizing the impact to mission accomplishment.

11. I have reviewed the declaration of Colonel Tonya Rans, dated January 31, 2022, regarding the effectiveness of the COVID-19 vaccine. My understanding of the effectiveness of the COVID-19 vaccine comports with the information in Colonel Rans's declaration.

---

[22] CDC, *The Possibility of COVID-19 After Vaccination: Breakthrough Infections* (Nov. 9, 2021), https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html

[23] Tenforde, Mark W., et al., "Association Between mRNA Vaccination and COVID-19 Hospitalization and Disease Severity," *JAMA* (2021).

[24] Two websites, https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status and https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, provide updated data regarding the effectiveness of vaccination against a) testing positive, b) being hospitalized, and c) dying from COVID-19. The data analyzed is from April through November 2021 and thus addresses vaccine efficacy during the Fall 2021 Delta variant wave.

[25] Collie, S, et al, Effectiveness of BNT162b2 Vaccine against Omicron Variant in South Africa, New England Journal of Medicine, DOI: 10.1056/NEJMc2119270; 29 Dec 2021.

[26] United Kingdom Health Security Agency, (UKHSA) SARS-CoV-2 variants of concern and variants under investigation in England, Technical briefing 34, pages 1-36, Publishing Reference: GOV-10924 (14 Jan 2022).

Masks

12. Masking is a critical public health measure for preventing the spread of respiratory diseases, like COVID-19. However, while wearing a mask may decrease transmission of some diseases, such as COVID-19, masking is not as effective as vaccination. The effectiveness of face masks depends upon the behavior of the wearer. Face masks are less effective if they are not tight fitting, not double layered, worn only around the mouth, taken off frequently, and adjusted frequently increasing hand/finger contact with one's face.

13. Cloth face coverings and surgical masks provide source control (reduction of virus shed by someone infected) and personal protection (filtering out of virus for the mask wearer) against small inhalable infectious particles. The Centers of Disease Control and Prevention (CDC) recently updated mask guidance by (a) clarifying that people can choose respirators such as N95s and KN95s, (b) removing concerns related to supply shortages for N95s, (c) clarifying that the "surgical N95s" are reserved for healthcare settings, and (d) some types of masks and respirators provide more protection than others.[27] Regarding types of masks to use, the CDC explained that N95 and KN95 masks work better than cloth masks which are better than no masks. They acknowledged human behavior limits the effectiveness of masks when they are not worn consistently and correctly and recommended wearing a mask with the best fit, protection, and comfort for the individual. As source control, consistent and correct wear of multiple-layered cloth masks filter out 50–70% of viral particles and limit the distance of spread for the remaining virus. For the wearer, consistent and correct wear of a multiple-layered cloth mask can filter out up to 50% of viral particles. When near others, many people do not constantly wear their mask and when wearing it, many do not wear a clean (or new) mask daily with a snug fit (no gaps)

[27] CDC, Types of Masks and Respirators, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html.

over the mouth and nose. Even when worn consistently and correctly, extended durations in close contact with an infectious person can still lead to transmission. Data suggest that consistent, correct mask wear decreases COVID-19 incidence by 10–79%,[28] but typical use in the general population is not nearly this effective. Mask mandates decrease transmission by 2–29% and mortality by 45.7%.[29]

14. If two individuals in an indoor environment are wearing a typical cloth mask, the receiver's time to an infectious dose increases by minutes. If both people are wearing a surgical mask, the time to receive an infectious dose increases to an hour. If both people are wearing a non-fit-tested N-95, the time to an infectious dose increases to over 6 hours.[30] The protection provided, however, varies based on human behavior – type of mask worn, how the mask is worn, in what settings it is worn, etc. Accordingly, mask wear is a supplement to, but not an effective substitute for, vaccination.

15. Additionally, masks are limited to controlling the spread of the virus. Masks provide no protection to a service member who is infected with COVID-19. Unlike vaccination, a mask does not decrease the risk of serious illness, complications (e.g., hospitalization, long COVID), or death, and does not shorten recovery time.

