IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

Governor GREG ABBOTT, in his official capacity as Governor of the State of Texas; and Governor MIKE DUNLEAVY, in his official capacity as Governor of the State of Alaska, *Plaintiffs*, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States; DEPARTMENT OF DEFENSE; LLOYD AUSTIN, in his official capacity as Secretary of Defense; DEPARTMENT OF THE AIR FORCE; FRANK KENDALL III, in his official capacity as Secretary of the Air Force; DEPARTMENT OF THE ARMY; and CHRISTINE WORMUTH, in her official capacity as Secretary of the Army, *Defendants*.	No. 6:22-cv-3-JCB

DEFENDANTS' OPPOSITION TO
PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Texas Governor Abbott and Alaska Governor Dunleavy challenge federal medical readiness standards that require all members of the National Guard to receive a COVID-19 vaccination, and they now seek the extraordinary preliminary injunctive relief of halting this policy for the Texas and Alaska National Guards. Plaintiffs contend that by adding one more vaccine to the nine vaccines that National Guard members already have been required to take for decades, the federal government has unlawfully "commandeer[ed] the daily administration of the Guard." Dunleavy's Br. ISO Abbott's Mot. for Prelim. Inj. ("Dunleavy Br."), ECF No. 27, at 8. That is wrong as both a matter of fact and law. This Court should deny Plaintiffs' motion because they fail to establish any of the required elements for emergency injunctive relief.

Plaintiffs will not succeed on the merits. The federal government has the authority to set medical readiness standards for National Guard members. This authority ultimately comes from the Constitution, which vests Congress with the authority to "organiz[e], arm[], and discipline[e], the Militia" and to set standards for training. U.S. Const., art. I, § 8, cls. 15-16. Congress delegated that authority to the President, 32 U.S.C. § 110, who sets regulations for the National Guard along with the Secretary of Defense and the Service Secretaries. As Governor Abbott concedes, the Constitution established a system where "the federal government would set the standards for the militia to maintain" so that "the militia would be prepared for federal service if it became necessary." Abbott's Mot. for Prelim. Inj. ("Abbott Br."), ECF No. 24, at 12.

National Guard members who are in federal active duty under Title 10 of the U.S. Code are under federal command and directly subject to federal regulations. National Guard members are also required to meet federal standards in order to participate in federally-funded activities under Title 32, such as training. *See* 32 U.S.C. § 110; 32 U.S.C. § 501; 10 U.S.C. § 12641. Members in Title 32 status serve under State command, but since service in Title 32 is paid through federal funds, a prerequisite

to participation is meeting federal medical readiness regulations—including being up-to-date on vaccinations. Indeed, the purpose of Title 32 training is to prepare for federal service. Members can also serve in State Active Duty, where members are commanded and funded by the State. State Active Duty does not require meeting federal requirements like COVID-19 vaccination.

Plaintiffs "do[] not contest the President's authority to withhold funds, in accordance with 32 U.S.C. § 108, from a State that fails to comply with a federal standard established by 32 U.S.C. § 110." Abbott Br. at 13; *see also* Dunleavy Br. at 5–6. The federal government has the right to determine whether National Guard members are eligible for federal military pay and to set the qualifications for who can earn credit (points) for federal retirement benefits while serving pursuant to Title 32. And here, the federal government has exercised its authority and decided that it will not pay for National Guard members who have failed to comply with the medical readiness standards set by the active duty federal military. Nov. 30, 2021 Secretary of Defense Memo, https://perma.cc/XA83-FNRM.

Remarkably, however, Plaintiffs argue that the federal government is powerless to set such standards and instead claim that federal regulations must give way when they conflict with a Governor's orders to a National Guard unit. This is plainly wrong. Texas and Alaska remain free to pay National Guard members for training or other service—like State Active Duty—for those who are not medically ready for federal service. But nothing requires the federal government to do so, and nothing requires the federal government to award retirement credit to members who fail to meet threshold medical requirements for federal service.

Plaintiffs thus cannot establish any likelihood of success on the merits for any preliminary injunctive relief. And Plaintiffs fail to satisfy any of the other requirements for a preliminary injunction, including irreparable harm, balance of the equities, and public interest. For these reasons and others described below, the Court should deny Plaintiffs' request for emergency injunctive relief. Indeed, the same arguments advanced by Plaintiffs in this case were recently rejected in a similar suit

brought by the State of Oklahoma, where the court denied a preliminary injunction motion. *Oklahoma v. Biden*, --- F. Supp. 3d ----, CIV-21-1136-F, 2021 WL 6126230 at *1 (W.D. Okla. Dec. 28, 2021).

BACKGROUND

I. Department of Defense COVID-19 Medical Readiness

Since the dawn of our Nation, the military has required inoculations as a part of military medical readiness because vaccines reduce infectious disease morbidity and mortality. *See* Cong. Rsch. Serv., Defense Health Primer: Military Vaccinations (updated Aug. 6, 2021), https://perma.cc/BMW3-HGJW. The U.S. military instituted its first immunization program in 1777, when General Washington directed the inoculation of the Continental Army for smallpox. Stanley Lemon et al., *Protecting Our Forces: Improving Vaccine Acquisition and Availability in the US Military*, National Academies Press (2002), https://perma.cc/E545-TQ9G. And for decades before COVID-19, the military has required at least nine immunizations, including an annual flu shot. *See* Army Regulation ("AR") 40–562 (Oct. 7, 2013), https://perma.cc/MB96-5JK3; *see also* Decl. of Steve L. Bradley, Ex. B, ¶ 3 (citing DoDI 6025.19 "Individual Medical Readiness"); *id.* ¶¶ 4–5.

On August 24, 2021, the day after the Food and Drug Administration ("FDA") provided full approval of a COVID-10 vaccine, the Secretary of Defense announced that he was adding the COVID-19 vaccine to the list of required vaccines. *See* Aug. 24, 2021 Secretary of Defense Memo, https://perma.cc/YZ9F-NNU2. He explained that "[t]o defend this Nation, we need a healthy and ready force" and that "mandatory vaccination against [COVID-19] is necessary to protect the Force and defend the American people." *Id.*; *see also* Ex. B ¶¶ 3–5. Secretary Austin directed the Secretaries of the Military Departments to immediately vaccinate all members of the armed forces, including the National Guard. *See* Aug. 24, 2021 Secretary of Defense Memo; Ex. B ¶¶ 6–8.

II. Organization and Regulation of the National Guard

The National Guard both (1) is a part of the official state militia and (2) includes reserve

members of the U.S. Army and U.S. Air Force. *See* Decl. of Col. Kevin A. Mulcahy, Ex. A. The Texas and Alaska National Guards include military members serving in different roles, including the following categories relevant to this lawsuit:

- Federal Active Duty. Under Title 10, federal active duty National Guard members serve under the direct control of a federal official. They are subject to the active duty COVID-19 vaccination compliance deadlines set by each Service. *See, e.g.*, 10 U.S.C. §§ 12301, 12302. Ex. A ¶ 7.

- Title 32 Drill Status Guardsmen. Most members of the National Guard are Drill Status Guardsmen. Ex. A ¶ 4. These individuals train pursuant to Title 32 at least one weekend a month and two weeks a year. *Id.* The State conducts Title 32 training, but it is paid for by the federal government. *Id.* Title 32 training "is primarily designed to prepare National Guard units and individual service members for military service as part of one of the reserve components of the United States, *i.e.*, service in the Army National Guard of the United States or the Air National Guard of the United State." *Id.* (citing 10 U.S.C. § 101(c)(3) & (5)). To participate in Title 32 training, Drill Status Guardsmen must comply with federal rules, including military vaccination requirements. *See* 32 U.S.C. §§ 110, 501; U.S. Const., art. I., § 8, cls. 15-16; Ex. A ¶ 4. Drill Status Guardsmen in the Air National Guard were required to comply with the COVID-19 vaccination by December 30, 2021, and those in the Army National Guard must comply by June 30, 2022. Ex. A ¶ 4.

- Title 32 Active Guard and Reserve ("AGR"). AGR members are full-time, uniformed service members serving under Title 32 under the direction of a State official. Ex. A ¶ 5. The purpose of AGR service is to prepare State National Guards for federal missions. *Id.*; *see* 10 U.S.C. § 101(d)(6) (AGR duty is "for the purpose of organizing, administering, recruiting, instructing, or training the reserve components"). AGRs must comply with Title 32 regulations set by the President and Secretaries, and continued service in the AGR requires the consent of the applicable service Secretary. 32 U.S.C. § 328. For AGRs serving in the Air National Guard, the deadline for compliance with the COVID-19 vaccination requirement was December 31, 2021, and for AGRs serving in the Army National Guard, the deadline was December 15, 2021 unless they have an approved exemption or pending exemption request or appeal. Ex. A ¶ 5.

- State Active Duty. Some National Guard members are on state orders, which are paid for by state funds. Although those National Guard members on State Active Duty may use federal equipment, the State must reimburse the federal government. Members in State Active Duty follow orders of the Governor and need not meet federal requirements in order to be paid by a State. Ex. A ¶ 8.

On November 30, the Secretary of Defense issued a memo regarding vaccination requirements for the National Guard. *See* Nov. 30, 2021 Secretary of Defense Memo, https://perma.cc/XA83-

FNRM. The memo explained that after the compliance deadline, National Guard members "must subsequently become vaccinated, in order to participate in drills, training and other duty conducted under title 32, U.S. Code." *Id.* The Secretary explained that "[n]o Department of Defense funding may be allocated for payment of duties performed under title 32 for members of the National Guard who do not comply with Department of Defense COVID-19 vaccination requirements." *Id.* And that "[n]o credit or excused absence shall be afforded to members who do not participate in drills, training, or other duty due to failure to be fully vaccinated against COVID-19." *Id.*

The Secretary of the Air Force followed with specific regulatory guidance for the Air National Guard. *See* Secretary of the Air Force Memo, Supplemental Coronavirus Disease 2019 Vaccination Policy (Dec. 7, 2021), https://perma.cc/72K5-SN8E. The memo explained members of the Air National Guard had until December 31, 2021, to initiate a vaccination regimen or have a pending exemption request, and those who failed to comply "may not participate in drills, training, or other duty conducted under Title 10 or Title 32." *Id.* The Secretary also withdrew consent for Active Guard Service "for members not fully vaccinated" by December 31, 2021, pursuant to 32 U.S.C. § 328. *Id.*; Ex. A ¶ 13.

The completion goal for the Army National Guard vaccination mandate is June 30, 2022, and only after July 1, 2022 will the federal government enforce a requirement for compliance as a condition for federal funding and for participation in federally funded activities. Ex. A ¶ 15. Soldiers seeking an exemption to the COVID-19 vaccination directive were required to submit exemption packets by March 1, 2022. *Id.* Title 32 Active Guard Reserve soldiers were required to be fully vaccinated by December 15, 2021, unless they have an approved exemption or pending exemption request or appeal. *Id.* ¶ 16.

III. National Guard Lawsuits

On December 2, 2021, the State of Oklahoma filed a lawsuit seeking to enjoin the military's

vaccine mandate as it applied to the Oklahoma National Guard. *Oklahoma*, 2021 WL 6126230, at *1. Oklahoma moved for a preliminary injunction alleging various claims, including that adding the COVID-19 vaccine to the list of required vaccines was unconstitutional and violated the Administrative Procedure Act. *Id.* The Court denied Oklahoma's motion for a preliminary injunction on December 28, 2021. *Id.*

A week later, Governor Abbott filed this lawsuit on January 4, 2022. ECF No. 1. On January 25, 2022, Plaintiffs filed an amended complaint which added Alaska Governor Dunleavy as a plaintiff. Plaintiffs allege that the medical readiness requirement for National Guard members to be vaccinated for COVID-19 violates the Constitution and the Administrative Procedure Act. Am. Compl., ECF No. 4. On February 7, 2022, Governor Abbott filed a motion seeking a preliminary injunction seeking to block the COVID-19 vaccine readiness requirement for all Texas National Guard members and to force the federal government to pay for Title 32 training and service for members of the Texas National Guard who have not met COVID-19 readiness requirements. *See* Abbott Br.; ECF No. 24-1 (Proposed Order). Governor Dunleavy filed a brief in support of Governor Abbott's motion on February 23, 2022. Dunleavy Br. Defendants now submit this opposition.

LEGAL STANDARD

"A preliminary injunction is an extraordinary remedy never awarded as of right." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008); *Anderson v. Jackson*, 556 F.3d 351, 360 (5th Cir. 2009). ("Injunctive relief is an extraordinary and drastic remedy[ ] and should only be granted when the movant has clearly carried the burden of persuasion."). Plaintiffs must "*by a clear showing*" establish that (1) they have a substantial likelihood of success on the merits; (2) they will suffer irreparable harm without an injunction; (3) the balance of equities tips in their favor; and (4) preliminary relief serves the public interest. *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997). Plaintiffs' failure to demonstrate any of the factors is sufficient to deny injunctive relief, *Allied Mktg. Grp., Inc. v. CDL Mktg., Inc.*, 878

F.2d 806, 809 (5th Cir. 1989), and "[t]he decision to grant a preliminary injunction is to be treated as the exception rather than the rule[,]" *Miss. Power & Light Co. v. United Gas Pipe Line Co.*, 760 F.2d 618, 621 (5th Cir. 1985).

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.); *Farmer v. Mabus*, 940 F.2d 921, 923 (5th Cir. 1991) ("We are keenly aware that judicial intrusion into military matters is to be most cautiously and charily approached."). Such deference extends to constitutional claims and military decisions about the health and welfare of the troops. *See Solorio v. United States*, 483 U.S. 435, 448 (1987); *Mazares v. Dep't of Navy*, 302 F.3d 1382, 1385 (Fed. Cir. 2002).

ARGUMENT

I. Plaintiffs Have No Likelihood of Success on the Merits.

A. The Constitution and Federal Statutes Authorize the Federal Government to Set Medical Readiness Regulations for the National Guard.

Plaintiffs are unlikely to succeed on the merits of their claims that the military readiness requirements for the National Guard, including the COVID-19 vaccine requirement, violates the Constitution or federal law. *See* Am. Compl. Counts I–III. Military readiness requirements applicable to the National Guard fall squarely within the authority the Constitution assigned to the federal government in the Militia clauses, U.S. Const., art. I, § 8, cls. 15-16. "[T]he power to impose the vaccination mandate at issue here is bottomed on an express Article I grant of power to Congress" and "this express grant of power to Congress (importantly, accompanied by an equally express allocation of responsibilities between federal and state authorities) leaves no room" for a viable Tenth Amendment claim. *Oklahoma*, 2021 WL 6126230, at *12 (citing *New York v. United States*, 505 U.S.

144, 156 (1992)).

The Constitution tasks Congress with "organizing, arming, and disciplining, the Militia and [with] governing such Part of them as may be employed in the Service of the United States." U.S. Const., art. I, § 8, cls. 15–16. The States may appoint militia officers and conduct training, so long as the training conforms with federal regulations. *Id.* In Federalist No. 29, Alexander Hamilton described the States' role as limited to "the appointment of the officers" and "training the militia according to the discipline prescribed by Congress" because "[i]f a well-regulated militia be the most natural defense of a free country, it ought certainly to be under the regulation and at the disposal of that body which is constituted the guardian of the national security"—*i.e.*, the federal government. The Federalist No. 29, (Alexander Hamilton), https://perma.cc/T2SQ-VQ89.

The Supreme Court has long recognized the States' subordinate role to Congress in military affairs. *See, e.g.*, *Houston v. Moore*, 18 U.S. (5 Wheat) 1, 16 (1820) ("Congress has power to provide for organizing, arming, and disciplining them; and this power being unlimited, except in the two particulars of officering and training them, according to the discipline to be prescribed by Congress, it may be exercised to any extent that may be deemed necessary by Congress."); *Gilligan*, 413 U.S. at 7 ("[T]he training, weaponry and orders of the Guard [are] critical areas of responsibility vested by the Constitution in the Legislative and Executive Branches of the [Federal] Government."); *Perpich v. Dep't of Def.*, 496 U.S. 334, 354 (1990) ("The Militia Clauses . . . subject[] state militia[s] to express federal limitations."); *see also Holdiness v. Stroud*, 808 F.2d 417, 420–21 (5th Cir. 1987) ("Pursuant to the power vested in Congress by the Constitution, the Guard was to be . . . subject to federal standards and capable of being 'federalized' soldiers.").

Moreover, Congress has unambiguously delegated the authority to regulate the National Guard to federal officials. "The President shall prescribe regulations, and issue orders, necessary to organize, discipline, and govern the National Guard." 32 U.S.C. § 110. The Secretaries of the Army

and Air Force likewise have authority to "prescribe such regulations as the Secretary considers necessary to carry out provisions of law relating to the reserve components," which include the National Guard. 10 U.S.C. § 10202(a). And each Service Secretary is "[s]ubject to the authority, direction, and control of the Secretary of Defense." *Id.* §§ 7013(b)(9), 9013(b)(9), 113(b). Congress further tasked the National Guard Bureau with "[i]ssuing directives, regulations, and publications consistent with approved policies of the Army and Air Force." 10 U.S.C. § 10503(11).

As Governor Abbott concedes, "the President is tasked with setting federal standards for Guardsmen's deployability, physical fitness, and the like." Abbott Br. at 4 (citing 32 U.S.C. § 110). And the challenged regulations are exactly that: federal standards for Guardsmen's physical fitness and deployability—part of the requirements that must be met by all members of the National Guard to meet the readiness standards of the Army National Guard of the United States or the Air National Guard of the United States, which are both part of the Reserve Components of United States. 10 U.S.C. § 12641(a); Ex. B, ¶ 5.

For decades, federal regulations have long required each service member to receive nine immunizations (apart from COVID-19) in order to be deemed medically qualified for military service. *See Oklahoma*, 2021 WL 6126230 at *8; AR 40-562, 3-2 ("Reserve component Servicemembers receive the same immunizations as active duty personnel"); Ex. B, ¶ 5. "If a [member of the] Reserve fails to comply with the standards and qualifications prescribed under subsection (a), he shall—(1) if qualified, be transferred to an inactive reserve status; (2) if qualified, be retired without pay; or (3) have his appointment or enlistment terminated." 10 U.S.C. § 12641(b). Thus, as members of the reserve components, members of National Guards must comply with federal readiness standards (regardless of duty status) or risk disqualification and termination of their status as a reservist. *See, e.g.*, DoDI 6205.02, "DoD Immunization Program" ¶ 1.2(c) (effective July 23, 2019), https://perma.cc/7G9K-

L94L; 32 U.S.C. §§ 301, 323.[1]

The federal government is not required to pay for reserve training or service that does not meet federal regulations. *See* 32 U.S.C. § 108. "If the Guard fails to comply with federal standards, the President is empowered to cut off its funding." *Oklahoma*, 2021 WL 6126230, at *10 (citing 32 U.S.C. § 108). The federal government exercised that power and now "[n]o Department of Defense funding may be allocated for payment of duties performed under title 32 for members of the National Guard who do not comply with Department of Defense COVID-19 vaccination requirements." Nov. 30, 2021 Secretary of Defense Memo, https://perma.cc/XA83-FNRM.

