IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

AF OFFICER,

Plaintiff,

v.

LLOYD J. AUSTIN, III, individually and in his official capacity as Secretary of Defense; FRANK KENDALL, III, individually and in his official capacity as Secretary of the Air Force; and ROBERT I. MILLER, individually and in his official capacity as Surgeon General of the Air Force,

Defendants.

Case No. 5:22-cv-00009-TES

DEFENDANTS' OPPOSITION TO PLAINTIFFS' CONSOLIDATED MOTIONS FOR CLASS CERTIFICATION AND CLASSWIDE PRELIMINARY INJUNCTION

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

RULES

OTHER AUTHORITIES

INTRODUCTION

On May 3, 2022, the four Plaintiffs in this case—Air Force Officer ("AF Officer"), Air Force NCO ("AF NCO"), Air Force Special Agent ("AF Special Agent"), and Air Force Engineer ("AF Engineer")—moved to certify the following class:

> [A]ll members of the United States Air Force who (a) are subject to a mandate of the Department of Defense or Air Force to receive a COVID-19 vaccine, (b) submitted a request for religious accommodation regarding such mandate based on a sincerely held religious belief, and (c) have received or will receive a final denial of such request from the Department of Defense or Air Force.

Pls.' Cons. Mots. ("Mot.") at 3, Dkt. 88.[1] Plaintiffs also simultaneously moved for a preliminary injunction "enjoining Defendants from enforcing certain COVID-19 vaccine mandates . . . against Air Force NCO, Air Force Special Agent, Air Force Engineer, or any member of the Class," as well as "from taking any adverse action against Air Force NCO, Air Force Special Agent, Air Force Engineer, or any member of the Class on the basis of this lawsuit or of any Plaintiff's or Class member's request for religious accommodation related to the Mandates." *Id.* at 1–2.

Plaintiffs' proposed class fails to meet the requirements of Rule 23. The Supreme Court has made clear that claims raised under the Religious Freedom Restoration Act ("RFRA") require an individualized assessment. *See Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682, 727 (2014). This highly individualized review precludes the propriety of classwide litigation. The class members have different bases for their requested religious accommodations, different job positions and responsibilities, and there are different potentially less restrictive means of achieving the Air Force's compelling governmental interest in maintaining a medically fit force ready for deployment at all times. Given the individualized injunctive and declaratory relief that Plaintiffs seek, Plaintiffs also fail to show that Defendants have "acted or refused to act on grounds that apply generally to the class." Fed. R. Civ.

[1] Ostensibly, the proposed class does not include the United States Space Force. Plaintiffs' request references the U.S. Air Force rather than the Department of the Air Force, the latter of which is comprised of *both* the U.S. Air Force and U.S. Space Force.

P. 23(b)(2). Nor do Plaintiffs address how they overcome conflicts between themselves and members of the putative class in light of the twelve lawsuits—including three putative class actions—that Air Force service members have filed around the country challenging the COVID vaccine requirements.

Plaintiffs' motion for a preliminary injunction also fails to satisfy any of the grounds for such extraordinary relief and should be denied. As an initial matter, none of the three additional named Plaintiffs have been subjected to any administrative action for their failure to obey their vaccination orders and, thus, none of their claims are ripe or exhausted. Extensive military procedures remain available to them to challenge the vaccination order and any future administrative actions. This defect alone warrants denial of this motion, as several Courts have held in actions asserting similar claims. *See, e.g.*, *Church v. Biden*, --- F. Supp. 3d ---, 2021 WL 5179215, at *10 (D.D.C. Nov. 8, 2021); *Roberts v. Roth*, --- F. Supp. 3d ---, 2022 WL 834148, at *4–5 (D.D.C. Mar. 21, 2022).