Temperature Checks & Testing

16. Checking a service member's temperature alone to screen for COVID-19 is not an adequate screening tool for several reasons. Temperature checks only identify if a service

[28] CDC, *Science Brief: Community Use of Masks to Control the Spread of SARS-CoV-2* (Dec. 6, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html.
[29] Talic S, et al., Effectiveness of Public Health Measures in Reducing the Incidence of COVID-19, SARS-CoV Transmission, and COVID-19 Mortality: Systematic Review and Meta-Analysis. *British Medical Journal* 2021; 375: e068302. https://www.bmj.com/content/375/bmj-2021-068302
[30] Brosseau, LM., et al., *Commentary: What Can Masks Do? Part 1: The Science Behind COVID-19 Protection* (Oct. 14, 2021), https://www.cidrap.umn.edu/news-perspective/2021/10/commentary-what-can-masks-do-part-1-science-behind-covid-19-protection.

member has a fever; they do not identify if a member is infected with SARS-CoV-2. A fever is a symptom of many illnesses or conditions, including influenza, common cold, injury, side effect from medication, or over-exertion. Additionally, an individual infected with COVID-19 may be asymptomatic or not have fever as one of their symptoms. Finally, non-contact thermometers and thermal cameras may not provide an accurate reading of the individual's core body temperature, have not been accurate when evaluating multiple people over time, or have mixed results when used to reduce the spread of disease at points of entry to countries.[31, 32]

17. Two primary tests are used to detect infection with SARS-CoV-2: PCR tests and antigen tests. Each test detects different parts of the virus in different ways and vary by cost, resources required, and speed or turn-around-time of the results. PCR tests are highly sensitive and accurate. However, they are expensive, may take an hour or more from start to finish and must be accomplished by skilled lab technicians in a certified lab. Antigen tests, on the other hand, do not require special skills to complete them, are less expensive and provide results in a quarter of the time required for a PCR test. However, antigen tests may provide less accurate results if not done properly or if the person is in the early stages of COVID-19 and asymptomatic with a small amount of virus in their body.

18. Antigen tests have a 52.5% chance in those asymptomatic and a 76.7% chance in those symptomatic to identify individuals with COVID-19.[33] With twice weekly testing, the

[31] Nuertey, BD, et al*, Performance of COVID-19 associated symptoms and temperature checking as a screening tool for SARS-CoV-2 infection,* PLOS One, (Sep 17, 2021) https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0257450

[32] US Food and Drug Administration, Thermal Imaging Systems (Infrared Thermographic Systems / Thermal Imaging Cameras), (updated 12 Jan 2021) https://www.fda.gov/medical-devices/general-hospital-devices-and-supplies/thermal-imaging-systems-infrared-thermographic-systems-thermal-imaging-cameras

[33] Brummer LE., et al., (2021) Accuracy of Novel Antigen Rapid Diagnostics for SARS-CoV-2: A Living Systematic Review and Meta-Analysis. *PLOS Medicine* 18(8): e1003735. https://doi.org/10.1371/journal.pmed.1003735

sensitivity increased to 76.3% without regard to symptoms, to 83.8% within the first week of symptoms, and 95.8% for those with a high viral load.[34] As most Service members who are using the antigen test for workplace entry or travel will likely be asymptomatic for the required weekly testing (symptomatic service members are more likely to get tested in a medical setting at the onset of symptoms with a PCR test), the chance to identify a member that is actually infected is a little better than 50% with a single antigen test.[35]

19. Most instructions for antigen tests direct at least twice a week, serial testing followed by confirmatory testing (PCR test) in case of a positive antigen test. Research indicates testing with an antigen test at least every three days increases the probability of detecting a true positive to a level closer to a weekly PCR test (98.7% accuracy), but detection may not be prior to infectivity. For example, serial antigen testing at least every three days detected true positives with a 95.9% accuracy within a 14-day period from infection. The rate of antigen test detection prior to the first day of infectivity is 37.5%. On the day of peak infectivity viral detection is only 90%.[36]

20. Overall, serial antigen testing of asymptomatic members will detect most infections, but the member will likely be infectious prior to the test becoming positive. Serial testing will curtail the exposure in the unit after the infection is detected, but this is not as effective as preventing the original infection.