Compliance with the funding limits does not "commandeer the daily administration of the Guard." Dunleavy Br. at 8. The Defense Finance and Accounting Services (DFAS), a DoD agency, determines the pay and benefits for National Guard members. Ex. A ¶ 20. DFAS also issues paychecks for members of the National Guard. *Id.* DFAS also has the authority to determine whether to withhold pay and benefits to Title 32 service members, and the Secretary of Defense has directed DFAS to withhold payments for service by members that does not meet military readiness requirements. *Id.* Moreover, service in the Active Guard may only be performed with the consent of the Secretary of the Army or Air Force. 32 U.S.C. § 328. And the Secretary of the Air Force has withdrawn consent for Air National Guard members who have not complied with the Air Force's

[1] Plaintiffs suggest that withholding federal funds is the "only" tool available for the federal government to encourage National Guard compliance with federal requirements. Abbott Br. at 13; Dunleavy Br. at 6. But that is not true. *See* Ex. A ¶¶ 17–22 (describing other tools federal government may use to ensure compliance). For example, the federal government has the power to discharge or withdraw federal recognition for individuals. To maintain membership in the National Guard, service members must remain in good federal standing, meeting "the qualifications prescribed by the Secretary." 32 U.S.C. § 301. The federal military has the unilateral authority to withdraw federal recognition for individual National Guard officers and to discharge enlisted members. 32 U.S.C. §§ 323, 322. Although withdrawal of federal recognition and discharge are generally done with close coordination of the State Adjutant General, the federal government has the statutory authority to do so without the consent of the State. *See id.* Officers in the National Guard also maintain rank in their respective federal service, and failure to comply with federal regulations can lead to individual adverse actions, including formal written reprimands up to court martial. Ex. A ¶¶ 19, 21.

current medical readiness requirements. Dec. 7, 2021 Secretary of the Air Force Memo.

The law is thus clear: Congress and those federal officers using the authority delegated from Congress set the standards for service in the United States military, including service in the National Guard. "If a state should find federal standards governing the *National* Guard to be too tight a fit, the state is free to establish (and pay for) its own, independent version." *Oklahoma*, 2021 WL 6126230, at *10. States like Texas have exercised that option and established separate defense forces under exclusive control of the State where the State sets the standards. *See* 32 U.S.C. § 109. But that does not change the fact that members of the *National* Guard must meet federal standards.

Consistent with the Constitutional and statutory authority described above, Texas law recognizes the supremacy of federal regulations that apply to the National Guard. Texas law acknowledges that the Federal Government "prescribes the terms and the qualifications and requirements for enlistment and appointment in the Texas National Guard." Tex. Gov't Code Ann. § 437.007. While the Governor appoints and commissions officers in the Texas National Guard, he may only appoint "a service member" who is "qualified under United States law and regulations." *Id.* § 437.006. And where state and federal laws conflict over eligibility to serve in the Texas National Guard, federal law preempts any conflicting state law: "The governor and legislature may prescribe additional terms, qualifications, and requirements that do not conflict with federal law." *Id.* § 437.007. Finally, while the Governor is the commander-in-chief of the Texas National Guard when under his command, *see id.* § 437.002, his orders and regulations must comply with "existing federal and state law," *id.* § 437.004.

Alaska statutes likewise "specifically provide that Alaska National Guard personnel are subject to the federal laws and regulations relating to the National Guard and any supplemental regulations adopted by the Alaska Adjutant General and approved by the Governor." *State, Dep't of Mil. & Veterans Affs. v. Bowen*, 953 P.2d 888, 899 (Alaska 1998) (citing Alaska Stat. §§ 26.05.060, 26.05.340).

Alaska National Guard requires its officers to meet "the qualifications prescribed by federal law and regulations" before they can be "appointed and commissioned" by the Alaska governor. Alaska Stat. § 26.05.030(a)(2). And while the governor is in command of "the Alaska National Guard and the Alaska Naval Militia while they are not in active federal service" and may "adopt necessary regulations for them," the next sentence makes clear that "[t]he Alaska National Guard and the Alaska Naval Militia and their members are subject to all federal laws and regulations relating to the National Guard." Alaska Stat. Ann. § 26.05.060. Alaska's Adjutant General and Governor may also adopt regulations for the "organization, discipline, and government of the National Guard or Naval militia" but only if such matters are "not otherwise provided for by the laws of the United States, . . . or regulations adopted by the president." Alaska Stat. § 26.05.340(d).

To the extent that Governor Abbott's and Dunleavy's orders conflict with federal regulations applicable to the National Guard, they are invalid under state law, under federal law, and under the Constitution.

B. Plaintiffs' APA Claim Is Unlikely to Succeed.

Plaintiffs are also unlikely to succeed on their Administrative Procedure Act claims that the COVID-19 readiness requirements are contrary to law and arbitrary and capricious. *See* Am. Compl. Counts IV, X, and VI. Indeed, the same arguments advanced by Plaintiffs in this case were recently rejected in a similar suit brought by Oklahoma. *See Oklahoma v. Biden*, 2021 WL 6126230. As in the *Oklahoma* case, the Governors of Texas and Alaska "have failed to demonstrate the vaccination mandate is not authorized by law" for all the reasons explained above. *Id.*, at *11 n.29; *see supra* Argument I.A. Plaintiffs have also failed to show that adding a requirement to be vaccinated for COVID-19 was arbitrary and capricious.

Arbitrary and capricious review of agency action is highly deferential. "In reviewing an agency's decision under the arbitrary and capricious standard, there is a presumption that the agency's

decision is valid, and the plaintiff has the burden to overcome that presumption by showing that the decision was erroneous." *Tex. Clinical Labs, Inc. v. Sebelius*, 612 F.3d 771, 775 (5th Cir. 2010). Judicial review under this standard is "narrow" and limited to "whether the [agency] examined 'the relevant data' and articulated 'a satisfactory explanation' for [its] decision, 'including a rational connection between the facts found and the choice made.'" *Dep't of Com. v. New York*, 139 S. Ct. 2551, 2569 (2019) (quoting *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983)). A court "may not substitute [its] judgment for that of the [agency], but instead must confine [itself] to ensuring that [the agency] remained 'within the bounds of reasoned decisionmaking.'" *Id.* (quoting *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council, Inc.*, 462 U.S. 87, 105 (1983)).

Challenges to military judgments under the APA are subject to an even higher bar. *See Goldberg*, 453 U.S. at 66. "Moreover, it is difficult to conceive of an area of governmental activity in which the courts have less competence. 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." *Gilligan*, 413 U.S. at 10; *see Oklahoma*, 2021 WL 6126230, at *11 n.29; *Doe #1-#14 v. Austin*, --- F. Supp. 3d ----, 2021 WL 5816632, at *4 (N.D. Fla. Nov. 12, 2021) (plaintiffs not likely to succeed on the merits of their APA claim challenging the military vaccination mandate).

The military's medical readiness requirement to be vaccinated against COVID-19 easily meets this deferential standard. There have been more than 603,736 cases of COVID-19 and more than 679 deaths associated with COVID-19 across DoD, and at least 388,000 cases and 94 deaths among Service members. Ex. B, ¶ 6; Decl. of Maj. S. Stanley, Ex. C ¶ 3. Beyond the human toll, the pandemic also had a significant impact on military operations. *See* Ex. C, ¶¶ 3–13 (detailing such impacts).[2]

[2] COVID-19 has "impacted exercises, deployments, redeployments, and other global force management activities," Ex. C ¶ 6 (including rendering one of the Navy's eleven aircraft carriers non-

After consulting with "medical experts and military leadership," the Secretary of Defense "determined that mandatory vaccination against [COVID-19] is necessary to protect the Force and defend the American people." Aug. 24, 2021 Secretary of Defense Memo, https://perma.cc/YZ9F-NNU2; *see also* Dec. 7, 2021 Secretary of the Air Force Memo. The Court must "give great deference" to these leaders' "professional military judgments." *See Winter*, 555 U.S. at 24–25 (citation omitted); *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986) ("courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest."); *see also Church v. Biden*, ---F. Supp. 3d---, 2021 WL 5179215, at *18 (D.D.C. Nov. 8, 2021) (similar).

"This deference is layered on top of the deference that courts must give to expert policymakers on matters involving complex medical or scientific uncertainties." *Short v. Berger*, No. 2:22-cv-01151, ECF No. 25 at 10 (C.D. Cal. Mar. 3, 2022). "When those officials undertake to act in areas fraught with medical and scientific uncertainties, their latitude must be especially broad" and "they should not be subject to second-guessing by an unelected federal judiciary, which lacks the background, competence, and expertise to assess public health and is not accountable to the people." *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613-14 (2020) (Roberts, C.J., concurring) (cleaned up).

Long before COVID-19, the military required service members to be vaccinated against a number of diseases. *See* AR 40-562; DoDI 6205.02, "DoD Immunization Program" ¶ 1.2, (effective July 23, 2019), https://perma.cc/7G9K-L94L (DoD requirements generally followed recommendations form CDC). The military's judgment that COVID-19 vaccination is necessary for medical readiness is supported by significant evidence showing COVID-19's harmful impact on the

operational because of an outbreak, *id.* ¶ 8); 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. In addition, 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 are required under military directives to maintain medical readiness." *Id.* ¶¶ 12–13.

military. Decl. of Col. T. Rans, Ex. D, ¶¶ 10–13; Ex. C, ¶¶ 3–13; *accord Church*, 2021 WL 5179215, at *18 (DoD vaccination requirement is "supported by a lengthy record replete with data demonstrating the necessity of a general vaccine mandate"). Vaccinations have promoted military readiness by reducing the risk of infections, hospitalizations, and deaths of service members. Ex. C ¶ 14; Ex. D ¶¶ 14–29; Ex. D ¶¶ 30–40 (specifically discussing impact of vaccines on Omicron variant). Of the 94 Service members who have died from COVID-19, 89 were unvaccinated, 3 were partially vaccinated, and 2 were vaccinated but not boosted. Ex. C ¶ 3. "[T]he 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." *Id.* ¶ 16; *see id.* ¶ 18. "Of all active duty personnel hospitalized with COVID-19 since December 2020 through this month, only 0.012% were vaccinated." Ex. C. ¶ 18. Individuals who have not been fully vaccinated against COVID-19 are at higher risk of serious illness, hospitalization, and death. Ex. B ¶ 6. Unvaccinated persons are also at higher risk of conditions like long-haul COVID. *Id.*

Vaccines have reduced the number of service members required to quarantine, and permitting a return to higher levels of occupancy in DoD facilities and in-person trainings. Ex. C ¶ 14. Vaccinations also permit service members to engage in joint training exercises with other countries that have vaccination requirements. Ex. C ¶ 10. Vaccinations are also required now to ensure troops can respond and deploy quickly. Ex. B ¶ 3. On this record and under the highly deferential standard of review, Plaintiffs are unlikely to show that the military's vaccine requirement are arbitrary and capricious. *See Oklahoma*, 2021 WL 6126230, at *11 n.29.

Governor Abbott claims that the COVID-19 requirements are arbitrary and capricious because the decision did not "consider[] any reliance interests that developed around the since-abandoned policy." Abbott Br. at 15 (citing *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 221 (2016)). But that factor does not apply here because it is only relevant when an agency "changes its

existing position" and, even then, an agency's actions are not arbitrary if the agency "show[s] that there are good reasons for the new policy." *Encino Motorcars*, 579 U.S. at 221 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

Plaintiffs fail to identify what policy was supposedly "abandoned" by adding COVID-19 vaccination as a medical readiness requirement. Abbott Br. at 15. Vaccine requirements are nothing new. "The COVID vaccination mandate should be understood against the backdrop of other military immunization mandates–which date back as far as General George Washington's mandate that troops in the Continental Army be inoculated against smallpox." *Oklahoma*, 2021 WL 6126230, at *8. National Guards have long required vaccinations, and members of both Texas and Alaska National Guards have complied with those regulations for decades. Plaintiffs provide "no basis upon which taking the COVID vaccine might be thought of as differing in some way from taking the other nine FDA-approved vaccines [National] Guard members are required to take." *Oklahoma*, 2021 WL 6126230, at *7.

To the extent Plaintiffs are arguing that there was some previous policy of not being required to vaccinate against COVID-19 that created reliance interests, those arguments likewise fail. Secretary Austin directed the force "to immediately begin full vaccination of all members of the Armed Forces . . . including the National Guard" on August 24, 2021, just one day after the FDA issued the first full approval for a COVID-19 vaccine. Aug. 24, 2021 Secretary of Defense Memo. Plaintiffs fail to explain how they could have possibly developed a reliance interest in not being required to receive a new vaccine in such a short period of time. *Compare with Encino Motorcars*, 579 U.S. at 222 (discussing reliance interests when agency reversed a regulation that had been in place for 33 years). But even if it were possible to have developed reliance, the military has sufficiently shown "good reasons" for the implementing the policy as described above.

Plaintiffs also argue that the policy of COVID-19 vaccines for medical readiness is arbitrary

and capricious because members of their National Guards might refuse to comply and some of those members may ultimately quit and/or be discharged. As a factual matter, Plaintiffs have not established that an unusually large number of individuals are leaving the State National Guards beyond average annual attrition. According to Texas, its Air National Guard normally loses 356 members every year. *See* Decl. of the Texas Adj. General Norris ECF No. 25-7, ¶ 28. And even assuming that every member of the Air National Guard who is still unvaccinated leaves this year, that is 244 people—well short of the 356 members it loses on average per year. *Id.* In any event, Defendants do not wish to see the Texas State Guard lose members— it seeks for those members to become vaccinated in order to be prepared for federal service and to continue to serve the people of Texas and the United States.

The federal vaccination requirement also does not impact Texas's law enforcement capabilities. Texas is free to employ those unvaccinated members in the Texas State Guard, which is their State Defense Force and is not subject to federal readiness requirements—the federal government will just no longer pay for them. In addition, in the short term, the federal government is not requiring states to discharge National Guard members who are not vaccinated against COVID-19. Thus, those members would still be available for State Active Duty, which is paid exclusively by the State.

Finally, even if Plaintiffs had established a factual nexus between the medical readiness requirements and some State interest in law enforcement, the federal medical readiness policy is still not arbitrary or capricious because the Constitution, federal and state law, and military regulations have placed the importance of federal military readiness above any residual state interest in receiving federal funds for soldiers who are no longer qualified for federal service.

II. Plaintiffs Fail To Establish Irreparable Injury.

"Without question, the irreparable harm element must be satisfied by independent proof, or no injunction may issue." *White v. Carlucci*, 862 F.2d 1209, 1211 (5th Cir. 1989). To satisfy their burden

of proving irreparable harm, Plaintiffs must demonstrate irreparable harm that is imminent and likely, not merely possible. *Winter*, 555 U.S. at 20. The harm shown "must be both certain and great," not "merely serious or substantial." *Prairie Band of Potawatomi Indians v. Pierce*, 253 F.3d 1234, 1250 (10th Cir. 2001) (citations omitted). Plaintiffs have not carried their burden here.[3]

Plaintiffs first allege the speculative claim that the COVID-19 readiness requirement "threaten[s] to hollow out the Texas National Guard." Abbott Br. at 19. But that is pure speculation. As explained above, the total number of unvaccinated Texas Air National Guard is less than average annual attrition, ECF No. 25-7, ¶ 28, and the Army National Guard deadline for Drill Status Guardsmen is still months away, June 30, 2022, Ex. A ¶ 4. Alaska provides no evidence that the vaccine requirement will have any impact whatsoever on its National Guard. "[B]ecause 'the court must decide whether the harm will *in fact* occur,' a party seeking injunctive relief must 'substantiate the claim of irreparable injury' and 'must show that the injury complained of is of such *imminence* that there is a clear and present need for equitable relief to prevent irreparable harm." *Sierra Club*, 482 F. Supp. 3d at 559 (quoting *Sierra Club v. U.S. Army Corps of Eng'rs*, 990 F. Supp. 2d 9, 39 (D.D.C. 2013) (emphasis in original)).

Moreover, Plaintiffs have failed to demonstrate how pulling of federal funding—which they admit the federal government has the right to do—would irreparably harm state law enforcement capabilities. Even without federal funding, there is nothing preventing Texas or Alaska from paying their own National Guard members, Ex. A ¶ 8 (discussing State Active Duty), or stopping those individuals from serving in state-funded State Guards, *Oklahoma*, 2021 WL 6126230, at *10 ("state[s]

[3] Plaintiffs have also failed to demonstrate standing, but Defendants focus here on irreparable harm since the Court can deny the present motion for failure to show irreparable harm. Plaintiffs bear the burden of showing irreparable harm and the standard for irreparable harm is stricter than standing. *See Sierra Club v. United States Army Corps of Engineers*, 482 F. Supp. 3d 543, 561 (W.D. Tex. 2020) (finding plaintiff had standing but failed to demonstrate irreparable harm).

[are] free to establish (and pay for) [their] own, independent" State Guards). For that reason, federal COVID-19 readiness requirements will have little impact on the "law-enforcement surge" that Texas calls Operation Lone Star because National Guard members participating in that capacity are serving in a state-funded, State Active Duty status, and are serving alongside the Texas State Guard whose members do not need to meet federal readiness requirements. Abbott Br. at 18. Governor Abbott's ability to deploy National Guard in State Active Duty status, including missions like Operation Lone Star, is thus not impacted by the federal military readiness requirements. Losing federal funds to pay for Texas State Guard activities, as consequence of disregarding military requirements the federal government has clear authority to set, is not irreparable harm. *See Elementary Orleans Par. Sch. Bd.*, No. CV 16-2323, 2016 WL 5390393, at *4 (E.D. La. Sept. 27, 2016) (no irreparable harm from loss of funding); *cf. S. Dakota v. Dole*, 483 U.S. 203, 212 (1987).

Plaintiffs next argue that they suffer irreparable harm because their orders to Guardsmen under their command conflict with federal regulations "scramble[] the chain of command, leaving Guardsmen to wonder whose orders they must follow." Abbott Br. at 20–21. But as explained above, any state orders that conflict with applicable federal regulations are *void ab initio* because they are unlawful under state law. *See* Tex. Gov't Code § 437.004; Alaska Stat. §§ 26.05.060, 26.05.340. In any event, this claim of irreparable harm fails because it is black-letter law that the federal government does not "invade[]" areas of state sovereignty "simply because it exercises *its* authority" in a way that preempts conflicting orders from a Governor acting as commander-in-chief. *See Hodel v. Va. Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 291 (1981) (emphasis added).

Finally, Plaintiffs' delay in seeking relief further confirms the absence of any irreparable injury. "[D]elay in seeking a remedy is an important factor bearing on the need for a preliminary injunction. Absent a good explanation, a substantial period of delay militates against the issuance of a preliminary injunction by demonstrating that there is no apparent urgency to the request for injunctive relief."

Gonannies, Inc. v. Goupair.Com, Inc., 464 F. Supp. 2d 603, 609 (N.D. Tex. 2006) (quoting *Wireless Agents, LLC v. T-Mobile USA, Inc.*, 2006 WL 1540587, at *3 (N.D. Tex. June 6, 2006)). The Secretary of Defense announced the military's new readiness requirements in August 2021 and made clear that those requirements applied to the National Guard. But Plaintiffs waited *months* to file suit, and provide no good explanation for the delay. In these circumstances, Plaintiffs' delay undercuts any claim of irreparable harm.

III. The Equities and Public Interest Weigh Against Injunctive Relief.

The third and fourth requirements for issuance of a preliminary injunction "merge when the Government is the opposing party." *Nken v. Holder*, 556 U.S. 418, 435 (2009). These factors tilt decisively against granting a preliminary injunction.

"[T]he court would be hard-put to find that the public interest would be served by entry of an order prohibiting the implementation of a vaccine mandate which adds one FDA-approved vaccine to the list of nine that all service members are already required to take—that tenth vaccine being the one which has been shown to be remarkably effective in mitigating the effects of the pandemic which has affected millions of Americans, including thousands of service members." *Oklahoma*, 2021 WL 6126230, at *14.

"[T]he military—and the public generally—undoubtedly have a strong interest in maintaining the combat readiness and health of the force, especially in these uncertain times." *Short*, No. 2:22-cv-1151, ECF No. 25 at 14; *Oklahoma*, 2021 WL 6126230, at *14 ("the public's interest in military readiness outweighs the interests claimed by the Plaintiffs"). Any injunction of military medical readiness requirements for the National Guard would seriously and adversely impact the national security of the United States. The National Guard serves as an integral part of our Nation's armed forces and National Guard units have heroically served in every major modern conflict. These soldiers and airmen need to be ready to deploy in short order to protect and defend America's interests around

the world. Ex. B ¶ 3. Any injunction that undermines the military's ability to keep its forces healthy runs contrary to public interest. *See generally* Ex. D ¶¶ 10–40.

The requested injunction would also impinge upon the military's authority to handle matters of good order and discipline without interference from the Judiciary. *Chappell v. Wallace*, 462 U.S. 296, 300-01 (1983); *Bois v. Marsh*, 801 F.2d 462, 467-68 (D.C. Cir. 1986). The National Guard has specific processes that must be followed prior any discipline or adverse employment action. *See* Ex. A ¶ 19, 21. An injunction prohibiting the military from initiating or completing those processes "would be a disruptive force as to affairs peculiarly within the jurisdiction of the military authorities." *Orloff v. Willoughby*, 345 U.S. 83, 95 (1953); *cf. White*, 862 F.2d at 1212 (the Supreme Court "explicitly mandates that courts must consider the disruptive effect on the administrative process of the federal government of granting preliminary injunctions in government-employment-related cases"). This, too, would be contrary to the public interest. *See Chilcott v, Orr*, 747 F.2d 29, 33 (1st Cir. 1984), 747 F.2d at 33 (noting the "strong judicial policy against interfering with the internal affairs of the armed forces"); *see also Reinhard v. Johnson*, 209 F. Supp. 3d 207, 221 (D.D.C. 2016); *Guerra v. Scruggs*, 942 F.2d 270, 275 (4th Cir. 1991); *Shaw v. Austin*, 539 F. Supp. 3d 169, 184 (D.D.C. 2021).

At a larger level, enjoining the military's vaccine requirements would harm the public interest in slowing the spread of COVID-19 among service members and the members of the public with whom they interact. In recognition of the Government's "compelling interest" in "[s]temming the spread of COVID-19," *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020), numerous courts reviewing "executive action designed to slow the spread of COVID-19" have concluded that "[t]he public interest in protecting human life—particularly in the face of a global and unpredictable pandemic—would not be served by" an injunction. *Tigges v. Northam*, 473 F. Supp. 3d 559, 573–74 (E.D. Va. 2020); *see also, e.g., Rydie v. Biden*, ---F. Supp. 3d---, 2021 WL 5416545, at *5-6 (D. Md. Nov. 19, 2021), *appeal filed*, No. 21-2359 (4th Cir. Dec. 7, 2021); Mem. Op., *Altschuld v. Raimondo*, No. 1:21-

cv-02779, ECF No. 23 at 11; *Church*, 2021 WL 5179215, at *18–19; *Smith v. Biden*, No. 1:21-cv-19457, 2021 WL 5195688, at *9 (D.N.J. Nov. 8, 2021), *appeal filed*, No. 21-3091 (3d Cir. Nov. 10, 2021); *Short*, 2:22-cv-01151, ECF No. 25.

On the other side of the equities, there is nothing to prevent Governors of Texas or Alaska to put their unvaccinated National Guard members into State Active Duty where the each state would pay for their service. Individuals who no longer meet federal readiness requirements can also move to their respective State Defense Force where they no longer serve in a Reserve Component and thus would no longer need to meet federal medical readiness requirements. In that role, where they would be subject to state rules regarding COVID-19 vaccinations, those service members could continue to serve their State and provide critical assistance in emergencies. The only purported harm alleged by Plaintiffs is that the States would then have to foot the bill—but that certainly is fair considering that those individuals are no longer eligible to deploy or serve in our Nation's Armed Forces.

IV. The Court Lacks Jurisdiction to Enjoin the President.

Finally, this Court lacks jurisdiction to enjoin the President in his official capacity. "With regard to the President, courts do not have jurisdiction to enjoin him . . . and have never submitted the President to declaratory relief." *Newdow v. Roberts*, 603 F.3d 1002, 1013 (D.C. Cir. 2010) (citation omitted); *see also Franklin v. Massachusetts*, 505 U.S 788, 802-03 (1992); *Willis v. U.S. Dep't of Health & Human Servs.*, 38 F. Supp. 3d 1274, 1277 (W.D. Okla. 2014) ("Longstanding legal authority establishes that the judiciary does not possess the power to issue an injunction against the President or Congress."). Thus, in no event can any injunctive relief be directed at the President or his actions.

CONCLUSION

The court should deny Plaintiffs' motion for a preliminary injunction.

Dated: March 9, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on March 9, 2022, this document and attachments were filed through the Court's CM/ECF system, which automatically serves all counsel of record.

/s/ Zachary A. Avallone

Exhibit A

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

GOVERNOR GREG ABBOTT, in his official capacity as Governor of the State of Texas, and GOVERNOR MIKE DUNLEAVY, in his official capacity as Governor of the State of Alaska, *Plaintiffs*, v. JOSEPH R. BIDEN, *et al.*, *Defendants*.	No. 6:22-cv-00003

DECLARATION OF COL KEVIN A. MULCAHY

I, Col Kevin A. Mulcahy, hereby state and declare as follows:

1. I am the Chief, Staff Support Services Office (SSSO) within the Directorate of Management and Administration (DM&A) of the National Guard Bureau in Arlington, Virginia. I have been in this position since 3 January 2022. Previously, I was assigned as the Deputy Director of Manpower and Personnel of the National Guard Bureau, from 10 Nov 2020 to 2 January 2022. As the Deputy Director, NGB-J1, I served as a principal advisor to the Chief of the National Guard Bureau and other senior National Guard Bureau leaders on Army National Guard and Air National Guard personnel policy matters that are included within the functions of the National Guard Bureau as prescribed by Congress in 10 U.S.C. § 10503 and the Secretary of

Defense in Department of Defense Directive 5105.77, *The National Guard Bureau*, October 15, 2015 (with change 1, October 10, 2017). I have also served in the Illinois State National Guard as a title 32 Human Resource Officer, and various other senior roles within the NGB-J1 and the state NG.

2. I make this declaration in my official capacity as the National Guard Bureau, SSSO Chief and as the prior Deputy Director for Manpower and Personnel based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

Overview of National Guard Statuses

3. The duties and responsibilities of Guard members differs depending on the title of the United States Code applicable to their role.

4. Most members of the National Guard are Drill Status Guardsmen, who are required to attend Title 32 training one weekend a month and two weeks a year. *See* 32 U.S.C. § 502(a). Title 32 training is conducted by states, but subject to regulation by Congress and the federal military. *See* 32 U.S.C. § 501 ("The training of the National Guard of the several states . . . shall be conducted in conformity with this title."). Title 32 training is primarily designed to prepare National Guard units and individual service members for military service as part of one of the reserve component of the United States, i.e., service in the Army National Guard of the United States or the Air National Guard of the United State. *See* 10 U.S.C. § 101(c)(3)&(5). Unless they have received an exemption, Drill Status Guardsmen are required to comply with vaccination requirements prescribed by the Secretaries of the Army or Air Force before attending Title 32 training. For Drill Status Guardsmen in the Air National Guard, the deadline was

December 31, 2021. For Drill Status Guardsmen in the Army National Guard, the deadline is June 30, 2022.

5. Members in the Title 32 Active Guard and Reserve (AGR) are full-time, uniformed service members serving at the state level but paid by federal funds. Title 32 allows the Governor, with the consent of the Secretaries of the Army or Air Force, to allow members of the National Guard to work full-time under the control of the state, subject to Title 32 regulations. *See* 32 U.S.C. §§ 328, 502(f). Federal consent may be withdrawn at any time and for any reason. *See* 32 U.S.C. § 328. AGR service is limited to "organizing, administering, recruiting, instructing, or training the reserve components." *See* 10 U.S.C. § 101(d)(6). Thus, the purpose of AGR service is to prepare a state National Guards for federal missions. Unless they have received an exemption, AGRs are required to comply with military vaccination requirements as prescribed by the Secretaries of the Army or Air Force. For AGRs serving in the Air National Guard, the deadline was December 31, 2021, and for AGRs serving in the Army National Guard, the deadline was December 15, 2021 unless they have an approved exemption or pending exemption request or appeal.

6. Military technicians (dual status) are full-time civilian employees of the United States whose employment is conditioned on maintaining their military position in the State National Guard. *See* 5 U.S.C. 3101 and 32 U.S.C. 709(b). Because they are required to maintain a military position as a condition of employment and are governed by two different titles of the United States Code, they are sometimes referred to as "dual-status technicians." Similar to AGR service, the roles military technicians include organizing, administering, recruiting, and training the Reserve components. Dual-status technicians are also members of the National Guard, so they are required to comply with military vaccine requirements as a matter of fitness for duty in

the Reserve components. *See* 32 U.S.C. §709(f)(4) and (j)(2). For dual-status Air National Guardsmen, they must comply with applicable military vaccination requirements by December 31, 2021 before they can participate in any Title 32 training or other Title 32 activities. Dual-status Army National Guard members must comply by June 30, 2022 before they can participate in any Title 32 training or activities.

7. Members of the National Guard serving under Title 10 are on federal active duty in the Army National Guard of the United States or the Air National Guard of the United States and are subject to the same rules and regulations as active duty military. For the Texas National Guard, this would include the United States Fiscal and Property Officer.

8. When members of the National Guard are serving in purely a state mission or duty and are not performing a federally authorized mission or training, they should be placed in State Active Duty (SAD). SAD is training or other duty, other than inactive duty, performed by a member of the National Guard of a State that is: A) not under section 502 of title 32 or under title 10; B) in service to the Governor of a State; and C) for which the member is not entitled to pay from the Federal Government. 38 U.S.C. § 4303 (15) and DODD 5105.83. Practically speaking, this means that SAD pay is set by state law, not federal law, members performing duty under SAD do not have FTCA coverage, and they may or may not get state retirement benefits. Operations under SAD may use federal equipment with the consent of the federal government, however, the State must pay for the use and maintenance of the equipment.

COVID-19 Vaccine Requirements For Guard Members

9. On August 24, 2021, the Secretary of Defense issued a memorandum directing the Secretaries of the Military Departments to immediately begin full immunization of all members of the Armed Forces against COVID-19, including members of the Army National Guard and

Air National Guard. Memorandum from Secretary of Defense to Service Secretaries, subject: Mandatory Coronavirus Disease 2019 Vaccination of Department of Defense Service Members, August 24, 2021, https://perma.cc/YZ9F-NNU2.

10. On November 30, 2021, the Secretary of Defense issued a memorandum emphasizing that the Covid-19 vaccination requirement was a readiness requirement that applied to all members of the National Guard, (including those not serving on active duty in a Title 10 military status), and directing the Secretaries of the Army and Air Force to "establish, as appropriate, policies and implementation guidance to address the failure to maintain this military medical requirement by members of the non-federalized National Guard who remain unvaccinated . . . ." of the National Guard who remain unvaccinated. Memorandum from Secretary of Defense to Service Secretaries, subject: Coronavirus Disease 2019 Vaccination for Members of the National Guard and the Ready Reserve, November 30, 2021, https://perma.cc/YZ9F-NNU2.

11. The Department of the Army and Department of the Air Force followed with specific regulatory guidance applicable to members of the Army National Guard and Air National Guard. Memorandum from Secretary of the Air Force to Commanders of Major Commands, Field Commands, Direct Reporting Units and Field Operating Agencies, subject "Supplemental Coronavirus Disease 2019 Vaccination Policy, December 7, 2021" Secretary of the Air Force (SecAF) Memo, Dec. 7, 2021, https://perma.cc/72K5-SN8E, and Army Fragmentary Order 11 to HQDA Exord 225-21 Covid-19 Steady State Operations, attached as Exhibit A.

12. The December 7, 2021 SecAF Memo explained that COVID-19 vaccination requirements apply to "Air National Guard performing any duty or training under both Title 10 and Title 32 of the United States Code." Dec. 7, 2021 Sec AF Memo, 1. The Secretary directed commanders to

"take appropriate administrative and disciplinary actions consistent with federal law and Department of the Air Force (DAF) policy in addressing service members who refuse to obey a lawful order to receive the COVID-19 vaccine and do not have a pending separation or retirement, or medical, religious or administrative exemption." *Id.* "[U]nvaccinated regular Airmen or Guardians with a request for medical, religious, or administrative exemption will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review." *Id.*

13. Attachment 2 to the December 7, 2021 SecAF Memo explains that pursuant to 32 U.S.C. § 328, "the Secretary of the Air Force hereby withdraws consent for members not fully vaccinated to be placed on or to continue on previously issued Title 32 Active Guard and Reserve (AGR) orders." Dec. 7, 2021 SecAF Memo, Att. 2, ¶ 2. Since consent of the Secretary is required for any unit or member to serve under Title 32, the withdrawal of consent means that unvaccinated members without a pending exemption are not allowed to participate in training or any other Title 32 activities (even those Title 32 activities are generally directed by state officials, like the governor).

14. The Secretary of the Air Force also explained that Air National Guard members "that have not initiated a vaccination regimen by 31 December 2021" and do not have a pending exemption request, "may not participate in drills, training, or other duty conducted Title 10 or Title 32." Dec. 7, 2021 SecAF Memo, Att. 2, ¶ 5.

15. National Guard members are required to comply with the COVID-19 vaccination medical readiness requirements. January 27, 2022 Army National Guard (ARNG) Directorate Fragmentary Order 17 to Annex B (COVID-19 Guidance) to ARNG EXORD 197-21 (Building Readiness in a COVID-19 Environment), attached as Exhibit B. Soldiers will have until March

1, 2022, to submit COVID-19 vaccination mandate exemption packets. *Id.* ¶ 3.D.4.A. The completion goal for the Army National Guard vaccination mandate is June 30, 2022. *Id.* ¶ 3.D.3.C.7.C. The Army will not enforce vaccination requirement as a precondition for Title 32 Army National Guard Drill Status and Annual Training prior to June 30, 2022. *Id.* ¶ 3.D.3.C.7.C.3.

16. Title 32 Active Guard Reserve soldiers are aligned with their Regular Army Active Component and must have been fully vaccinated by December 15, 2021, unless they have an approved exemption or pending exemption request or appeal. ANGRC Fragmentary Order 18 at paragraph 3.D.15.B. Unless they comply with those readiness requirements, the Secretary of the Army may withdraw consent to allow them to continue AGR service.

Enforcement of Federal Regulations

17. There are various means for the federal government to ensure that state National Guards comply with federal military regulations when they are performing federally authorized training and missions in a Title 32 status.

18. Federal inspections may be ordered to ensure National Guard units and members meet federal standards and to determine eligibility for the issuance of military property and federal recognition. 32 U.S.C. § 105. For example, the National Guard Bureau conducts readiness checks of National Guard units to ensure that federal equipment is being properly maintained and operated according to Air Force or Army standards. In the event a state were to fail an inspection, the Department of Defense may reassign the entire mission and the unit's military property, such as its aircraft, to another state National Guard or to another DOD organization.

19. The federal military has the power to administratively remove a service member from the National Guard if that member fails to comply with federal regulatory standards (withdrawal of

federal recognition for officers, or administrative discharge for enlisted). *See* 32 U.S.C. § 323; *see also* 32 U.S.C. §§ 322, 324. Although the state National Guard currently may initiate an action against a service member, administrative discharge and withdrawal of federal recognition are federal functions, the final decision in such actions are made by federal officials, and the federal government does not need the consent of the State. In addition, the Military Departments have the authority to take lesser forms of disciplinary and corrective actions on Title 32 service members, such as they may issue formal written reprimands to senior officers in the state National Guards, who violate DOD regulations.

20. If a state's National Guard fails to comply with a regulatory requirement prescribed according to Title 32, Congress has authorized the President to withhold federal funds from the state under authority of 32 U.S.C. § 108. However, prior to formally reducing federal funds allotted to a State under section 108, the Department of Defense can employ less drastic financial controls to encourage a state to come in compliance with regulatory requirements. For example, while the states control the day-to-day performance of service members in Title 32 status, the Defense Finance and Accounting Service (DFAS), a DOD agency, actually determines their pay and benefits and issues paychecks for members of the National Guard. A state National Guard does not have any control over DFAS, and DFAS can determine to withhold federal military pay and benefits to Title 32 service members who do not meet military readiness requirements.

21. Congress has also provided a means for courts-martial of National Guard service members who are not in Federal service. Pursuant to 32 U.S.C. § 326, "[i]n the National Guard not in Federal service, there are general, special, and summary courts-martial constituted like similar courts of the Army and the Air Force. They have the jurisdiction and powers, except as to punishments, and shall follow the forms and procedures, provided for those courts." Section

327 of title 32 of the U.S. Code enumerates the specific convening authorities for such courts-martial.

22. Finally, Department of Defense policy prohibits state National Guards from issuing regulations on National Guard matters that are inconsistent with federal military regulations issued by the Department of Defense, Departments of the Army and the Air Force, or the National Guard Bureau. For example, Department of Defense Directive 5105.83, *National Guard Joint Force Headquarters - State (NG JFHQs-State)*, provides: "The NG JFHQs-State may issue State regulations on NG matters pertaining to their respective States consistent with State and U.S. laws and DOD, CJCS, Departments of the Army and the Air Force, and NGB policies, regulations, instructions, and directives."

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 9th day of March 2022.