---

[34] More frequent antigen testing increases the chance of detecting the optimal amount of virus at the earliest possible moment. For example, if an individual is infected on Sunday, takes an antigen test on Monday, but has an optimal amount of viral antigen on Wednesday, Monday's test will likely be a false negative.

[35] Brummer LE., et al., Accuracy of Novel Antigen Rapid Diagnostics for SARS-CoV-2: A Living Systematic Review and Meta-Analysis. *PLOS Medicine* 18(8): e1003735 (2021); https://doi.org/10.1371/journal.pmed.1003735.

[36] Smith, Rebecca L., et al., "Longitudinal assessment of diagnostic test performance over the course of acute SARS-CoV-2 infection," *medRxiv* (2021).

21. Additionally, testing can only identify the virus and does not prevent the Service member from becoming infected in the first place. Likewise, temperature checks identify only if a member has a fever and do not prevent a member from becoming infected. As with masking, testing and temperature checks provide no protection for an individual who is already infected and do not reduce the risk of illness, complications (e.g., long COVID, hospitalization), or death. Nor do temperature checks and testing reduce the length of recovery time after infection.

"Natural Immunity"

22. Contrary to 2d Lt Poffenbarger's assertion, there is no "recognized, long standing, natural immunity" against COVID-19. While evidence of prior infection is considered adequate documentation for some vaccine requirements such as measles, mumps, rubella, varicella (chickenpox), and hepatitis B virus, there are other vaccine-preventable pathogens where previous infection does not induce life-long sterilizing immunity, and prior infection is not considered an acceptable medical exemption (e.g., influenza, adenovirus).[37]

23. Although COVID-19 disease does provide some degree of natural immunity to SARS-CoV-2 virus, the length and completeness of protection varies. Current evidence has not determined an antibody threshold indicative of protection from re-infection. Nor is there an FDA-authorized or FDA-approved test to assess this. Evidence is also inadequate to associate specific antibody levels with the degree of re-infection risk for an individual.[38] One to ten percent of people do not develop long-lasting (IgG-type) antibodies following confirmed COVID-19 infection (vs. 100% developing antibodies for the mRNA vaccines and 90% for

[37] Defense Health Agency Procedural Instruction, *Guidance for the DoD Influenza Vaccination Program* (Aug. 21, 2020).
[38] CDC, *Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity* (Oct. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html.

Johnson & Johnson/Janssen).[39, 40] Antibody titers, a measurement of the amount of antibody in a person's blood, peak at 3 to 5 weeks after infection and then begin to wane. Neutralizing antibodies, or antibodies which eliminate a pathogen before an infection takes place, demonstrate approximately a 50% reduction within 2 to 3 months and become undetectable in up to 30% of people within 10 months post-infection.[41] Mild or asymptomatic COVID-19 infections tend to generate lower antibody levels than those with severe disease.[42] Overall, the duration of protection varies depending on disease severity, person's age, antibody assay utilized, and variants of the virus.[43] After infections with the original SARS-CoV-2 strain, detectable neutralizing antibodies were found in 84% of people for the Alpha variant, 68% for the Delta variant, and 55% for the Beta variant.[44]

24. Both natural and vaccine immunity decrease the risk of re-infection. Studies vary on their conclusions regarding whether the infection rate is equivalent, lower, or higher in those fully vaccinated compared to those previously infected. The varying conclusions show there is still a lot that is unknown about the strength, consistency, and duration of protection from prior SARS-CoV-2 infection. These studies are not conclusive and it is not prudent to rely on isolated studies as authoritative. In two studies, prior infection (without subsequent vaccination) was associated with 2.3 times the odds of reinfection and 5.49 times the rate of hospitalization with