MULCAHY.KEVIN.ALAN.1087832518 Digitally signed by MULCAHY.KEVIN.ALAN.1087832518 Date: 2022.03.09 10:40:25 -05'00'

KEVIN A. MULCAHY
Colonel, USAF
Chief, Staff Support Services Office
National Guard Bureau

Exhibit A to Decl. of Col. Kevin A. Mulcahy

RUIAAAA/CDR USAR NORTH FT SAM HOUSTON TX
RUIAAAA/CDR USARCENT SHAW AFB SC
RUIAAAA/CDR USASOC COMMAND CENTER FT BRAGG NC
RUIAAAA/CDR USASOC FT BRAGG NC
RUIAAAA/CDR USASOC MESSAGE CENTER FT BRAGG NC
RUIAAAA/CDR3RD ARMY USARCENT WATCH OFFICER SHAW AFB SC
RUIAAAA/CDRAMC REDSTONE ARSENAL AL
RUIAAAA/CDRFORSCOM FT BRAGG NC
RUIAAAA/CDRHRC G3 DCSOPS FT KNOX KY
RUIAAAA/CDRINSCOM FT BELVOIR VA
RUIAAAA/CDRINSCOMIOC FT BELVOIR VA
RUIAAAA/CDRMDW WASHINGTON DC
RUIAAAA/CDRUSACE WASHINGTON DC
RUIAAAA/CDRUSACIDC FT BELVOIR VA
RUIAAAA/CDRUSACYBER FT BELVOIR VA
RUIAAAA/CDRUSACYBER G3 FT BELVOIR VA
RUIAAAA/CDRUSACYBER G33 FT BELVOIR VA
RUIAAAA/CDRUSAEIGHT G3 CUROPS SEOUL KOR
RUIAAAA/CDRUSAEIGHT SEOUL KOR
RUIAAAA/CDRUSAMEDCOM FT SAM HOUSTON TX
RUIAAAA/CDRUSARC G33 READ FT BRAGG NC
RUIAAAA/CDRUSARCYBER WATCH OFFICER FT BELVOIR VA
RUIAAAA/CDRUSARPAC CG FT SHAFTER HI
RUIAAAA/CDRUSARPAC FT SHAFTER HI
RUIAAAA/COMDT USAWC CARLISLE BARRACKS PA
RUIAAAA/HQ IMCOM FT SAM HOUSTON TX
RUIAAAA/HQ INSCOM IOC FT BELVOIR VA
RUIAAAA/HQ SDDC CMD GROUP SCOTT AFB IL
RUIAAAA/HQ SDDC OPS MSG CNTR SCOTT AFB IL
RUIAAAA/HQ USARSO FT SAM HOUSTON TX
RUIAAAA/HQ USARSO G3 FT SAM HOUSTON TX
RUEADWD/HQDA ARMY STAFF WASHINGTON DC
RUEADWD/HQDA CSA WASHINGTON DC
RUEADWD/HQDA EXEC OFFICE WASHINGTON DC
RUEADWD/HQDA IMCOM OPS DIV WASHINGTON DC
RUEADWD/HQDA SEC ARMY WASHINGTON DC
RUEADWD/HQDA SECRETARIAT WASHINGTON DC
RUEADWD/HQDA SURG GEN WASHINGTON DC
RUIAAAA/MEDCOM HQ EOC FT SAM HOUSTON TX
RUIAAAA/NETCOM G3 CURRENT OPS FT HUACHUCA AZ
RUIAAAA/NGB WASHINGTON DC
RUIAAAA/SMDC ARSTRAT CG ARLINGTON VA
RUIAAAA/SMDC ARSTRAT G3 ARLINGTON VA
RUIAAAA/SUPERINTENDENT USMA WEST POINT NY
RUIAAAA/SURGEON GEN FALLS CHURCH VA
RUIAAAA/USAR AROC FT BRAGG NC
RUIAAAA/USAR CMD GRP FT BRAGG NC
RUIAAAA/USAR DCS G33 OPERATIONS FT BRAGG NC
RUIAAAA/USARCENT G3 FWD
RUIAAAA/USARPAC COMMAND CENTER FT SHAFTER HI
RUIAAAA/CDR USAREUR-AF WIESBADEN GE
RUIPAAA/CDR SETAF-AF VICENZA IT
INFO RUIAAAA/HQDA AOC DAMO ODO OPS AND CONT PLANS WASHINGTON DC
RUIAAAA/HQDA AOC G3 DAMO CAT OPSWATCH WASHINGTON DC
RUIAAAA/HQDA AOC G3 DAMO OD DIR OPS READ AND MOB WASHINGTON DC
BT
UNCLAS CUI
SUBJ/FRAGO 11 TO HQDA EXORD 225-21 COVID-19 STEADY STATE OPERATIONS
CONTROLLED BY: HQDA DCS, G-3/5/7
CONTROLLED BY: DAMO-OD
CUI CATEGORY: OPSEC
LIMITED DISSEMINATION CONTROL: FEDCON

POC: LTC NYKEBA L. ANTHONY 703-692-2804

SUBJECT: (CUI) FRAGO 11 TO HQDA EXORD 225-21 COVID-19 STEADY STATE OPERATIONS//

(U) REFERENCES.
REF//A/ THROUGH REF/QQ/ NO CHANGE.
REF//RR/ [ADD] FRAGO 10 TO HQDA EXORD 225-21 COVID-19 STEADY STATE OPERATIONS, DTG 190336Z NOV 21 //

1. (U) SITUATION. NO CHANGE.

1.A. THROUGH 1.K. NO CHANGE.

2. (U) MISSION. NO CHANGE.

3. (U) EXECUTION.

3.A. (U) COMMANDER'S INTENT. NO CHANGE.

3.B. (U) CONCEPT OF OPERATION. NO CHANGE.

3.C. (U) TASKS TO ARMY STAFF AND SUBORDINATE COMMANDS.

3.C.1. (U) COMMANDERS, ALL ARMY COMMANDS (ACOM), ARMY SERVICE COMPONENT COMMANDS (ASCC), AND DIRECT REPORTING UNITS (DRU).

3.C.1.A. THROUGH 3.C.1.D. NO CHANGE.

3.C.1.E. (U) [ADD] REPORT NUMBER OF SOLDIERS WHO HAVE REFUSED COVID-19 VACCINATION AND HAVE NOT REQUESTED OR RECEIVED AN APPROVED EXEMPTION. REPORT INFORMATION IN ANNEX ZZZ NLT MONDAY, 06 DECEMBER 2021, WITH SUBSEQUENT REPORTS DUE EVERY TUESDAY NLT 1000R BEGINNING ON
14 DECEMBER 2021. REPORT INFORMATION BY ACOM/ASCC/DRU IN CONSOLIDATED

FORMAT. ACOM/ASCC/DRUS WILL SUBMIT CONSOLIDATED REPORT TO THE HQDA COVID-19 OPT AT USARMY.PENTAGON.HQDA-DCS-G-3-5-7.MBX.COVID-OPT@ARMY.MIL.

3.C.1.E.1. (U) (U) [ADD] MEDPROS DOES NOT HAVE A DECLINE OR REFUSAL OPTION FOR INDIVIDUAL RECORDS KEEPING. THEREFORE, WE RELY SOLELY ON COMMAND REPORTING. EFFECTIVELY IMMEDIATELY, ONLY SOLDIER REFUSALS WILL BE RECORDED AS "BLANK" IN MEDPROS TO ENSURE ACCURATE NUMBER OF REFUSALS ARE REFLECTED IN THE SYSTEM OF RECORD.

3.C.2. THROUGH 3.C.33. NO CHANGE.

3.D. (U) COORDINATING INSTRUCTIONS.

3.D.1. THROUGH 3.D.20. NO CHANGE.

3.D.21. (U) [ADD] READ AND COMPLY WITH SECRETARY OF DEFENSE MEMORANDUM, "CORONAVIRUS DISEASE 2019 VACCINATION FOR MEMBERS OF THE NATIONAL GUARD AND THE READY RESERVE," DATED 30 NOVEMBER 2021 (ANNEX AAAA).

4. (U) SUSTAINMENT. NOT USED.

5. (U) COMMAND AND SIGNAL.

5.A. (U) COMMAND. NOT USED.

5.B. (U) SIGNAL.

5.B.1. (U) HEADQUARTERS DEPARTMENT OF THE ARMY COVID-19 POINTS OF CONTACT (POC). HQDA COVID-19 OPT AT USARMY.PENTAGON.HQDA-DCS-G-3-5-7.MBX.COVID-OPT@ARMY.MIL;

5.B.1.A. (U) G-1 POC IS COL MICHAEL A. ZWEIFEL, MICHAEL.A.ZWEIFEL.MIL@ARMY.MIL, (703) 697-8469.

5.B.1.B. (U) G-2 POC IS LTC LEON SATCHELL, LEON.R.SATCHELL.MIL@ARMY.MIL, (703)697-5484.

5.B.1.C. (U) G-4 POCS ARE LTC KYLE FERRARINI (MEDLOG TF), KYLE.FERRARINI2.MIL@ARMY.MIL, (703) 693-6704 OR ALOC USARMY.PENTAGON.HQDA.MBX.AALOCATC@ARMY.MIL, (703) 614-2159.

5.B.1.D. (U) LABORATORY RESPONSE NETWORK POC IS DR. WILLIAM NAUSCHUETZ, LABORATORY BIOPREPAREDNESS COORDINATOR, WILLIAM.F.NAUSCHUETZ.CIV@MAIL.MIL, (210) 295-7269 OR (210) 386-1480.

5.B.1.E. (U) USAMEDCOM PUBLIC HEALTH POC IS COL RICK CHAVEZ, RODRIGO.CHAVEZ5.MIL@MAIL.MIL, (703) 681-9510 OR COL MICHELE A. SOLTIS, MICHELE.A.SOLTIS.MIL@MAIL.MIL, (703) 681- 6043.

5.B.1.F. (U) ARMY PUBLIC HEALTH CENTER POC IS DR. STEVEN CERSOVSKY, STEVEN.B.CERSOVSKY.CIV@MAIL.MIL, (410) 436-4311.

5.B.1.G. (U) ARMY PUBLIC AFFAIRS POC IS LTC TERENCE KELLEY, TERENCE.M.KELLEY.MIL@ARMY.MIL.

5.B.1.H. (U) OFFICE OF THE JUDGE ADVOCATE GENERAL POC LTC JAMES MCINERNEY, JAMES.A.MCINERNEY.MIL@ARMY.MIL, (703) 614-4630,

5.B.1.I. (U) ARMY NATIONAL GUARD POC IS MAJ TIMOTHY MCCORMIC, TIMOTHY.A.MCCORMIC.MIL@MAIL.MIL, (703) 601-7620.

5.B.1.J. (U) UNITED STATES ARMY RESERVES POC IS LTC RAYMOND D. HARPER, RAYMOND.D.HARPER4.MIL@MAIL.MIL, 703.614-5271.

5.B.1.K. (U) OFFICE OF THE SURGEON GENERAL POC IS COL DUBRAY KINNEY, DUBRAY.KINNEY2.MIL@MAIL.MIL, (703) 681-9672.

5.B.1.L. (U) ASSISTANT SECRETARY OF THE ARMY (FINANCIAL MANAGEMENT AND COMPTROLLER) POC IS LTC DALE BERRY, DALE.E.BERRY2.MIL@ARMY.MIL, (703) 614-1680.

5.B.1.M. (U) ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS) POCS ARE MS. CONSTANCE B. RAY, CONSTANCE.B.RAY2.CIV@ARMY.MIL, (703) 344-8047 OR COL BENITO RODRIGUEZ, BENITO.E.RODRIGUEZ.MIL@MAIL.MIL, (703) 695-4402.

5.B.1.N. (U) ARMY CONFERENCES PROGRAM, OFFICE OF THE ADMINISTRATIVE ASSISTANT TO THE SECRETARY OF THE ARMY POC: HQDA.CONFERENCES.INBOX@MAIL.MIL.

5.B.1.O. (U) ASSISTANT SECRETARY OF THE ARMY (ACQUISITION, LOGISTICS

AND TECHNOLOGY) POCS ARE LTC RACHAEL M. HOAGLAND, RACHAEL.M.HOAGLAND.MIL@ARMY.MIL, (703) 614-2500 OR COL ROBERT L. VON

TERSCH,
ROBERT.L.VONTERSCH.MIL@ARMY.MIL, (703) 614-6586.

5.B.1.P. (U) HEADQUARTERS DEPARTMENT OF THE ARMY WATCH: NIPR EMAIL USARMY.PENTAGON.HQDA.MBX.ARMYWATCH@ARMY.MIL, SIPR EMAIL USARMY.PENTAGON.HQDA.MBX.ARMYWATCH@MAIL.SMIL.MIL.

5.B.1.Q. (U) HEADQUARTERS DEPARTMENT OF THE ARMY COVID-19 CRISIS ACTION TEAM INFO:

NIPR PORTAL:
HTTPS://G357.ARMY.PENTAGON.MIL/OD/ODO/ARMYOPCENTER/CAWG/CAT/SITEPAGES ORONAVIRUS%20(COVID-19).ASPX

SIPR PORTAL:
HTTPS://G357.ARMY.PENTAGON.SMIL.MIL/OD/ODO/ARMYOPCENTER/CRISISACTIONP GE/SITEPAGES/HOME.ASPX

DOMS NIPR OMB:
USARMY.PENTAGON.HQDA-DCS-G-3-5-7.MBX.DOMS-OPERATIONS@ARMY.MIL

DOMS SIPR OMB:
USARMY.PENTAGON.HQDA-DCS-G-3-5-7.MBX.AOC-DOMS-TEAM@MAIL.SMIL.MIL

6. (U) THE EXPIRATION DATE OF THIS MESSAGE IS 31 DECEMBER 2026, UNLESS FORMALLY RESCINDED OR SUPERSEDED.

ATTACHMENT:
ANNEX A - ARMY INSTALLATION GATING CRITERIA REPORT.
ANNEX B - SECRETARY OF DEFENSE MEMORANDUM, "UPDATE TO CONDITIONS-BASED
APPROACH TO CORONAVIRUS DISEASE 2019 PERSONNEL MOVEMENT AND TRAVEL RESTRICTIONS," 15 MARCH 2021.
ANNEX C - COVID-19 PERSONAL PROTECTIVE EQUIPMENT, LOGSTAT REPORT.
ANNEX D - HQDA COVID-19 POSITIVE CASE AND ROM TRACKER.
ANNEX E - SECRETARY OF THE ARMY MEMORANDUM, "DELEGATION OF AUTHORITY TO APPROVE TRAVEL OF ARMY PERSONNEL-TRANSITION FRAMEWORK," 20 APRIL 2021.
ANNEX F - SECRETARY OF DEFENSE MEMORANDUM, "GUIDANCE FOR COMMANDERS' RISK-BASED RESPONSES AND IMPLEMENTATION OF THE HEALTH PROTECTION CONDITION (HPCON) FRAMEWORK DURING THE CORONAVIRUS DISEASE 2019 PANDEMIC," 29 APRIL 2021.
ANNEX G - FORCE HEALTH PROTECTION SUPPLEMENT 20, DEPARTMENT OF DEFENSE
GUIDANCE FOR PERSONNEL TRAVELING DURING THE CORONAVIRUS DISEASE 2019 PANDEMIC, 12 APRIL 2021.
ANNEX H - FORCE HEALTH PROTECTION SUPPLEMENT 16.1, DEPARTMENT OF DEFENSE GUIDANCE DEPLOYMENT AND REDEPLOYMENT OF INDIVIDUALS AND UNITS,
04 MAY 2021.
ANNEX I - FORCE HEALTH PROTECTION SUPPLEMENT 15.2, DEPARTMENT OF DEFENSE GUIDANCE FOR CORONAVIRUS DISEASE 2019 LABORATORY TESTING SERVICES, 02 JULY 2021.
ANNEX J - IMPLEMENTATION OF REQUIRED COVID-19 PROTECTIONS PUBLIC AFFAIRS GUIDANCE.
ANNEX K - TIER 4 TESTING CONCEPT AND APPROVAL AUTHORITY.
ANNEX L - DOD COVID TASK FORCE, COVID-19 TESTING PROTOCOLS, 08 MARCH 2021.
ANNEX M - CLMS FORM 1D, CLINICAL LABORATORY IMPROVEMENT PROGRAM WAIVED
COMPLEXITY REGISTRATION/RENEWAL FORM.

ANNEX N - DEPUTY SECRETARY OF DEFENSE MEMORANDUM, "METHODS TO ENABLE AND ENCOURAGE VACCINATION AGAINST CORONAVIRUS DISEASE 2019," 20 MAY 2021.
ANNEX O - [RESCINDED]
ANNEX P - DEPUTY SECRETARY OF DEFENSE MEMORANDUM, "CORONAVIRUS DISEASE
19 VACCINE GUIDANCE," 07 DECEMBER 2020.
ANNEX Q - UNDER SECRETARY OF DEFENSE MEMORANDUM SUPPLEMENTAL GUIDANCE

FOR PROVIDING DOD CORONAVIRUS DISEASE 2019 VACCINE TO DOD CONTRACTOR EMPLOYEES AND SELECT FOREIGN NATIONALS, 31 DECEMBER 2020.
ANNEX R - SECRETARY OF DEFENSE MEMORANDUM, "SECRETARIAL DESIGNEE STATUS FOR SELECT DEPARTMENT OF DEFENSE CIVILIAN EMPLOYEE AND CONTRACTOR EMPLOYEE DEPENDENTS OUTSIDE THE UNITED STATES FOR THE LIMITED
PURPOSE OF RECEIVING CORONAVIRUS DISEASE 2019 VACCINATIONS," 03 JUNE 2021.
ANNEX S - SECRETARY OF DEFENSE MEMORANDUM, "USE OF MASKS AND OTHER PUBLIC HEALTH MEASURES," 04 FEBRUARY 2021.
ANNEX T - FORCE HEALTH PROTECTION SUPPLEMENT 17.1, DEPARTMENT OF DEFENSE GUIDANCE FOR THE USE OF MASKS, PPE, AND NPI, 22 JUNE 2021.
ANNEX U - SECRETARY OF ARMY MEMORANDUM, USE OF MASKS AND DELEGATION OF
AUTHORITY TO GRANT EXCEPTIONS, 24 FEBRUARY 2021.
ANNEX V - [RESCINDED]
ANNEX W - POOLED TESTING GUIDANCE AND STRATEGY, 02 JUNE 2021.
ANNEX X - UNDER SECRETARY OF DEFENSE MEMORANDUM GUIDANCE FOR PARTICIPATION OF INTERNATIONAL MILITARY STUDENTS AND TRAINEES, 07 MAY

2021.
ANNEX Y - UNDER SECRETARY OF DEFENSE MEMORANDUM, "SUPPLEMENTAL GUIDANCE ON REQUESTING AUTHORIZATION AND ELIGIBILITY TO OFFER AND ADMINISTER CORONAVIRUS DISEASE 2019 VACCINATIONS," 08 JUNE 2021.
ANNEX Z - SECRETARY OF THE ARMY MEMORANDUM, "DELEGATION OF AUTHORITY FOR HEALTH PROTECTION CONDITION (HPCON) IMPLEMENTATION AND OCCUPANCY REQUIREMENTS," 09 JUNE 2021.
ANNEX AA - UNDER SECRETARY OF DEFENSE (PERSONNEL AND READINESS) MEMORANDUM, "FORCE HEALTH PROTECTION GUIDANCE (SUPPLEMENT 22) - DEPARTMENT OF DEFENSE GUIDANCE FOR CORONAVIRUS DISEASE 2019 SURVEILLANCE
AND SCREENING TESTING," 21 JULY 2021.
ANNEX BB - DEPUTY SECRETARY OF DEFENSE MEMORANDUM, "UPDATED MASK GUIDANCE FOR ALL DOD INSTALLATIONS AND OTHER FACILITIES," 28 JULY 2021.
ANNEX CC - CDC GUIDANCE FOR IMPLEMENTING COVID-19 PREVENTION STRATEGIES, 27 JULY 2021.
ANNEX DD - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1419, " (J&J) JANSSEN COVID-19 VACCINE SHELF-LIFE EXTENSION," 28 JULY 2021.
ANNEX EE - COVID-19 VACCINATION REQUIREMENT REPORT.
ANNEX FF - MANDATORY CORONAVIRUS DISEASE 2019 VACCINATION OF DEPARTMENT OF DEFENSE SERVICE MEMBERS, 24 AUGUST 2021.
ANNEX GG - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1463, "PFIZER LICENSE AND SHELF LIFE EXTENSION," 24 AUGUST 2021.
ANNEX HH - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21- 1425, "UPDATED COVID-19 VACCINE ORDERING GUIDELINES," 09 AUGUST 2021.
ANNEX II - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1454, "ADDITIONAL DOSE OF COVID 19 VACCINE FOR IMMUNOCOMPROMISED PERSONS," 13 AUGUST 2021.
ANNEX JJ - ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) MEMORANDUM,
"MANDATORY VACCINATION OF SERVICE MEMBERS USING THE PFIZER-BIONTECH COVID-19 AND COMIRNATY COVID-19 VACCINES," 14 SEPTEMBER 2021.