[39] World Health Organization, *COVID-19 Natural Immunity: Scientific Brief* (2021), https://apps.who.int/iris/handle/10665/341241.
[40] CDC, *Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity* (Oct. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html.
[41] CDC, *Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity* (Oct. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html.
[42] Long, Q.X., Tang, X.J., Shi, Q.L., Li, Q., Deng, H.J., Yuan, J., Hu, J.L., Xu, W., Zhang, Y., Lv, F.J., et al., Clinical and immunological assessment of asymptomatic SARS-CoV-2 infections, *Nat. Med*. 26, 1200-1204, (2020).
[43] World Health Organization, *COVID-19 Natural Immunity: Scientific Brief* (2021), https://apps.who.int/iris/handle/10665/341241.
[44] CDC, *Science Brief: SARS-CoV-2 Infection-Induced and Vaccine-Induced Immunity* (Oct. 29, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html.

re-infection compared with being fully vaccinated.[45,46] In contrast, another study showed that at six months from vaccination or infection, the rate of breakthrough or re-infection was 13-fold higher for those vaccinated without prior infection than those with only prior infection,[47] indicating prior infection imparts some protection. Similarly, a recent study indicates during the Delta wave, both COVID-19 vaccination and surviving a prior infection provided protection against infection and hospitalization from COVID-19 as case rates and related hospitalizations increased at a lower rate among both vaccinated and unvaccinated persons with prior COVID-19 diagnosis. This study, however, did not include information on the severity of initial infection[48] and did not reflect the risk of morbidity and mortality from COVID-19 infection.[49] Both latter studies, while indicating prior infection imparts some protection, show the added benefit of vaccination for those previously infected. Vaccination provides a strong boost in protection for people who have recovered from COVID-19, resulting in a 1.85 to 2.34-fold decreased risk of re-

[45] Cavanaugh, A. M., Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination—Kentucky, May–June 2021, *MMWR. Morbidity and Mortality Weekly Report*, 70(32) (Aug. 13, 2021), *available at* https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm.

[46] Bozio CH., et al. Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity—Nine States, January-September 2021, *MMWR. Morbidity and Mortality Weekly Report*, 70(44) (Nov. 5, 2021), *available at* https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm.

[47] Gazit S., et al., Comparing SARS-CoV-2 Natural Immunity to Vaccine-Induced Immunity: Reinfections Versus Breakthrough Infections (Aug. 25, 2021), https://doi.org/10.1101/2021.08.24.21262415.

[48] Personnel with more severe infection have a larger antibody response. In a study of SARS-CoV-2 infected indiviuduals, a more severe disease indicated a larger memory B cell response to the SARS-CoV-2 spike protein. Guthmiller JJ, Stovicek O, Wang J, et al. SARS-*CoV-2 Infection Severity Is Linked to Superior Humoral Immunity against the Spike*. mBio. 2021;12(1):e02940-20. Published 2021 Jan 19. doi:10.1128/mBio.02940-20,

[49] León TM, Dorabawila V, Nelson 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. (Jan. 19, 2022), https://www.cdc.gov/mmwr/volumes/71/wr/mm7104e1.htm?s_cid=mm7104e1_w.

infection.[50,51,52] Overall, boosting the immune system with a vaccine after infection or initial vaccine series is effective for decreasing the risk of subsequent infection.

Isolation & Social Distancing

25. Effectiveness of social distancing depends on the specific activity being conducted (e.g., sitting quietly vs. yelling orders or speaking loudly in a classroom setting vs. constant intermingling during a social event, such as a holiday party). A systematic review of physical distancing of at least three feet to prevent SARS-CoV-2 transmission demonstrated a 25% reduction in transmission.[53] Although infections through inhalation at distances greater than three to six feet from an infectious source are less likely than at closer distances, infections even at these distances have been repeatedly documented under certain preventable circumstances.[54,55,56] These transmission events have involved the presence of an infectious person exhaling virus indoors for an extended time (more than 15 minutes and in some cases hours) leading to virus concentrations in the air space sufficient to transmit infections to people more than six feet away, and in some cases to people who have passed through that space soon after the infectious person left.

---

[50] Cavanaugh, A. M., Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination—Kentucky, May–June 2021. *MMWR. Morbidity and Mortality Weekly Report*, *70*(32) (Aug. 13, 2021), *available at* https://www.cdc.gov/mmwr/volumes/70/wr/mm7032e1.htm.
[51] Stamatatos L., et al., mRNA Vaccination Boosts Cross-Variant Neutralizing Antibodies Elicited by SARS-CoV-2 Infection, *Science* 372 (6549): at 1413–1418 (Mar. 25, 2021), https://doi.org/10.1126/science.abg9175.
[52] Gazit S., et al., Comparing SARS-CoV-2 Natural Immunity to Vaccine-Induced Immunity: Reinfections Versus Breakthrough Infections (Aug. 25, 2021), https://doi.org/10.1101/2021.08.24.21262415.
[53] Talic S, et al. Effectiveness of Public Health Measures in Reducing the Incidence of COVID-19, SARS-CoV Transmission, and COVID-19 Mortality: Systematic Review and Meta-Analysis. *British Medical Journal* 2021; 375: e068302. https://www.bmj.com/content/375/bmj-2021-068302.
[54] Lendacki F, et al., COVID-19 Outbreak Among Attendees of an Exercise Facility — Chicago, Illinois, August–September 2020. MMWR, 70(9):321-325 (Mar. 5, 2021), https://pubmed.ncbi.nlm.nih.gov/33661859/.
[55] Katelaris AL, et al., Epidemiologic Evidence for Airborne Transmission of SARS-CoV-2 during Church Singing, Australia, 2020. Emerg Infect Dis. 27(6) (June 6, 2021), https://doi:10.3201/eid2706.210465.
[56] Hamner L, Dubbel P, Capron I, et al. High SARS-CoV-2 Attack Rate Following Exposure at a Choir Practice – Skagit County, Washington, March 2020. MMWR 69(19): 606-610 (May 15, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6919e6.htm.

26. United States data shows isolation/lock-downs have been associated with a 4.9% to 14-fold decrease in transmission.[57] But even if an individual works in an isolated environment by full-time teleworking, that individual still interacts with others in the local community and their household. Thus, working in an isolated environment removes risk from viral transmission to others at work, but it does not eliminate risk of infection and disease complications to the individual to include long-COVID symptoms, hospitalizations, ICU admissions, and deaths.

27. Additionally, isolation is not practicable in this case. 2d Lt Poffenbarger is an (as yet untrained) intelligence officer, where telework or remote work are not feasible. Because he would have to access classified materials and systems, his duties would require him to be trained and then to work in a secured location, which is shared with other Service members and personnel. At his workspace, his desk is a cubicle that is in close proximity to others. While plexiglass barriers are almost ubiquitous in customer service settings for the short interaction between a customer and cashier or bank teller, physical barriers formed by cubicle walls or bookshelves are not as effective in a workplace with multiple people. In a work setting, with a single point of air supply and a single point of extract, the barriers promote the formation of air re-circulation zones, which in turn promote the accumulation of contaminates.[58]

Herd Immunity

28. Herd immunity is not as effective in preventing and controlling the spread of a virus as being vaccinated. Herd immunity occurs when a large portion of the community becomes immune to a disease, thus reducing the spread and impact of the disease. Early in 2020, as the

[57] Talic S, et al. Effectiveness of Public Health Measures in Reducing the Incidence of COVID-19, SARS-CoV Transmission, and COVID-19 Mortality: Systematic Review and Meta-Analysis. *British Medical Journal* 2021; 375: e068302. https://doi.org/10.1136/bmj-2021-068302.