ANNEX KK - DD FROM 3150, "CONTRACTOR PERSONNEL AND VISITOR CERTIFICATION OF VACCINATION," OCTOBER 2021.
ANNEX LL - VACCINE INFORMATION FACT SHEET
ANNEX MM - DEPUTY SECRETARY OF DEFENSE MEMORANDUM, "UPDATED CORONAVIRUS DISEASE 2019 GUIDANCE RELATED TO TRAVEL AND MEETINGS," 24

SEPTEMBER 2021.
ANNEX NN - SAMPLE DA FORM 4856 FOR ENLISTED VACCINE REFUSALS.
ANNEX OO - SAMPLE DA FORM 4856 FOR OFFICER VACCINE REFUSALS.
ANNEX PP - EXECUTIVE ORDER 14043 OF SEPTEMBER 9, 2021, REQUIRING VACCINATION FOR FEDERAL EMPLOYEES.
ANNEX QQ - EXECUTIVE ORDER 14042 OF SEPTEMBER 9, 2021, ENSURING ADEQUATE COVID SAFETY PROTOCOLS FOR FEDERAL CONTRACTORS.
ANNEX RR - ABBOTT BINAXNOW COVID-19 AG CARD PRODUCT EXPIRY UPDATE, MAY
2021.
ANNEX SS - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1538, DISPOSITION GUIDANCE FOR MODERNA COVID VACCINE, 23 SEPTEMBER 2021.
ANNEX TT - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1549, PFIZER-BIONTECH/COMIRNATY COVID-19 VACCINE BOOSTER DOSE RECOMMENDATIONS, 27 SEPTEMBER 2021.
ANNEX UU - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1549, SUPPLEMENT 1, KEY MESSAGES AND TALKING POINTS, 27 SEPTEMBER 2021.
ANNEX VV - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1549, SUPPLEMENT 2, FACT SHEET FOR HEALTHCARE PROVIDERS ADMINISTERING VACCINE (VACCINATION PROVIDERS), 27 SEPTEMBER 2021.
ANNEX WW - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1549, SUPPLEMENT 3, VACCINE INFORMATION FACT SHEET FOR RECIPIENTS AND CAREGIVERS ABOUT COMIRNATY (COVID-19 VACCINE, MRNA) AND PFIZER-BIONTECH
COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19), 27 SEPTEMBER 2021.
ANNEX XX - REFUSALS AND MEDICAL/RELIGIOUS EXEMPTIONS PROCESS.
ANNEX YY - COVID-19 VACCINATION PERMANENT MEDICAL EXEMPTION REQUEST STANDARD OPERATION PROCEDURE.
ANNEX ZZ - PERMANENT MEDICAL EXEMPTION REQUEST PROCESS ASSIGNMENTS.
ANNEX AAA - REQUEST FOR PERMANENT MEDICAL EXEMPTION TO COVID-19 VACCINATION TEMPLATE MEMORANDUM.
ANNEX BBB - ARMY DIRECTIVE 2021-33 (APPROVAL AND APPEAL AUTHORITIES FOR MILITARY AND MEDICAL ADMINISTRATIVE IMMUNIZATION EXEMPTIONS), 24 SEPTEMBER 2021.
ANNEX CCC - SAFER FEDERAL WORKFORCE TASK FORCE, COVID-19 WORKPLACE SAFETY: AGENCY MODEL SAFETY PRINCIPLES, LAST UPDATED 13 SEPTEMBER 2021.
[CHANGE TO READ] ANNEX DDD - SAFER FEDERAL WORKFORCE TASK FORCE, COVID-19 WORKPLACE SAFETY: GUIDANCE FOR FEDERAL CONTRACTORS AND SUBCONTRACTORS, UPDATED 10 NOVEMBER 2021.
ANNEX EEE - MANDATORY CORONAVIRUS DISEASE 2019 VACCINATION OF DOD CIVILIAN EMPLOYEES, ISSUED 1 OCTOBER 2021.
ANNEX FFF - OFFICE OF PERSONNEL MANAGEMENT (OPM) AND SAFER FEDERAL WORKFORCE TASK FORCE GUIDANCE ON VACCINATION REQUIREMENTS, 5 OCTOBER 2021.
ANNEX GGG - UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS MEMORANDUM, "FORCE HEALTH PROTECTION GUIDANCE (SUPPLEMENT 23) REVISION
2 - DEPARTMENT OF DEFENSE GUIDANCE FOR CORONAVIRUS DISEASE 2019 VACCINATION ATTESTATION, SCREENING TESTING, AND VACCINATION VERIFICATION," 29 OCTOBER 2021.
ANNEX HHH - DD FORM 3175, CIVILIAN EMPLOYEE CERTIFICATION OF VACCINATION, OCTOBER 2021.
ANNEX III - ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS MEMORANDUM, "UPDATED GUIDANCE ON CO-ADMINISTRATION OF CORONAVIRUS

DISEASE 2019 VACCINE WITH OTHER VACCINES," 7 OCTOBER 2021.
ANNEX JJJ - UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS MEMORANDUM, "CORONAVIRUS DISEASE 2019 VACCINATION FOR PREGNANT AND BREASTFEEDING SERVICE MEMBERS," 5 OCTOBER 2021.
ANNEX KKK - SECRETARY OF THE ARMY MEMORANDUM, "DELEGATION OF AUTHORITY-ADDITIONAL CORONAVIRUS DISEASE 2019 GUIDANCE RELATED TO TRAVEL AND MEETINGS," 12 OCTOBER 2021.
ANNEX LLL - MEDICAL MATERIAL QUALITY CONTROL MESSAGE, MMQC-21-1613, "DISPOSITION GUIDANCE FOR MODERNA COVID VACCINE," 28 OCTOBER 2021.
ANNEX MMM - DEFENSE CIVILIAN PERSONNEL ADVISORY SERVICE MESSAGE, "COVERAGE FOR INJURIES RESULTING FROM THE COVID-19 VACCINATION MANDATE
FOR FEDERAL EMPLOYEES," 14 OCTOBER 2021.
ANNEX NNN - ASSISTANT SECRETARY OF THE ARMY FOR MANPOWER AND RESERVE AFFAIRS MEMORANDUM, "FORCE HEALTH PROTECTION GUIDANCE (SUPPLEMENT 23)

- REVISION 2 - DEPARTMENT OF DEFENSE GUIDANCE FOR CORONAVIRUS DISEASE 2019 VACCINATION ATTESTATION, SCREENING TESTING, AND VACCINATION VERIFICATION," 8 NOVEMBER 2021.
ANNEX OOO - ASSISTANT SECRETARY OF THE ARMY FOR MANPOWER AND RESERVE AFFAIRS, ASSISTANT G-1 (CIVILIAN PERSONNEL) NUMBERED MESSAGE (# 2021082) ARMY TEMPLATE MEMO FOR EMPLOYEE NOTIFICATION OF COVID-19 VACCINATION REQUIREMENT, "SUBJECT: EMPLOYEE NOTIFICATION, MANDATORY COVID-19 VACCINATION FOR FEDERAL EMPLOYEES."
ANNEX PPP - DD FORM 3176, "REQUEST FOR MEDICAL EXEMPTION OR DELAY TO THE COVID-19 VACCINATION REQUIREMENT," OCTOBER 2021.
ANNEX QQQ - DD FORM 3177, "REQUEST FOR RELIGIOUS EXEMPTION TO THE COVID-19 VACCINATION REQUIREMENT," OCTOBER 2021.
ANNEX RRR - OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER

AND RESERVE AFFAIRS MEMORANDUM, "VACCINATION ADVISORY STATEMENT FOR NON-USMEPCOM ACCESSIONS," 22 OCTOBER 21.
ANNEX SSS - DEFENSE LOGISTICS AGENCY, "COVID-19 HOME TEST KITS ORDERING PROCEDURES," 05 NOVEMBER 2021.
ANNEX TTT - MEDCOM "GENERAL INSTRUCTIONS FOR ALL SCREENING TESTS OF UNVACCINATED PERSONNEL"
ANNEX UUU - ARMY BUDGET OFFICE, "REIMBURSEMENT AND PROCESS FOR EMPLOYEE PURCHASED COVID-19 SELF-TESTS."
ANNEX VVV SAMPLE DECISION MEMO REQUESTING APPROVAL OF TRAVEL FOR UNVACCINATED INDIVIDUALS
ANNEX WWW PROCESS FOR REQUESTING MISSION ESSENTIAL APPROVAL OF TRAVEL

FOR UNVACCINATED INDIVIDUALS
ANNEX XXX SAMPLE DECISION MEMO MEETINGS OVER 50 PARTICIPANTS
ANNEX YYY - SECRETARY OF THE ARMY MEMORANDUM, "FLAGGING AND BARS TO CONTINUED SERVICE OF SOLDIERS WHO REFUSE THE COVID-19 VACCINATION ORDER," 16 NOVEMBER 2021.
[ADD] ANNEX ZZZ - SOLDIER COVID 19 VACCINATION REFUSALS REPORT
[ADD] ANNEX AAAA - CORONAVIRUS DISEASE 2019 VACCINATION FOR MEMBERS OF
THE NATIONAL GUARD AND THE READY RESERVE, 30 NOVEMBER 2021.

BT
#1035

NNNN
Received from AUTODIN 302322Z Nov 21

Exhibit B to Decl. of Col. Kevin A. Mulcahy

EXCERPTED COPY OF ARNG DIRECTORATE FRAGO 17 TO ANNEX B
(COVID-19 VACCINE GUIDANCE) TO ARNG EXORD 197-21
(BUILDING READINESS IN A COVID-19 ENVIRONMENT)

ARNG DIRECTORATE
TARC
ARLINGTON, VA
27 JANUARY 2022

(U) SUBJECT: FRAGO 17 TO ANNEX B (COVID-19 VACCINE GUIDANCE) TO ARNGEXORD 197-21 (BUILDING READINESS IN A COVID-19 ENVIRONMENT)

(U) REFERENCES. [CHANGE] APPENDIX 1 TO ANNEX B [FRAGO 17] TO ARNG EXORD 197-21 (BUILDING READINESS IN A COVID-19 ENVIRONMENT) CONTAINSCOMPREHENSIVE LIST OF REFERENCES FOR THIS FRAGO.

1. (U) SITUATION.

1.A. (U) THIS ORDER ADDRESSES SECRETARY OF THE ARMY IMPLEMENTATION OF REF BB, MANDATORY CORONAVIRUS DISEASE 2019 VACCINATION OF DEPARTMENT OF DEFENSE SERVICE MEMBERS, 24 AUGUST 2021. ON 09SEP21, THE PRESIDENT ISSUED EXECUTIVE ORDER 14042 (REF KK) AND 14043 (REF LL) REQUIRING VACCINATION FOR ALL FEDERAL EMPLOYEES AND CONTRACTORS, RESPECTIVELY. ON 01OCT21, THE DEPUTY SECDEF DIRECTED ALL CIVILIAN FEDERAL EMPLOYEES TO BE VACCINATED NLT 22NOV21 (REF MM). EXECUTIVE ORDER DOES NOT APPLY TO DUAL STATUS MILITARY TECHNICIANS, BUT ONLY TO TITLE 5 CIVILIAN EMPLOYEES AND NON-APPROPRIATED CIVILIAN EMPLOYEES.

. . . .

3.D.3. (U) VACCINATIONS BY PHASE.

3.D.3.C.7.C. (U) THE HQDA COMPLETION GOAL FOR ARNG VACCINATION MANDATE COMPLIANCE IS 30 JUNE 2022. IMPLEMENTATION OF SECRETARY OF DEFENSE MEMORANDUM DATED 30 NOVEMBER 2021 (REFERENCE FFF) WILL BE EXECUTED NO EARLIER THAN 1 JULY 2022. IMPLEMENTATION GUIDANCE IS FORTHCOMING. THE ARNG WILL CONTINUE TO EXECUTE PHASE 1 IAW ARNG EXORD 197-21 IN THE INTERIM.

3.D.3.C.7.C.1. PHASE 2 ACTIONS WILL BE EXECUTED ON ORDER BY THE SECRETARY OF THE ARMY.

3.D.3.C.7.C.2. IMPLEMENTATION OF REFERENCE FFF WILL BE FULLY COORDINATED THROUGH THE COVID-19 SYNCHRONIZATION WORKING GROUP (CSWG) COMPRISED OF MEMBERS ACROSS THE ARNG AND NGB STAFFS AND RELEVANT STATE ADVISORY COUNCILS.

3.D.3.C.7.C.3. ARNG DRILL OR ANNUAL TRAINING (AT) PAY WILL NOT BE AFFECTED PRIOR TO 30 JUNE 2022.

. . . .

3.D.4. EXEMPTIONS

3.D.4.A. (U) [CHANGE TO READ] THE TWO TYPES OF EXEMPTIONS FROM IMMUNIZATION ARE MEDICAL AND ADMINISTRATIVE. ADMINISTRATIVE EXEMPTIONS INCLUDE RELIGIOUS ACCOMMODATIONS, AS WELL AS OTHERS ENUMERATED IN AR 40-562, TABLE C-2 (IMMUNIZATIONS AND CHEMOPROPHYLAXIS FOR THE PREVENTION OF INFECTIOUS DISEASES). COMMANDERS WILL REFER TO AR 40-562, PARAGRAPH 2-6, AND AR 600-20, APPENDIX P-2, WHEN PROCESSING IMMUNIZATION EXEMPTION REQUESTS. SOLDIERS WITH PREVIOUS INFECTIONS OR POSITIVE SEROLOGY ARE NOT AUTOMATICALLY EXEMPT FROM FULL VACCINATION REQUIREMENTS AND SHOULD CONSULT WITH THEIR PRIMARY CARE MANAGER (PCM) AND/OR A MILITARY MEDICAL PROVIDER. FOR FLAGGING PURPOSES A SOLDIER SHOULD ONLY BE CONSIDERED TO BE "IN THE EXEMPTION PROCESS" ONCE SUBSTANTIATING DOCUMENTATION HAS BEEN RECEIVED BY THE CHAIN OF COMMAND AND VALIDATED FOR AUTHENTICITY AND APPROPRIATENESS. SOLDIERS SHOULD ONLY BE AFFORDED UNTIL THE NEXT IDT PERIOD TO PRODUCE SUBSTANTIATING DOCUMENTATION, ONCE VERBALIZING THE INTENT TO SEEK AN EXEMPTION. ALL EXEMPTION PACKETS NEED TO BE SIGNED BY SOLDIERS COMMANDER NLT 1 MARCH 2022. **ALL EXEMPTION PACKETS MUST BE SIGNED BY SOLDIERS COMMANDER NLT 1 MARCH 2022. EXEMPTION PACKETS MUST BE RECEIVED AT NGB NLT 4 APRIL 2022 IN ORDER TO ENSURE ALL ADMINISTRATIVE PROCESSES AND APPEALS ARE CONDUCTED BEFORE THE 26 MAY 2022 SUSPENSE FOR SOLDIERS TO RECEIVE THEIR 1ST DOSE TO BE FULLY VACCINATED BY 30 JUNE 2022.**

Exhibit B

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

GOVERNOR GREG ABBOTT, in his official capacity as Governor of the State of Texas, and GOVERNOR MIKE DUNLEAVY, in his official capacity as Governor of the State of Alaska, Plaintiffs, v. JOSEPH R. BIDEN, in his official capacity as President of the United States, et al., Defendants.	No. 6:22-cv-00003

DECLARATION OF STEVE L. BRADLEY

I, Colonel Steve L. Bradley, hereby state and declare as follows:

1. I am currently employed by the U.S. Air Force as the Deputy Director of Air National Guard Medical Service at the Air National Guard Readiness Center (ANGRC), located at Joint Base Andrews, Maryland. I have held this position since June 1, 2021. I previously served as Chief, Medical Readiness Division, Air National Guard Medical Service at the Air National Guard Readiness Center located at Joint Base Andrews, Maryland for 5 years since January 19, 2016. My responsibilities include coordinating with the Air Force Surgeon General, National Guard Bureau Surgeon General, gaining Major Commands, State Adjutant Generals, State Air Surgeons, and commanders to ensure the National Guard Bureau, as the management agency, maintains a viable, operationally ready Air National Guard medical force. Our office develops and coordinates strategic Air National Guard public health policies, publications, and programs to

optimize readiness and promote force health protection initiatives. Our office advocates for public health activities, provides oversight for public health programs, and promotes the public health interests and initiatives of the USAF Surgeon General. In addition, we consult with other Military Health System healthcare providers, Public Health Emergency Officers, and Senior Leaders to detail, clarify, and apply evidence-based, public health recommendations from the Centers for Disease Control and Prevention, the United States Preventive Services Task Force, and other organizations to Department of Defense Service Member and beneficiary populations.

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 knowledge made available to me during the routine execution of my official duties. Attached to this declaration are authentic copies of relevant military regulations, instructions, and directives, referenced throughout.

Medical Readiness

3. All members of our Armed Services, including members of the National Guard, are required to maintain individual medical readiness. *See* DoDI 6025.19 "Individual Medical Readiness." In the National Guard and the Air National Guard, service members need to be prepared to deploy in an emergency with little or no notice. For some deployments Guardsmen and Airmen receive months of lead-time to prepare. However, that is not true for unplanned deployments, which can range from natural (*e.g.,* hurricanes, earthquakes, forest fires) or manmade disasters (*e.g.,* oil spills like Deepwater Horizon, civil unrest). Similarly terrorist attacks (conventional, chemical, nuclear or biological) are rarely telegraphed by the responsible organization beforehand. In a crisis every minute and hour matters. Delays spent mobilizing can cost lives. Disaster deployments routinely begin hours or days after notice is received by the activating members of the National Guard. Underscoring just how quickly members must deploy, many of these emergency recalls of NG Airmen and Guardians are based upon an oral (VOCO,

Verbal Orders of Commanding Officer) order, which is subsequently memorialized in writing since there is sometimes insufficient time to prepare written orders before deploying. Finally, even mundane unexpected Temporary Duty orders (TDYs) require short notice deployment (*i.e.* selected Airman has a medical emergency, family crisis, or similar disqualifying event), and thus necessitate last minute unplanned military personnel substitution.

4. The military has detailed regulations about what is required to be "Fully Medically Ready." DoDI 6025.19 at 12. A service member must be "current" in their Physical Health Assessment (PHA), "dental readiness assessment," "immunization status," and meet other requirements. DoDI 6025.19 at 12.

5. Immunizations are a key component of individual military medical readiness. In addition to COVID-19 vaccinations, service members are required to be up-to-date on at least nine other mandatory vaccines, including the annual influenza vaccine, and may be required to take others depending on special circumstances. Multi-Service Regulation (AR 40–562, BUMEDINST 6230.15B, AFI 48–110_IP, CG COMDTINST M6230.4G), "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," dated October 7, 2013 (hereinafter AFI 48-110_IP). The Military Vaccination Program, and associated Air Force immunization programs, which include the processes and procedures by which vaccines and vaccinations are managed, as well as those by which vaccines are administered and exemption requests are reviewed and adjudicated, are implemented in accordance with several DoD, Defense Health Agency (DHA), Multi-Service, and Army Instructions, Regulations, and other publications. In particular, National Guard Commanders are authorized to ensure the administration of required immunizations to Airmen unless Airmen are medically or administratively exempted from the immunization requirements.

Mandatory Coronavirus Disease 2019 (COVID-19) Vaccination

6. To date, there have been more than 603,736 cases of COVID-19 and more than 679 deaths associated with COVID-19 reported across the DoD. As of this time, 388,151 of those cases and 93 COVID-associated deaths have been reported among Service members. ("DoD COVID-19 Cumulative Totals," https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/, accessed March 2, 2022). The Reserve component, including the National Guard, has been impacted by COVID-19. The National Guard has had 55,722 cases of COVID-19. ("DoD COVID-19 Cumulative Totals," https://www.defense.gov/Explore/Spotlight/Coronavirus-DOD-Response/, accessed March 2, 2022). Persons who have not been fully vaccinated against COVID-19 are at higher risk of serious illness, hospitalization, and death. ("COVID Data Tracker-Rates of COVID-19 Cases and Deaths by Vaccination Status," https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status; *See also,* "COVID Data Tracker-Rates of laboratory confirmed COVID-19 hospitalizations by vaccination status," https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, both accessed March 2, 2022). They are also at increased risk of post-COVID conditions (i.e.,long-COVID or long-haul COVID).

7. On August 24, 2021, the Secretary of Defense issued a memorandum directing 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, including the National Guard, who are not fully vaccinated against COVID-19 (Secretary of Defense Memorandum, "Mandatory Coronavirus Disease 2019 Vaccination of Department of Defense Service Members," dated August 24, 2021, hereinafter "Memorandum"). The purpose of the vaccine requirement is to protect the health of the force, optimize readiness, and defend the Nation.

8. The Secretary of Defense Memorandum directs that the COVID-19 mandatory vaccination requirements will be implemented consistent with DoD Instruction (DoDI) 6205.02,

"DoD Immunization Program," dated July 23, 2019. Finally, the Memorandum states that Military Departments should use existing policies and procedures to manage the mandatory vaccination of Service members to the extent practicable, and that mandatory vaccination of Service members will be subject to any identified contraindications, as well as any administrative or other exemptions established in Military Department policy.

Air Force Implementation Order for Mandatory COVID-19 Vaccination

9. On September 3, 2021 the U.S. Air Force implemented the Secretary of Defense's recent Memorandum by way of a Memorandum for Department of Air Force Commanders from the Secretary of the Air Force (SAF Memorandum, "Mandatory Coronavirus Disease 2019 Vaccination of Department of the Air Force Military Members," dated September 3, 2021).

10. The Secretary of the Air Force memo directed every Airman and Guardian who is not otherwise exempt to be fully vaccinated against COVID-19 no later than December 2, 2021. The Deputy Director of Staff also provided COVID-19 Mandatory Vaccination Implementation Guidance for Service Members, September 3, 2021. *See* https://usaf.dps.mil/teams/COVID-19/SitePages/Home.aspx. The Key Messages in that guidance are at paragraph 1.3., which emphasizes that the "vaccine is safe and effective," that the "threat from COVID-19 is real and deadly," and that "vaccination offers a layer of protection."

11. The Secretary of the Air Force issued a memorandum on December 7, 2021, which explained that members of the Air Force National Guard are required to have started a vaccination regime or have submitted or received an exemption request by December 31, 2021. December 7, 2021 SecAF Memo. For those who have not sought an exemption or who have their exemption requests denied (after all eligible appeals) and still refuse to be immunized, the member is subject to adverse administrative actions as outlined in that memorandum. *Id.* For eligible Air Force members, the Air Force allows for voluntary retirement or separation in lieu of vaccination.

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

Executed on March ___, 2022, at Joint Base Andrews, Maryland.

BRADLEY.STEVE.LAURENCE.1178536547

Digitally signed by BRADLEY.STEVE.LAURENCE.1178536547
Date: 2022.03.08 17:03:03 -05'00'

Steve L. Bradley
Colonel, U.S. Air Force
Deputy Director, Medical Services
Air National Guard Readiness Center
Joint Base Andrews, Maryland

Exhibit C

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

GOVERNOR GREG ABBOTT, in his official capacity as Governor of the State of Texas, and GOVERNOR MIKE DUNLEAVY, in his Official capacity as Governor of the State of Alaska, Plaintiffs, v. JOSEPH R. BIDEN, *et al.*, Defendants.	No. 6:22-cv-00003

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. 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 March 1, 2022, there have been 387,621 cases of Coronavirus Disease 2019 (COVID-19) in service members across the Department of Defense (DoD) which have led to 94 deaths (89 were unvaccinated, 3 were partially vaccinated, and 2 fully vaccinated but not boosted). 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. 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-times more likely to die 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

[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.

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

18. DoD specific data is equally compelling in terms of demonstrating the value of vaccinations. Between July and November of 2021, non-fully-vaccinated active-duty service members had a 14.6-fold increased risk of being hospitalized when compared to fully vaccinated active-duty service members. In December 2021 unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults. Furthermore, unvaccinated adults over 50 years of age were 44 times more likely to be hospitalized than individuals who were vaccinated and received a booster dose. Of all active duty personnel hospitalized with COVID-19 since December of 2020 thru this month, only 0.012% were vaccinated. This amounts to 13 active duty personnel with boosters and breakthrough infections requiring hospitalization – an extremely rare occurrence. And as mentioned previously, of the 94 deaths among uniformed service members, only two had completed a primary series of a COVID-19 vaccine (one with Moderna and one with J&J) and neither had received a booster dose. It is also worth noting that there have been no COVID-19 related deaths among active duty personnel since the vaccination deadlines have passed.

19. While some have pointed to the increase in the number of breakthrough cases in general, and with the Delta and Omicron variants in particular, as a reason to question the effectiveness of the vaccines, it is important to keep in mind that as vaccination rates increase among service members, vaccinated service members will make up a larger percentage of the population available to become infected. In other words, vaccinated personnel are disproportionately represented in the pool of individuals exposed to the virus that causes COVID-

19. Taken to the extreme, if *every* service member were vaccinated, only vaccinated service members *could* have infections. So it is important to view the number of breakthrough infections in this light and not as a reflection of vaccine effectiveness.

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

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

Executed on March 7, 2022 in Washington, DC.

STANLEY.SCOTT.E.1169637659 Digitally signed by STANLEY.SCOTT.E.1169637659 Date: 2022.03.07 09:15:20 -05'00'

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

Exhibit D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

GOVERNOR GREG ABBOTT, in his official capacity as Governor of the State of Texas, and GOVERNOR MIKE DUNLEAVY, in his Official capacity as Governor of the State of Alaska, Plaintiffs, v. JOSEPH R. BIDEN, *et al.*, Defendants.	No. 6:22-cv-00003

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

[1] https://www.yalemedicine.org/news/5-things-to-know-delta-variant-covid, last accessed March 4, 2022.

can result in virus death and therefore do not infect the host. This is part of the normal biology cycle of all viruses.

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 March 2, 2022, CDC reports that over 78 million individuals in the U.S. have been diagnosed with COVID-19 disease, over 4.5 million have been hospitalized, and over 952,000 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 history of

[2] https://www.cdc.gov/coronavirus/2019-ncov/faq.html, last accessed March 4, 2022.

[3] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, last accessed March 4, 2022.

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

cardiovascular disease, diabetes, chronic respiratory disease, smoking, being overweight or obese, pregnancy, immunocompromising conditions, or cancer are more likely to develop serious illness.[5] However, it is a misguided belief that those who are otherwise young and healthy could 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 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]

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[5] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, last accessed March 4, 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 March 5, 2022.

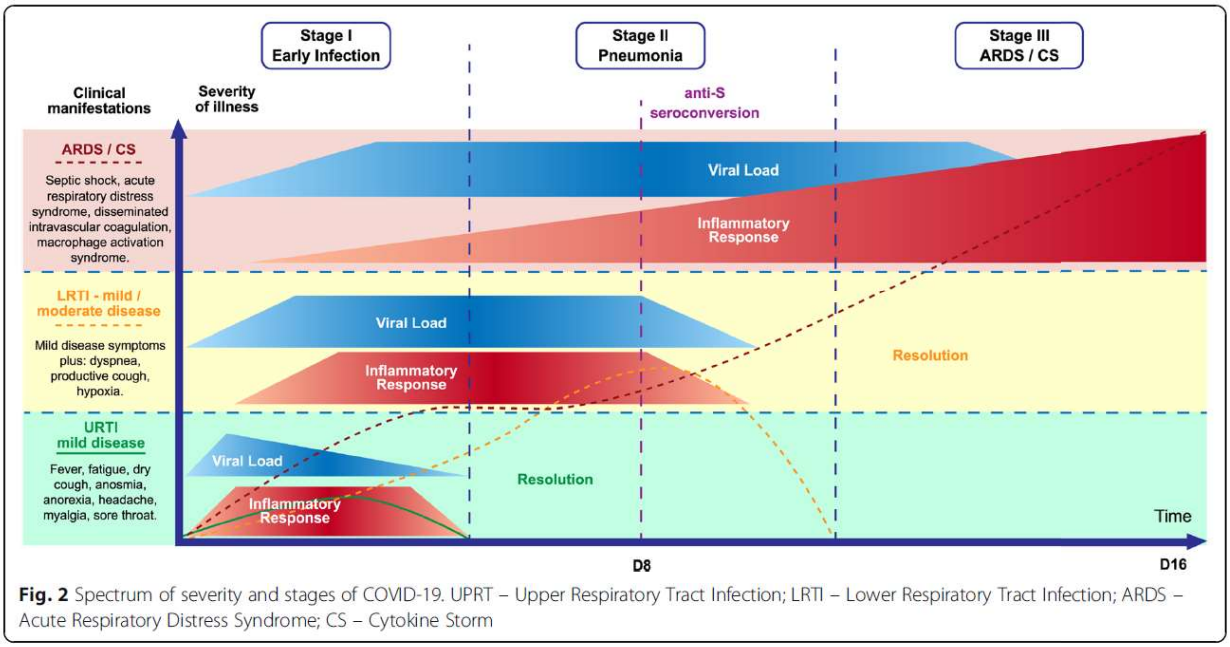


Fig. 2 Spectrum of severity and stages of COVID-19. UPRT – Upper Respiratory Tract Infection; LRTI – Lower Respiratory Tract Infection; ARDS – Acute Respiratory Distress Syndrome; CS – Cytokine Storm

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 antivirals 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, treatment efficacy is impacted by the variant in the infected person. Currently, few treatments are effective against the omicron variant, 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 genetics, medical history, and immune response. Just as it is acknowledged that there have been

[8] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/nonhospitalized-adults--therapeutic-management// last accessed March 5, 2022.

adverse events following COVID-19 vaccine receipt, it should also be understood that there are risks to treatment of COVID-19 disease, even in those who can be managed in the outpatient setting. A non-exhaustive list includes cardiovascular events, liver toxicity, and drug interactions. Further, some treatments 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 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

[9] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/ last accessed March 5, 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.

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] A recent study, conducted within the Department of Veterans Affairs, described long-term cardiovascular outcomes of 153,760 people with COVID-19 who survived the first 30 days after infection as compared with controls.[13] They provided evidence that, beyond the first 30 days of infection, people with a history of COVID-19 exhibited "increased risks and 12-month burdens of incident cardiovascular diseases, including cerebrovascular disorders (i.e. stroke), dysrhythmias (abnormal heart rhythms), inflammatory heart disease (i.e. myocarditis, pericarditis), ischemic heart disease (decreased blood flow to the heart), heart failure, thromboembolic disease (blood clots that can break loose and occlude a blood vessel), and other cardiac disorders." Of all cardiovascular diagnoses studied, the burdens of atrial fibrillation (AF) and Heart Failure (HF) were greatest. Risks of all cardiovascular disorders increased with severity of the acute COVID illness, with patients who required intensive care having particularly high risk. In an oversimplified interpretation of the figure below, any cardiovascular outcome to the right of the black vertical dashed line is seen higher in those with COVID-19 disease. The farther to the right, the higher the risk . The authors report that the risks were evident regardless of age, race, sex, and other cardiovascular risk factors, including obesity,

[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.

[13] Xie, Y., Xu, E., Bowe, B. *et al.* Long-term cardiovascular outcomes of COVID-19. *Nat Med* (2022). https://doi.org/10.1038/s41591-022-01689-3.

hypertension (high blood pressure), diabetes, chronic kidney disease, and hyperlipidemia (high cholesterol); they were also evident in people without any cardiovascular disease before exposure to COVID-19, "providing evidence that these cardiovascular risks might manifest even in people at low risk for cardiovascular disease."[14]

[14] *Id.*

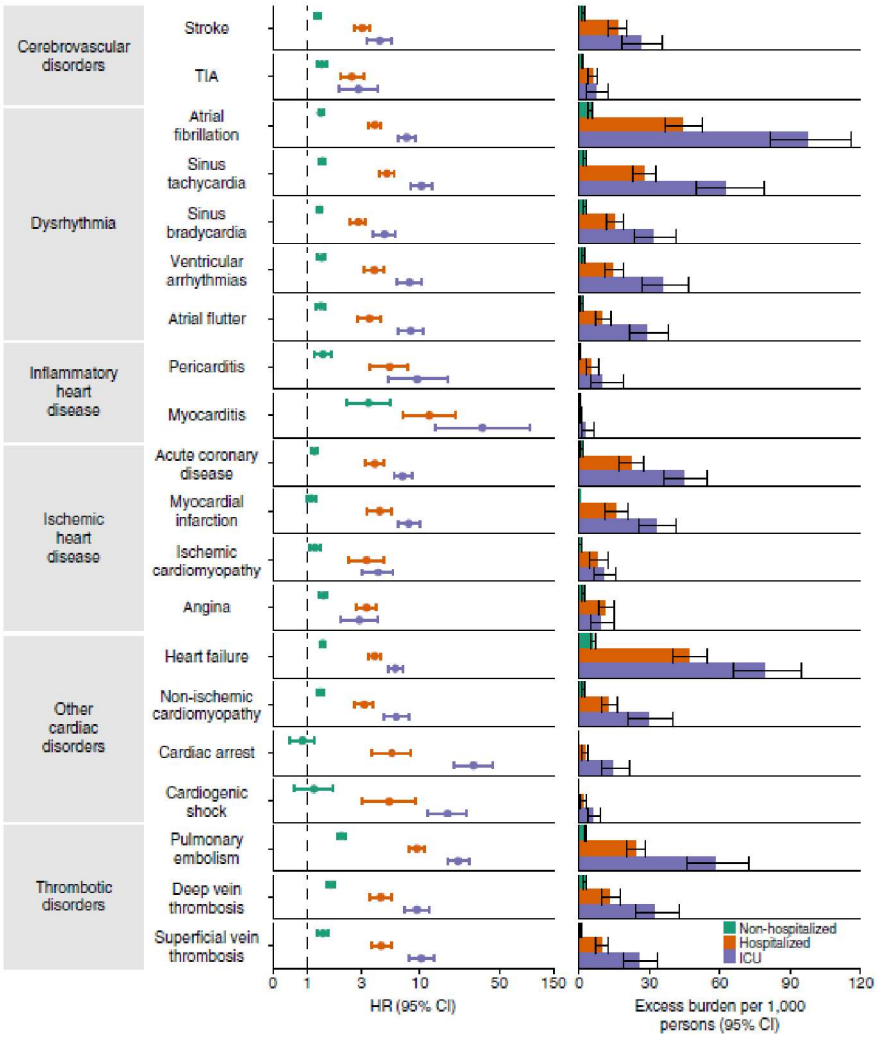


Fig. 5 | Risks and 12-month burdens of incident post-acute COVID-19 cardiovascular outcomes compared with the contemporary control cohort by care setting of the acute infection. Risks and burdens were assessed at 12 months in mutually exclusive groups comprising non-hospitalized individuals with COVID-19 (green), individuals hospitalized for COVID-19 (orange) and individuals admitted to intensive care for COVID-19 during the acute phase (first 30 d) of COVID-19 (blue). Outcomes were ascertained 30 d after the COVID-19-positive test until the end of follow-up. The contemporary control cohort served as the referent category. Within the COVID-19 cohort, non-hospitalized (n=131,612), hospitalized (n=16,760), admitted to intensive care (n=5,388) and contemporary control cohort (n=5,637,647). Adjusted HRs and 95% CIs are presented. The length of the bar represents the excess burden per 1,000 persons at 12 months, and related 95% CIs were also presented.

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.[15] Therefore, upon exposure, these individuals may be at higher risk to be diagnosed with COVID-19 compared to those who can robustly maintain all recommended mitigation strategies. Further, although the elderly population and those with medical conditions are more likely to have severe disease, otherwise healthy Service members have developed "long-haul" COVID-19, potentially impacting their long-term ability to perform their missions. Data presented from DoD's COVID-19 registry has demonstrated that of 111,767 active duty service members who had COVID-19 disease between February 1, 2020 to August 12, 2021, 37,838 (33.9%) had diagnoses for conditions requiring a healthcare visit 30-180 days following their illness, the most common being joint/muscle pain (15,614 or 14%) followed by chest pain/cough (7,887 or 7.1%). In comparison, only 8.3% and 1.81%, respectively, of active duty service members had a healthcare visit for those diagnoses 30-180 days after vaccination. All diagnoses

[15] The U.S. military's rapid response to the crisis in Ukraine and the surrounding areas serves as a prime example of the difficulty in not only predicting where and when service members will be required to serve, but also of the challenges in preventing the spread of COVID-19 and other diseases in undeveloped and austere environments. *See, e.g.,* https://www.dvidshub.net/image/7065893/82nd-airborne-division-place-their-equipment-inside-tent-they-settle-their-new-location, last accessed March 7, 2022.

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 February 2022, there were 373,750 new and repeat cases of COVID-19 among active duty service members (see Table below). The largest monthly peak in cases occurred in January 2022, with 119,943 cases identified (see Figure below**)**. 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 2.0% in July 2021, and decreased to 0.5% in December 2021. The percentage of hospitalized cases remained low at 0.3% in January 2022 and 0.4% in February 2022. However, this recent 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 February 2022. 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). The most recently reported active duty service member death occurred in November 2021.

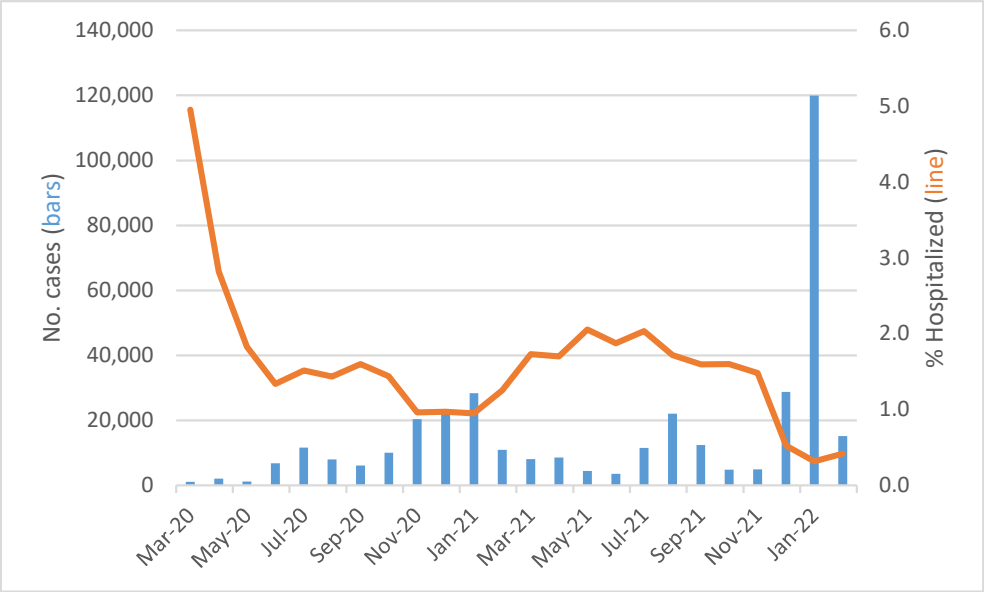
Table. COVID-19 cases, hospitalizations, and deaths among active duty service members, February 2020 - February 2022

	No. cases	No. hospitalizations	% hospitalizations	No. deaths
Feb-20	7	2	28.6	0
Mar-20	1,150	57	5.0	0
Apr-20	2,127	60	2.8	1
May-20	1,204	22	1.8	0
Jun-20	6,791	91	1.3	0
Jul-20	11,609	176	1.5	0
Aug-20	8,013	115	1.4	0
Sep-20	6,120	98	1.6	0
Oct-20	10,066	145	1.4	1
Nov-20	20,433	197	1.0	0
Dec-20	22,137	215	1.0	2
Jan-21	28,429	270	0.9	2
Feb-21	10,987	138	1.3	5
Mar-21	8,150	141	1.7	0
Apr-21	8,589	146	1.7	1
May-21	4,426	91	2.1	0
Jun-21	3,572	67	1.9	0
Jul-21	11,593	236	2.0	1
Aug-21	22,094	380	1.7	5
Sep-21	12,462	199	1.6	6
Oct-21	4,816	77	1.6	6
Nov-21	4,997	74	1.5	1
Dec-21	28,797	151	0.5	0
*Jan-22	119,943	383	0.3	0

*Feb-22	15,238	64	0.4	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 – February 2022



Note: February 2020 is not shown due to the very small number of cases. Hospitalization data for January - February 2022 not complete due to data lags

12. The DoD regularly updates its information concerning the number of vaccinations provided by DoD, the vaccination of the force, and health impact of those who developed COVID-19 infections.[16] As depicted below, data through March 2, 2022 demonstrated that of the 603,736 COVID-19 cases within the DoD, 6,180 individuals were hospitalized and 679 have died, including 93 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 unvaccinated or not fully vaccinated.