[58] Khankari, Kishor, Analysis of Spread of Airborne Contaminants and Risk of Infection, American Society of Heating, Refrigerating and Air Conditioning Engineers Journal, pgs 15-20, July 2021.

COVID-19 vaccine was being developed, many estimated a vaccine rate of 60-70% would impart herd immunity upon the population and thus end the pandemic. However, there are many reason why this has proven to be a faulty assumption.[59] First, vaccine roll-out and vaccine acceptance rates vary among populations in the community. The vaccination rate among the military cannot be viewed in isolation for determining "herd immunity." For example, while 97% of Active Duty Service members and 92% of Reservists in the Department of the Air Force are fully vaccinated, the vaccination rate for the U.S. population is 75.5%.[60, 61] Considering only one subset of the population (e.g., the U.S. military or Department of the Air Force) to determine herd immunity would be erroneous, since these populations intermingle with other less-vaccinated populations, thus increasing the risk the disease will continue to spread and virus will continue to mutate. The community vaccination rate also varies based on region. For example, as of January 21, 2022, Greene County and Montgomery County, Ohio (where Wright-Patterson Air Force Base is located) have COVID-19 vaccination rates of 58.1% and 58.4% respectively.[62] These vaccination rates may be even lower among small cohorts of people in the community. Thus, while the military may have a higher rate of vaccination, communities and social groups with which military service members associate, may not have as high of a vaccination rate, thus presenting a greater risk of disease. Indeed, 2d Lt Poffenbarger is a Traditional Reservist, meaning that he does not work full-time at Wright-Patterson Air Force Base, and may spend more time than active duty Service members intermingling with the surrounding community.

[59] Aschwanden, Christine, Five Reasons why COVID Herd Immunity is Probably Impossible, Nature Vol. 591 (Mar. 25, 2021).
[60] Official site for the AF's Aeromedical Services Information Management System (ASIMS) Reports, Data current as of Jan. 21, 2022; https://asimsimr.health.mil/main/main.aspx
[61] CDC COVID Data Tracker (data current as of Jan. 24, 2022), https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-total.
[62] State of Ohio Department of Health COVID-19 Vaccine Dashboard (data current as of Jan. 21, 2022), https://coronavirus.ohio.gov/wps/portal/gov/covid-19/dashboards/covid-19-vaccine/covid-19-vaccination-dashboard.

29. Second, the COVID-19 disease continues to mutate, which degrades the overall effectiveness of herd immunity. The Delta and Omicron variants developed in populations which had low rates of vaccination – India for the Delta variant and South Africa for the Omicron variant. Within months, both variants spread throughout the world causing increases in cases, hospitalizations, and deaths. Herd immunity does not necessarily provide protection against these variants. For example, although Israel and the United Kingdom have higher vaccine rates than the United States and likely decreased the rate of hospitalization and death for the vaccinated, herd immunity was insufficient to protect them from increases in COVID-19 cases.[63]

30. The impact of mutations is demonstrated with seasonal influenza, where a new vaccine is required each year to protect against the changing influenza virus. The current COVID-19 vaccines, developed for the Alpha variant, provide better protection than being unvaccinated, but are slightly less effective for the Delta variant, and less effective for the Omicron variant. As the viruses mutate, any herd immunity gained may be lost with subsequent mutations. Persistent mutations, or viral changes which increase the viruses chance of surviving and being transmitted to others, have a greater risk of developing in an unvaccinated, unprotected population. The lower the rate of vaccination, the greater the chance of infection and subsequent mutations.

31. Additionally, although the original belief was that 60%-70% vaccination rate would help end the pandemic, the Air Force's vaccine program is not meant to prevent a pandemic. Instead, as previously noted, the Air Force relies on the Department of Defense vaccine program (and medical readiness program as a whole) to protect Service members from potential health risks to

[63] COVID-19 case, vaccination, hospitalization and death rate data for this statement taken from (a) Johns Hopkins University, Center for Systems Science and Engineering (CSSE) as used by Google search engine (i.e., www.google.com, search terms "Israel COVID case graph") (last accessed Jan. 27, 2022) and (b) Our World Data In Data (https://ourworldindata.org/coronavirus).

ensure a healthy fighting force and mission readiness. Military medical readiness requirements aim to mitigate risk. The Department of Defense requires vaccination for many diseases unrelated to the COVID-19 pandemic, including, for example, influenza, measles, and diphtheria. These requirements include vaccination from diseases that are not contagious through human-to-human transmission, such as tetanus. This is similar to the requirement for Service members to undergo annual dental examinations and meet specific dental requirements (e.g., root canals) in order to be considered medically ready. The need for a root canal could result in a medical evacuation from a deployed environment. As such, the Department of Defense has determined that these requirements are the best method of ensuring mission accomplishment because the vaccine program maximizes the number of Service members vaccinated for each immunization requirement in order to minimize the risk to the individual Service member and to the force of illness, hospitalization, transmission, and adversely impacting the mission of the United States military to protect and defend the nation.

32. Finally, while herd immunity may eventually reduce some of the risk to unvaccinated Service members, it would not be as effective as the member being vaccinated. An unvaccinated individual increases risk of disease to themselves, their colleagues, their family and community. Increased risk of disease in any of these groups may impact the mission by either eliminating the service member, depleting medical resources, or distracting the service member from focusing their work.

Sanitization

33. Improved sanitation also cannot replace vaccination. Many vaccine-preventable diseases are spread through fomites. Fomites are objects or surfaces that, when exposed to infectious agents from bodily secretions (e.g., nasal fluid from sneezing or wiping nose, oral secretions

from coughing) can transmit to others who contact the objects or surfaces. Disease transmission is greatly reduced when surfaces which people touch are clean and when clean water and soap are available to wash hands and surfaces. However, such mitigation efforts must be continuous and do not counter the principle mode of SARS-CoV-2 transmission, exposure to respiratory droplets carrying infectious virus.[64] When individuals work in close proximity and handle the same materials (e.g., documents, desk space, consoles, equipment, door knobs), it is difficult to keep those materials and areas constantly disinfected.

34. Handwashing also is not enough to replace the effectiveness of vaccines. Germs can spread from other people or surfaces when you: (a) touch your eyes, nose, and mouth with unwashed hands, (b) prepare or eat food and drinks with unwashed hands, (c) touch a contaminated surface or objects, or (d) blow your nose, cough, or sneeze into hands and then touch other people's hands or common objects. Washing hands for 20 seconds, with soap and clean water, is one, very important step for preventing the spread of germs, but is less effective for diseases primarily transmitted via airborne transmission. Handwashing is especially important for people before eating or preparing food, before touching your face, after using the restroom, after leaving a public place, after blowing your nose, coughing, or sneezing, after handling your mask, after changing a diaper, after caring for someone who is sick, and after touching animals or pets.[65]

35. Unlike vaccination, hand washing would not provide continuous protection. To effectively reduce disease, hand washing and sanitation regiments must be rigorously and

[64] CDC, *SARS-CoV-2 and Surface (Fomite) Transmission for Indoor Community Environments*, updated Apr. 5, 2021, https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html.
[65] CDC, *When and How to Wash Your Hands* (Aug. 10, 2021), https://www.cdc.gov/handwashing/when-how-handwashing.html.

systematically followed. Individuals frequently touch their face, handle their masks, and can unknowingly touch contaminated objects or surfaces. It is not realistic for the Air Force to put in a system that ensures a member washes their hands for at least 20 seconds any time they touch their face (including when they sneeze or cough) or sanitizes any shared surface after any team member touches it. Finally, even if strict sanitation and hand-washing regiments can eliminate fomites, several studies among animals, in labs, and in human populations prove the primary mode of transmission for SARS-CoV-2 is airborne transmission.[66, 67, 68]