[16] https://www.defense.gov/Spotlights/Coronavirus-DOD-Response/, last accessed March 5, 2022.

DOD COVID-19 CUMULATIVE TOTALS

	Cases	Hospitalized	Recovered	Deaths
Military	388,151	2,543	359,343	93
Civilian	119,302	2,340	100,535	412
Dependent	61,236	552	54,168	35
Contractor	35,047	745	30,800	139
Total	603,736	6,180	544,846	679

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. During the winter months, DoD had 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

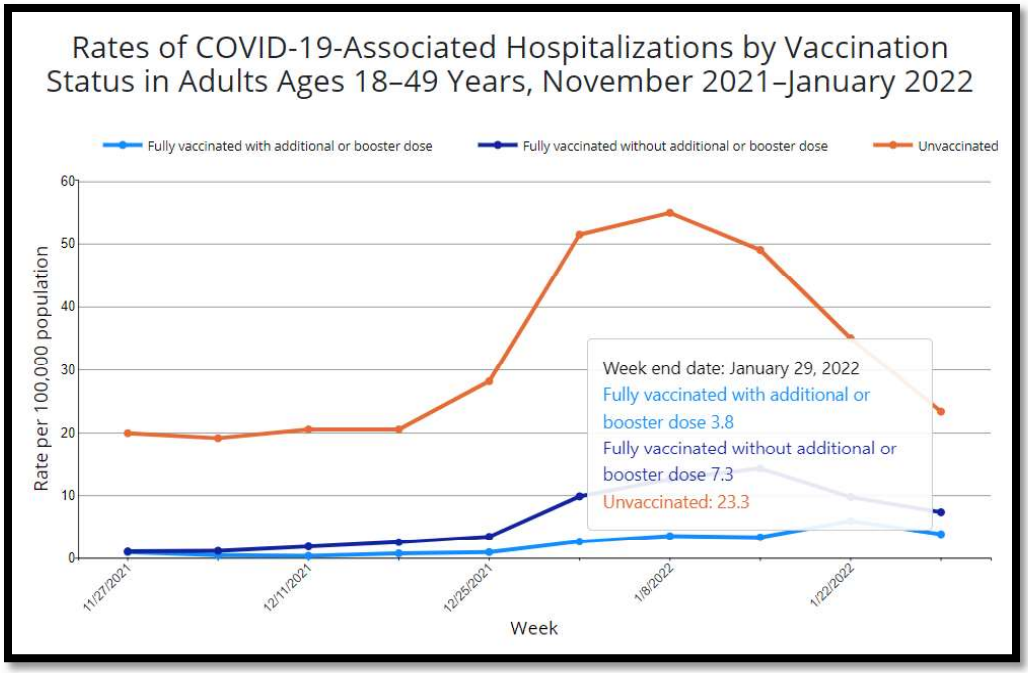
prevention through immunization also mitigates the need for pharmacologic treatment (antibiotics for sepsis, etc.), reducing the risk of drug-resistant pathogen development.

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 553 million doses of COVID-19 vaccine have been given in the United States from December 14, 2020, through February 28, 2022.[17] Evidence consistently shows that the incidence of SARS-CoV-2-associated, hospitalizations and deaths are higher in unvaccinated than vaccinated persons. During the week ending January 29, 2022, the rate of COVID-19 associated hospitalization was 3.8 per 100,000 in those who were fully vaccinated with an additional or booster dose; 7.3 per 100,000 in those who were fully vaccinated without an additional or booster dose; and 23.3 per 100,000 in those who were unvaccinated.[18]

[17] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html, last accessed March 5, 2022.

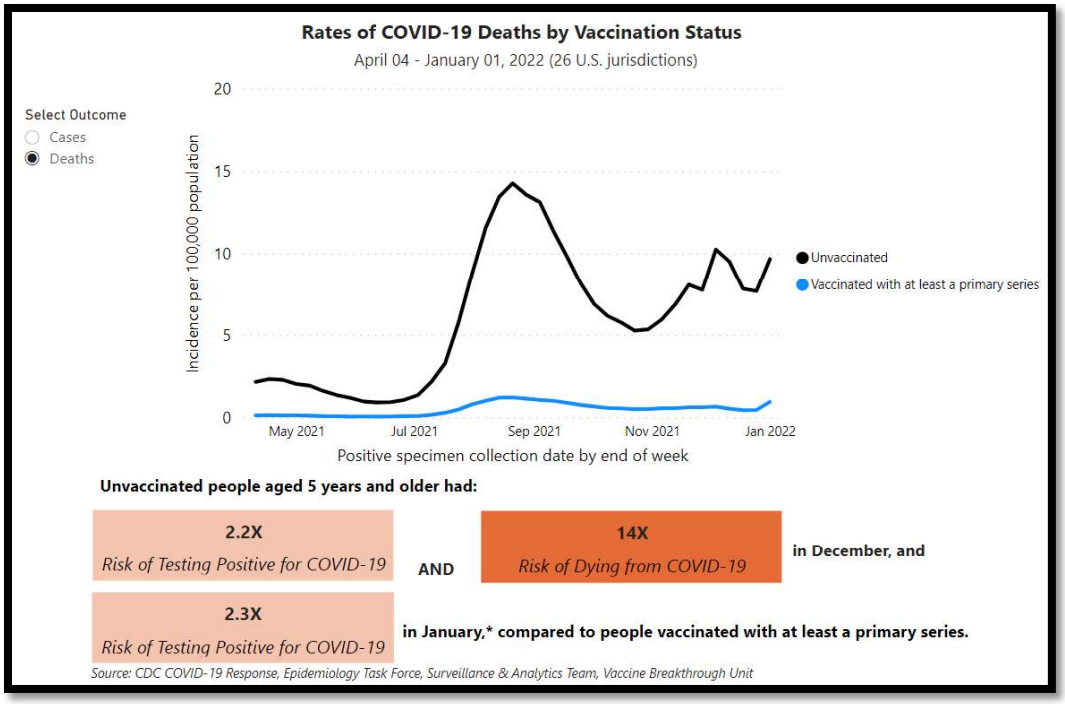
[18] https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, last accessed March 5, 2022.

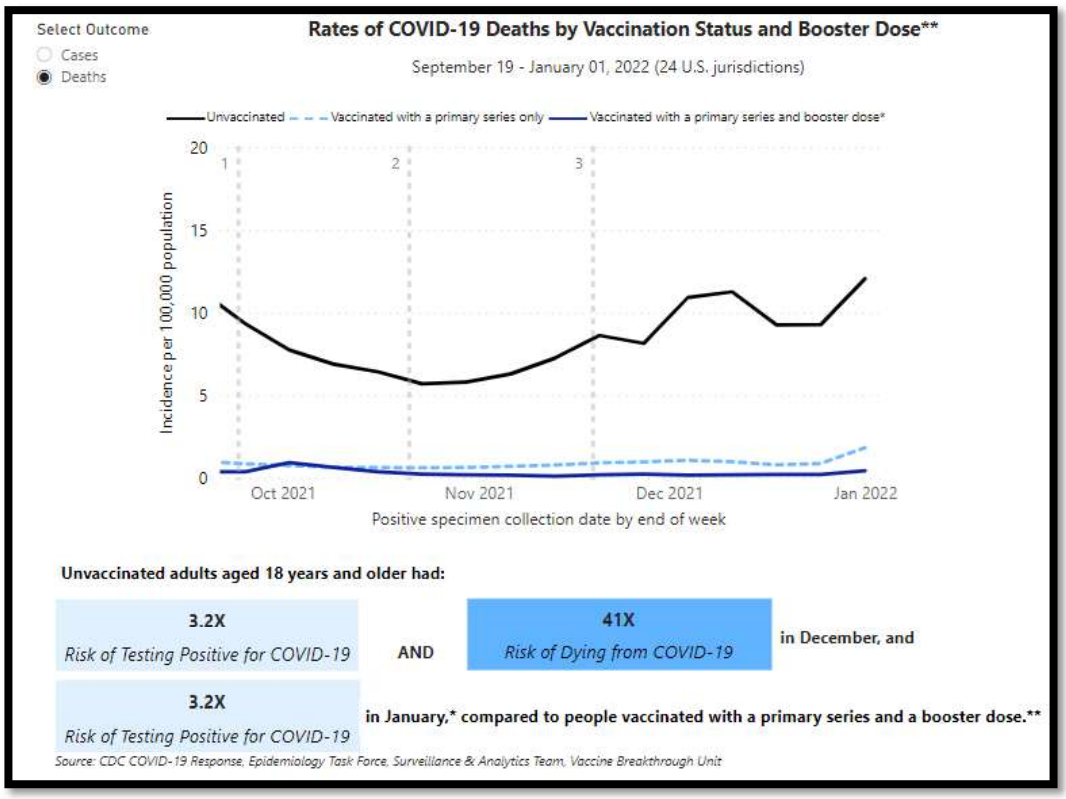


According to CDC data in December 2021, unvaccinated persons 5 years of age and older had a 2.2 times greater risk of testing positive for COVID-19 and a 14 times greater risk of dying from COVID-19 compared to fully vaccinated individuals, and unvaccinated persons 18 years of age and older had a 3.2 times greater risk of testing positive for COVID-19 and 41 times greater risk of dying from COVID-19 compared to fully vaccinated adults with a booster dose.[19] In January 2022, unvaccinated adults aged 5 years and older had a 2.3 times greater risk of testing positive for COVID-19 compared to fully vaccinated adults and a 3.2 times greater risk of testing positive for COVID-19 compared to fully vaccinated adults with booster doses.[20]

[19] https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status, last accessed March 5, 2022.

[20] *Id.*


Rates of COVID-19 Deaths by Vaccination Status
April 04 - January 01, 2022 (26 U.S. jurisdictions)
Select Outcome
Cases
Deaths
Incidence per 100,000 population
20
15
10
5
0
May 2021
Jul 2021
Sep 2021
Nov 2021
Jan 2022
Positive specimen collection date by end of week
Unvaccinated
Vaccinated with at least a primary series
Unvaccinated people aged 5 years and older had:
2.2X
Risk of Testing Positive for COVID-19
AND
14X
Risk of Dying from COVID-19
in December, and
2.3X
Risk of Testing Positive for COVID-19
in January,* compared to people vaccinated with at least a primary series.
Source: CDC COVID-19 Response, Epidemiology Task Force, Surveillance & Analytics Team, Vaccine Breakthrough Unit


Select Outcome
Cases
Deaths
Rates of COVID-19 Deaths by Vaccination Status and Booster Dose**
September 19 - January 01, 2022 (24 U.S. jurisdictions)
Unvaccinated
Vaccinated with a primary series only
Vaccinated with a primary series and booster dose*
Incidence per 100,000 population
20
15
10
5
0
1
2
3
Oct 2021
Nov 2021
Dec 2021
Jan 2022
Positive specimen collection date by end of week
Unvaccinated adults aged 18 years and older had:
3.2X
Risk of Testing Positive for COVID-19
AND
41X
Risk of Dying from COVID-19
in December, and
3.2X
Risk of Testing Positive for COVID-19
in January,* compared to people vaccinated with a primary series and a booster dose.**
Source: CDC COVID-19 Response, Epidemiology Task Force, Surveillance & Analytics Team, Vaccine Breakthrough Unit

17. As of March 4, 2022, DoD immunization sites have administered over 7.83 million doses of COVID-19 vaccine. Adverse events 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 February 26, 2022, a total of 8,384 unique VAERS reports (approximately 11 VAERS reports/10,000 doses administered) were submitted by DoD beneficiaries or those authorized to receive vaccine from DoD. Note that the number of VAERS reports/10,000 doses administered for DoD beneficiaries is likely to be lower, as the denominator does not take into account beneficiaries who receive vaccine in the civilian sector though DoD would still receive their VAERS report if the submitter indicated military affiliation. Additionally, individuals who had an adverse event but did not submit a VAERS would not be known and therefore would not be counted. It must be stressed that a VAERS submission to the CDC does not mean that the vaccine of concern caused or contributed to the medical issue reported.

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

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

Instruction 48-110_IP, Coast Guard Commandants Instruction M6230.4G, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases," October 7, 2013, further states the Military Service policy concerning immunizations follows the recommendations of the CDC, ACIP, and the prescribing information on the manufacturer's package inserts, unless there is a military-relevant reason to do otherwise. This document also describes general examples of medical exemptions, which include "evidence of immunity based on serologic tests, documented infection, or similar circumstances." Some interpret this as a diagnosis of COVID-19 disease and/or results of a COVID-19 serologic test means that a medical exemption should be granted. However, of significance is the phrase "evidence of immunity." CDC defines immunity as "protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected."[21] 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, "Antibody tests should not be used to diagnose a current SARS-CoV-2 infection or COVID-19 and, at this time, should also not be used to check for immunity. More research is needed to determine what, if anything, antibody tests can tell us about a person's immunity."[22] 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 history of COVID-19 disease or serology

[21] https://www.cdc.gov/healthyschools/bam/diseases/vaccine-basics.htm, accessed February 16, 2022.

[22] https://www.fda.gov/consumers/consumer-updates/coronavirus-disease-2019-testing-basics, accessed March 6, 2022.

results does not meet "evidence of immunity." The presence of antibodies is not the same thing as being immune.

20. The CDC states that "COVID-19 vaccination is recommended for everyone aged 5 years and older, regardless of a history of symptomatic or asymptomatic SARS-CoV-2 infection. This includes people with prolonged post-COVID-19 symptoms and applies to primary series doses and booster doses. This recommendation also applies to people who experience SARS-CoV-2 infection before or after receiving any COVID-19 dose… Current evidence demonstrates a robust immune response to vaccination after infection, but information is lacking about whether and how the amount of time since infection affects the immune response to vaccination. Growing epidemiologic evidence from adults and adolescents indicates that vaccination following infection further increases protection from subsequent infection, including in the setting of increased circulation of more infectious variants. 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."[23]

21. Further, CDC states "antibody testing is not currently recommended to assess the need for vaccination in an unvaccinated person or to assess immunity to SARS-CoV-2 following COVID-19 vaccination. If antibody testing was done, vaccination with the primary series, an additional dose, or a booster dose should be completed as recommended regardless of the antibody test result. SARS-CoV-2 antibody tests currently authorized under an Emergency Use Authorization have variable performance characteristics and limitations. Furthermore, serologic

[23] 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 March 6, 2022

correlates of protection have not been established and antibody testing does not evaluate the cellular immune response."[24]

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

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

24. "Herd immunity" is an epidemiologic concept that explains how a community may be protected from an infectious disease that is human-to-human transmitted.[25]-[26] 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

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[24] 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 March 6, 2022.

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

[26] 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

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.

25. The percentage of the population needing to be immune to drive herd immunity varies from disease to disease. Generally, the more contagious a disease is, the greater proportion of the population needs to be immune to stop its spread. For example, with regards to the highly contagious measles disease, approximately 95% immunity within a population is needed to interrupt the chain of transmission. When the immunity levels of a population falls, local outbreaks can, and have, occurred. In 2019, 1,282 individual cases of measles were confirmed in 31 states,

the highest level since 1992. The majority of those cases were among those who were not vaccinated.[27,28]

26. This herd immunity threshold – the level above which the spread of disease will decline – is currently unknown for COVID-19. As described above, in order to interpret an antibody response as it pertains to immunity, a correlate of protection (i.e. what antibody result 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 and none of them are licensed. 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 who are asymptomatic or with mild symptoms.

27. Those who receive the COVID-19 vaccine contribute to the information available from studying the outcomes from 553 million doses administered in the US and over the 10.85 billion doses administered globally.[29] Responses to vaccination are more consistent and there is minimal risk compared to the potential long-term complications and treatments needed to treat COVID-19 disease. Although 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.[30]

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[27] https://www.cdc.gov/measles/cases-outbreaks.html, accessed March 6, 2022.

[28] https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6840e2-H.pdf, accessed March 6, 2022.

[29] https://ourworldindata.org/covid-vaccinations?country=OWID_WRL, accessed March 6, 2022.

[30] Ferdinands JM, et al Waning 2-Dose and 3-Dose Effectiveness of mRNA Vaccines Against COVID-19-Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among Adults During Periods of Delta and Omicron Variant Predominance – VISION Network, 10 States, August 2021-January 2022. MMWR Morb Mortal Wkly Rep

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.[31] 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%).
    - 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.

2022:71:1-9 https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm, accessed February 16, 2022.

[31] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html, accessed March 6, 2022.

- 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.[32] These findings have not been reproduced in a peer-reviewed or prospective publication. However, an observational study,[33] also out of Israel, compared adverse events in Pfizer-BioNTech vaccinated versus unvaccinated individuals in addition to

[32] https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1, last accessed March 6, 2022.

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

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.

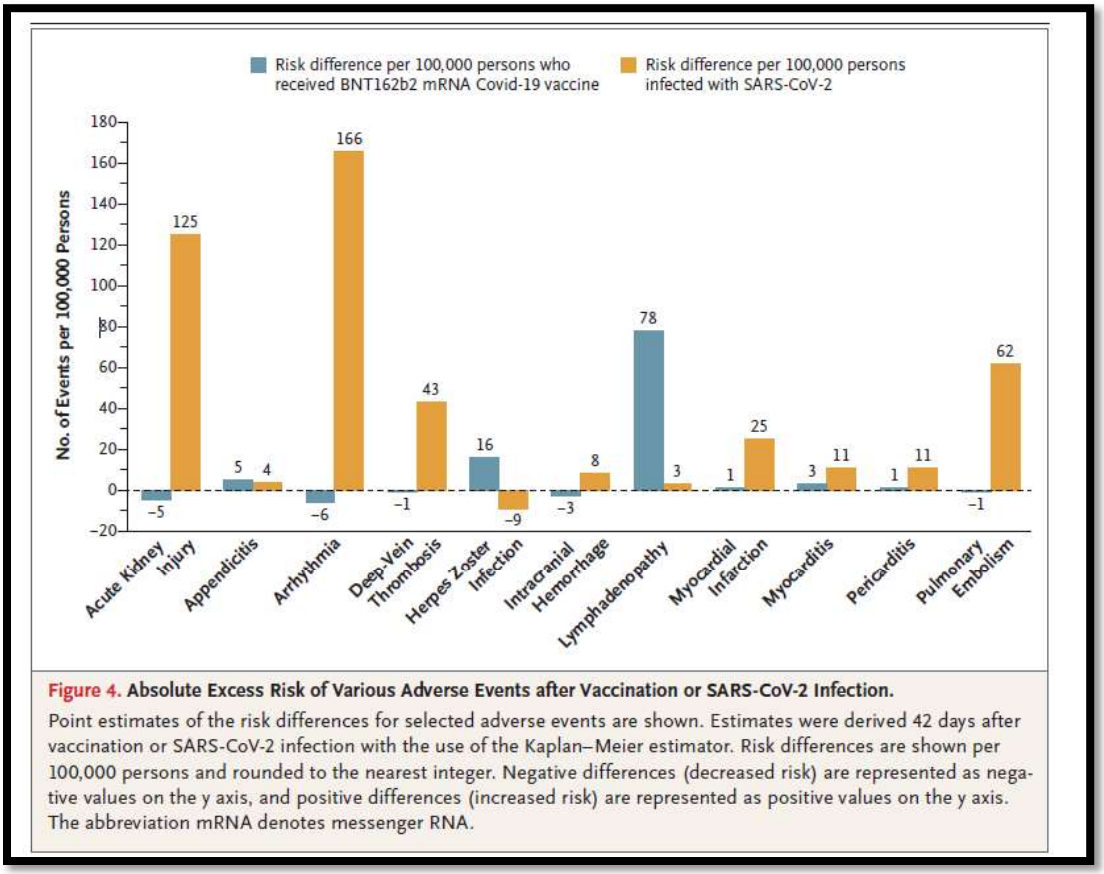


Figure 4. Absolute Excess Risk of Various Adverse Events after Vaccination or SARS-CoV-2 Infection.