36. Typical air filtration systems are also ineffective in preventing the spread of illness. While some research has found SARS-CoV-2 virus in a building's heating, ventilation and air conditioning (HVAC) system,[69] the HVAC systems in most non-medical buildings play only a small role in reducing infectious disease transmission. Because neither the training facility where 2d Lt Poffenbarger would attend intelligence technical school nor the vault where 2d Lt Poffenbarger would be assigned to work are medical buildings, it is unlikely the HVAC systems would provide sufficient protection to eliminate or even greatly reduce COVID-19 transmission in the training facility or his work area.

SARS-CoV-2 Is Not Comparable to Human Immunodeficiency Virus (HIV) Infection

37. I understand that 2d Lt Poffenbarger has argued that vaccination against COVID-19 is not the least restrictive means of achieving the Air Force's interests because "Defendants

[66] J Port et al. SARS-CoV-2 disease severity and transmission efficiency is increased for airborne compared to fomite exposure in Syrian hamsters. Nature Communications DOI: 10.1038/s41467-021-25156-8 (2021).
[67] Wang, CC, Prather, KA, et al, Airborne transmission of respiratory viruses, SCIENCE, Vol 373, Issue 6558 DOI: 10.1126/science.abd9149 (Aug. 27, 2021) *available at* https://www.science.org/doi/10.1126/science.abd9149
[68] National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, Science Brief: SARS-CoV-2 and Surface (Fomite) Transmission for Indoor Community Environments, updated Apr. 5, 2021, *available at* https://www.cdc.gov/coronavirus/2019-ncov/more/science-and-research/surface-transmission.html.
[69] Lednicky, JA, et al., Viable SARS-CoV-2 in the air of a hospital room with COVID-19 patients, *International Journal of Infectious Disease*, Vol. 100, pages 476–482 (Nov. 2020), *available at* https://www.ijidonline.com/article/S1201-9712(20)30739-6/fulltext.

accommodate HIV positive soldiers, demonstrating that the existence of a disease, even a lethal or transmittable disease, does not require the discharge of soldiers."[70] The Air Force has different policies concerning Service members with HIV. Any comparison between the viruses is not appropriate as SARS-CoV-2 and HIV are transmitted in totally different ways. SARS-CoV-2 is transmitted via infected respiratory droplets from a COVID-19 positive person to another person, in essence from exhaling, sneezing, coughing, singing, shouting, etc. HIV is a blood-borne pathogen and exposure takes place when an HIV positive person's blood or body fluid (e.g., semen, vaginal fluid, breast milk) comes in direct contact with another individual's mucosal membranes found in the eyes, ears, nose, mouth, anus, penis, or vagina. HIV also does not survive long outside the body and is not transmitted via the air or by touching.[71]

Conclusion

38. In sum, none of the measures discussed above are as effective as being fully vaccinated against COVID-19, and relying on them instead of vaccines would hinder the Air Force's mission accomplishment. 2d Lt Poffenbarger is required to work in a secured location and in coordination with other members. No alternative would reduce 2d Lt Poffenbarger's risk of morbidity and mortality associated with COVID-19, to himself and others, as effectively as him being vaccinated.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 31st day of January 2022.

POEL.JAMES.R.1181237550 Digitally signed by POEL.JAMES.R.1181237550 Date: 2022.01.31 13:17:51 -05'00'

JAMES R. POEL, Col, USAF
Chief, Public Health Branch

[70] Pl.'s Mot. for an Emergency Temporary Restraining Order and Prelim. Inj. at 10, Doc. No. 2.
[71] CDC Division of HIV Prevention, National Center for HIV, Viral Hepatitis, STD, and TB Prevention, updated Apr. 21, 2021, https://www.cdc.gov/hiv/basics/hiv-transmission/not-transmitted.html.