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.[34] 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, 2021, it has been found to spread more easily than the original and Delta variants.[35] 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."[36]

[34] https://www.who.int/news/item/26-11-2021-classification-of-omicron-(b.1.1.529)-sars-cov-2-variant-of-concern, last accessed March 6, 2022.

[35] https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html, last accessed March 6, 2022.

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

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) 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."[37]

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.[38] The better the neutralization, the better the protection. Results showed that Omicron was totally or partially resistant to neutralization by all mAbs tested. Sera from those

[37] 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.

[38] 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).

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 COVID-19 vaccine dose did generate an anti-Omicron neutralizing response, though lower than what has been seen against the Delta variant. A second study[39] 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 activity of sera from convalescent patients, 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.[40] 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

[39] 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.

[40] 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).

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%."[41]

[41] *Id.* at 2.

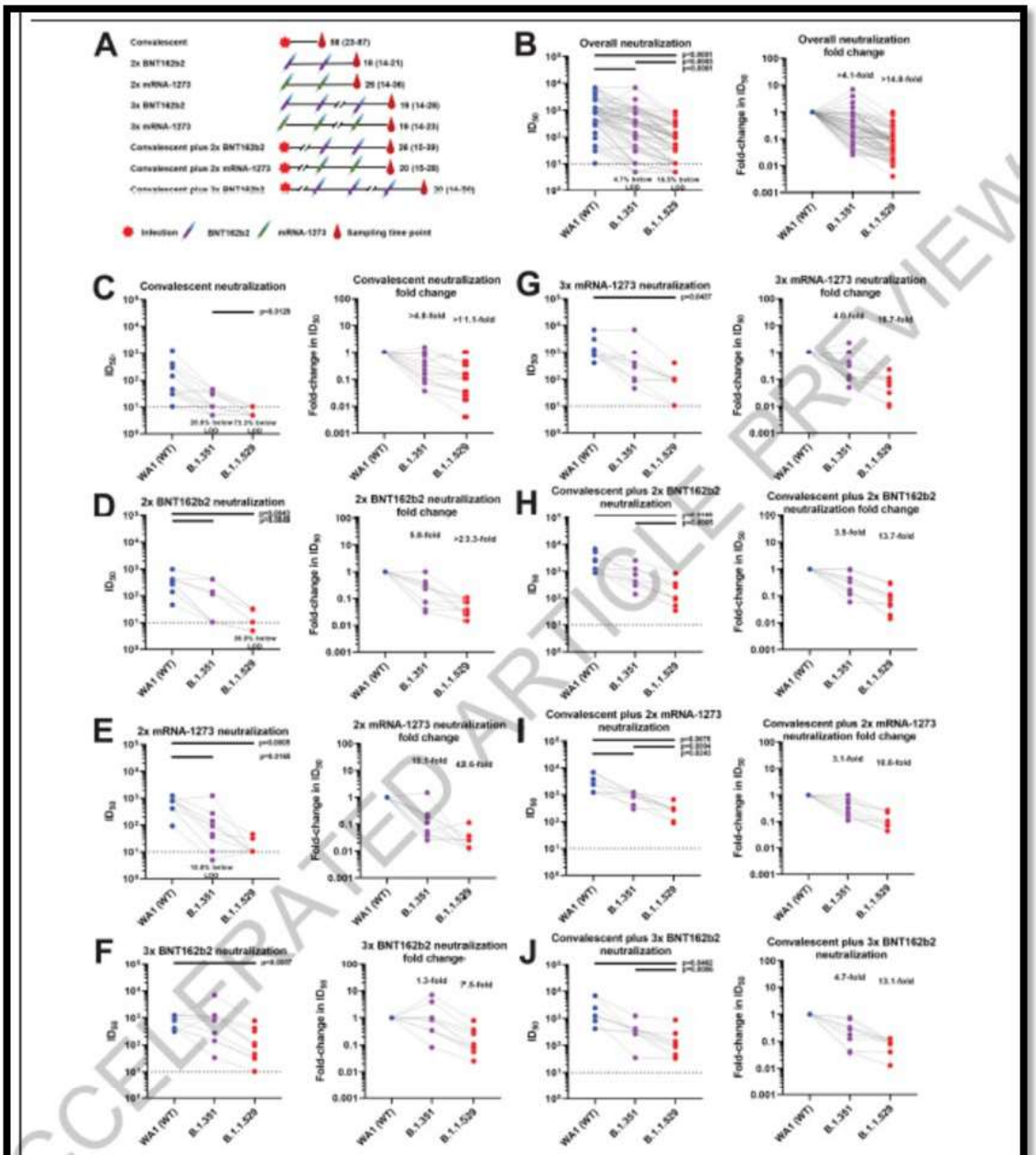
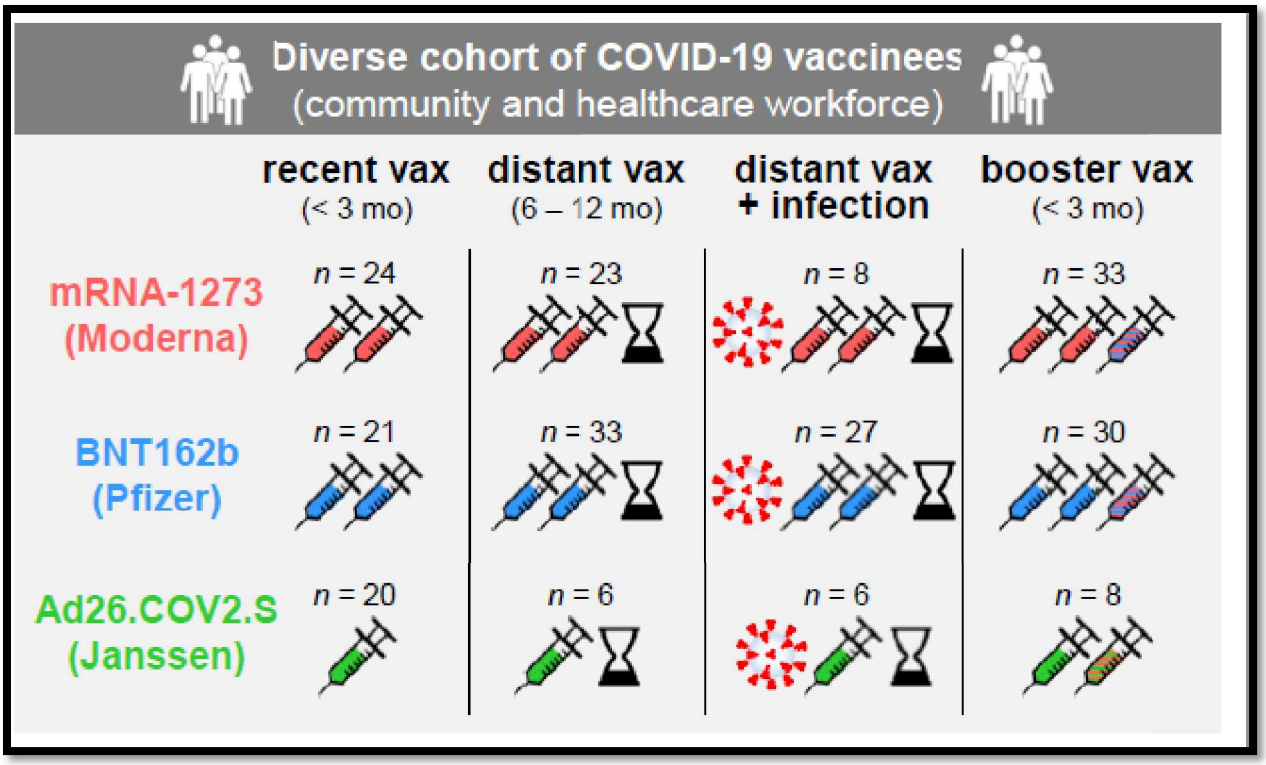


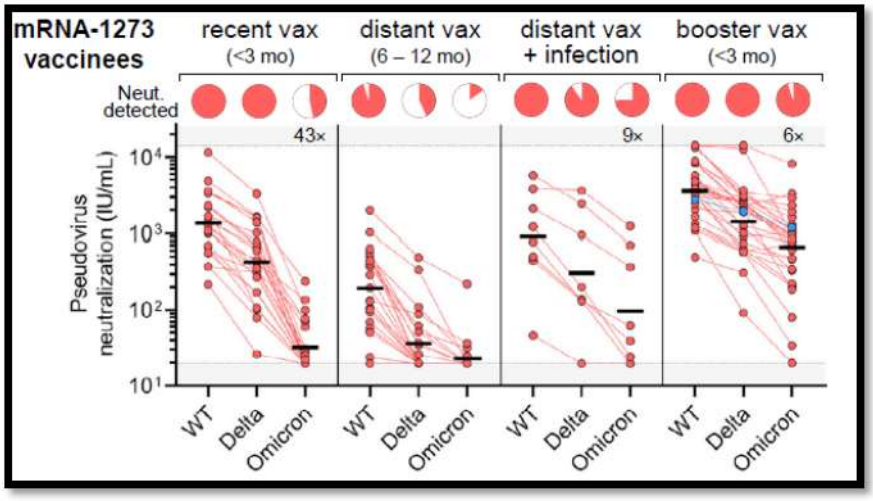
Fig. 1 | Sera of convalescent and vaccinated individuals have strongly reduced neutralizing activity against Omicron as compared to wild type SARS-CoV-2. A Overview of different exposure groups from whom samples were obtained. Further details are provided in Supplemental Table 1 and 2. **B** shows absolute 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[42] 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.

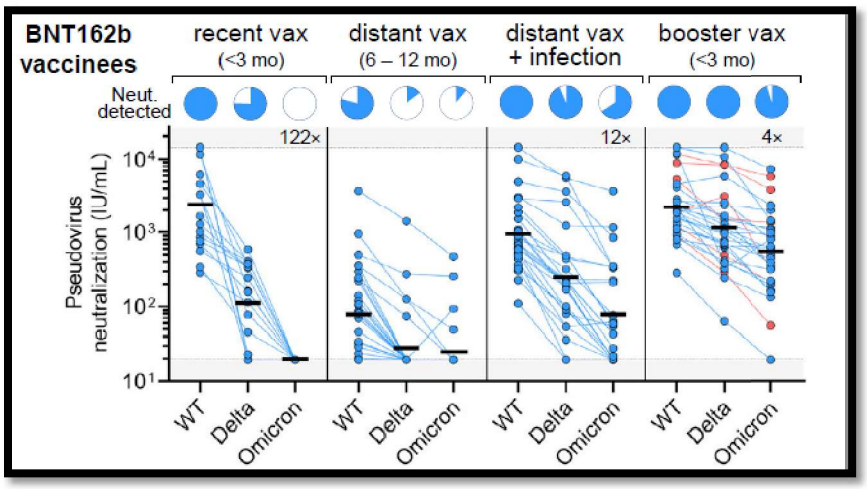


34. Against the Omicron variant, recent (< 3 months) vaccine recipients exhibited a 43-fold lower neutralization than against the wild type (WT) strain. Those with a history of vaccination and infection had a 9-fold decrease in neutralization than WT, whereas those who received a booster dose less than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

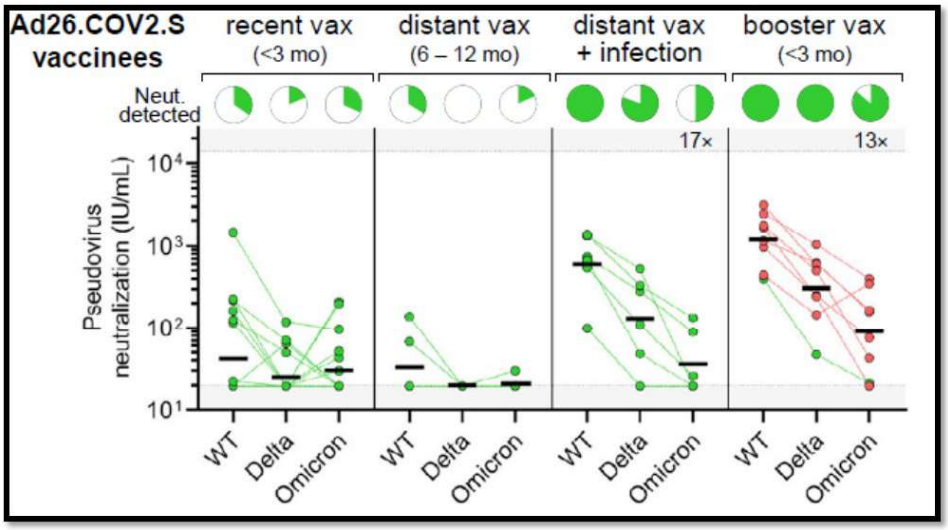
[42] Garcia-Beltran WF, et al mRNA-based COVID-19 vaccine boosters induce neutralizing immunity against SARS-CoV-2 Omicron variant. Cell 185, 1-10..



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. Finally, two recent CDC publications described vaccine effectiveness during periods of Delta and Omicron dominance. The first study evaluated the benefit of a third COVID-19 vaccine dose in those who were and were not immunocompromised between August and December 2021. In those who were not immunocompromised vs immunocompromised, vaccine effectiveness (VE) was 82% and 69%, respectively, in those who were fully vaccinated and 97% and 88%, respectively in those who had received 3 doses of COVID-19 vaccine.[43] The second publication reported on the waning 2- and 3-dose effectiveness of mRNA vaccines against COVID-19 associated emergency department (ED) and urgent care (UC) encounters and hospitalizations among adults during Delta and Omicron between August 2021 and January 2022. During the Delta period, those who sought ED or UC care and received 2 doses versus 3 doses of a mRNA vaccine had an overall VE of 80% and 96%, respectively. Of those admitted to the hospital, COVID-19 VE was 85% and 95%, respectively. During the Omicron period, those who

[43] Tenforde MW, et al Effectiveness of a Third Dose of Pfizer-BioNTech and Moderna Vaccines in Preventing COVID-19 Hospitalization Among Immunocompetent and Immunocompromised Adults – United States, August-December 2021 MMWR Morb Mortal. Wkly Rep 2022;71(4) :118-121. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7104a2.htm.

sought ED or UC care and received 2 doses versus 3 doses of a mRNA vaccine had an overall VE of 41% and 83%, respectively. Those who were admitted to the hospital demonstrated overall VE of 55% and 88%, respectively[44]. Although there was a noticeable decrease in VE during the Omicron period, comparatively mRNA COVID-19 VE is higher than annual influenza vaccine, where VE ranged between 29-48% over the last 5 seasons.[45]

38. In contrast to the above studies, the CDC recently published a study examining the impact of primary COVID-19 vaccination and previous SARS-CoV-2 infection on COVID-19 incidence and hospitalization rates from California and New York.[46] 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 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-

[44] Ferdinands JM, et al. Waning 2-Dose and 3-Dose Effectiveness of mRNA Vaccines Against COVID-19-Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among Adults During Periods of Delta and Omicron Variant Predominance – VISION Network, 10 States, August 2021-January 2022. MMWR Morb Mortal. Wkly Rep 2022;71:1-9. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm.

[45] https://www.cdc.gov/flu/vaccines-work/past-seasons-estimates.html, last accessed March 6, 2022.

[46] 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.

19 through November 30, 2021, and that "vaccination remains the safest and primary strategy to prevent SARS-CoV-2 infections, associated complications, and onward transmission."

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

40. In summary, unvaccinated persons without a history of COVID-19 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 breakthrough disease, although vaccination continues to be protective against severe disease, hospitalization, and death. 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. Hospitalization rates 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."[47]

Risks from COVID-19 Vaccination

41. Risks from immunization, including COVID-19 vaccines are rare. CDC provides routine updates on specific adverse events temporally associated with COVID-19 vaccines.[48] CDC updates as of March 1, 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 February 24, 2022, more than 18.4 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. 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 muscle weakness and

[47] 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.

[48] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html, last accessed March 6, 2022.

sometimes paralysis. Most people fully recover from GBS, but some have permanent nerve damage. After more than 18.4 million J&J/Janssen COVID-19 Vaccine doses administered, there have been around 303 preliminary reports of GBS identified in VAERS as of February 24, 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 February 24, 2022, VAERS has received 2,261 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 1,328 reports of myocarditis or pericarditis.

E. **Reports of death after COVID-19 vaccination are rare**. More than 553 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through February 22, 2022. During this time, VAERS received 12,775 reports of death (0.0023%) 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. CDC has identified nine deaths that have been caused by or were directly attributed to TTS following J&J/Janssen COVID-19 vaccination.

42. Additionally, on October 27 2021, the COVID-19 subcommittee of the WHO Global Advisory Committee on Vaccine Safety (GACVS) provided an updated statement regarding myocarditis and pericarditis reported with COVID-19 mRNA vaccines, stating, in part: The GACVS COVID-19 subcommittee notes that myocarditis can occur following SARS-CoV-2 infection (COVID-19 disease) and that mRNA vaccines have clear benefit in preventing hospitalisation and death from COVID-19. Countries should continue to monitor reports of myocarditis and pericarditis following vaccination by age, sex, dose and vaccine brand. Countries should consider the individual and population benefits of immunization relevant to their epidemiological and social context when developing their COVID-19 immunisation policies and programs.[49]

COVID-19 Antibody Tests

43. As described above, testing to assess for acute SARS-CoV-2 infection or serologic testing to assess for prior infection is not recommended for the purposes of vaccine decision-making. Last updated December 3, 2021, the FDA's EUA Authorized Serology Test Performances[50] lists approximately 90 products, of which all of them had one of the following three statements about immunity interpretation:

[49] https://www.who.int/news/item/27-10-2021-gacvs-statement-myocarditis-pericarditis-covid-19-mrna-vaccines-updated, last accessed March 6, 2022.

[50] https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/eua-authorized-serology-test-performance, last accessed March 6, 2022.

A. "You should not interpret the results of this test as an indication or degree of immunity or protection from reinfection."[51]

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."[52]

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."[53]

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

Executed on March 9, 2022, in Falls Church, Virginia

RANS.TONYA.SUE.1081263031 Digitally signed by RANS.TONYA.SUE.1081263031 Date: 2022.03.09 10:16:15 -05'00'

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

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[51] https://www.fda.gov/media/146369/download, last accessed March 6, 2022.

[52] https://www.fda.gov/media/138627/download, last accessed March 6, 2022.

[53] https://www.fda.gov/media/137542/download, last accessed March 6, 2022.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

Governor GREG ABBOTT, in his official capacity as Governor of the State of Texas; and Governor MIKE DUNLEAVY, in his official capacity as Governor of the State of Alaska, *Plaintiffs*, v. JOSEPH R. BIDEN, JR., in his official capacity as President of the United States; DEPARTMENT OF DEFENSE; LLOYD AUSTIN, in his official capacity as Secretary of Defense; DEPARTMENT OF THE AIR FORCE; FRANK KENDALL III, in his official capacity as Secretary of the Air Force; DEPARTMENT OF THE ARMY; and CHRISTINE WORMUTH, in her official capacity as Secretary of the Army, *Defendants*.	No. 6:22-cv-3-JCB

[PROPOSED] ORDER DENYING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

After considering Plaintiff Governor Abbott's Motion for Preliminary Injunction, ECF No. 24, Plaintiff Governor Dunleavy's Brief in Support, ECF No. 27, Defendants' opposition, and all other documents and evidence submitted to the Court regarding the motion, the Court hereby DENIES Plaintiffs' motion for preliminary injunction.