Moreover, Plaintiffs cannot demonstrate likely success on the merits of their claims. The vaccination requirement satisfies RFRA because the Air Force has an extraordinarily compelling interest in military readiness and the health and readiness of its forces—Plaintiffs included—and no less restrictive measure serves those interests equally well as vaccination. This conclusion is all the more evident given the well-established deference afforded to the military's professional judgments concerning the importance of particular military interests and acceptable military risk. Indeed, the Supreme Court recently granted the government's request for a partial stay of an injunction that prevented the Navy from making assignment decisions that take service members' vaccination status into account. As Justice Kavanaugh emphasized in his concurrence, "[u]nder Article II of the Constitution, the President of the United States, not any federal judge, is the Commander in Chief of the Armed Forces," and there is no basis to "employ[] the judicial power in a manner that military commanders believe would impair the military of the United States as it defends the American people." *Austin v. U.S. Navy SEALs 1–26*, 142 S. Ct. 1301, 1302 (2022) (mem.) (Kavanaugh, J.,

concurring). The Supreme Court also recently denied a service member's request for an injunction pending appeal in a case asserting RFRA and First Amendment claims against the military's vaccination requirement. *See Dunn v. Austin*, --- S. Ct. ---, 2022 WL 1133402 (Apr. 18, 2022) (mem.).

Plaintiffs also fail to demonstrate irreparable injury or to show that the balance of equities and public interest weigh in their favor.

For these reasons and others, the Court should deny Plaintiffs' consolidated motions for class certification and a classwide preliminary injunction.

ARGUMENT

I. Plaintiffs Fail to Establish the Requirements Necessary to Certify a Class.

Class actions are an exception to the ordinary course of American legal practice. *See Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 348 (2011); *Brown v. Electrolux Home Prod., Inc.*, 817 F.3d 1225, 1233 (11th Cir. 2016) ("[T]he presumption is against class certification because class actions are an exception to our constitutional tradition of individual litigation."). To obtain class certification, a plaintiff must first "demonstrate that the class is 'adequately defined and clearly ascertainable.'" *Sellers v. Rushmore Loan Mgmt. Servs., LLC*, 941 F.3d 1031, 1039 (11th Cir. 2019) (quoting *Little v. T-Mobile USA, Inc.*, 691 F.3d 1302, 1304 (11th Cir. 2012)). If the proposed class is ascertainable, then the plaintiff must satisfy Rule 23(a) by showing:

> (1) [T]he class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class.

Id. (quoting Fed. R. Civ. P. 23(a)). These four threshold requirements are commonly known as "numerosity, commonality, typicality, and adequacy of representation." *Id.* In addition, a plaintiff seeking class certification must also satisfy one of the three requirements of Rule 23(b). *Id.* Here, Plaintiffs seek certification under Rule 23(b)(2), which requires the district court to find that "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final

injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2).

A district court must conduct a "rigorous analysis" to ensure that the plaintiff meets his burden of establishing these requirements. *Brown*, 817 F.3d at 1234 (quoting *Comcast Corp. v. Behrend*, 569 U.S. 27, 33 (2013)). Under this standard, a district court does not presume a plaintiff's allegations to be true; rather, the plaintiff "'must affirmatively demonstrate his compliance' with Rule 23 by proving that the requirements are '*in fact*' satisfied." *Id.* (quoting *Comcast*, 569 U.S. at 33). Thus, to the extent there is a disputed question of fact, "the district court has a duty to actually decide it and not accept it as true or construe it in anyone's favor." *Id.* That analysis "will frequently entail 'overlap with the merits of the plaintiff's underlying claim.'" *Id.* (quoting *Wal–Mart*, 564 U.S. at 351).

Plaintiffs fail to show that the class is ascertainable; fail to show in fact that the class has the requisite commonality, typicality, or adequate representation under Rule 23(a); and fail to show in fact that the class meets the requirements of Rule 23(b)(2).

A. The Proposed Class Is Not Ascertainable.

"A proposed class is ascertainable if it is adequately defined such that its membership is capable of determination." *Cherry v. Dometic Corp.*, 986 F.3d 1296, 1304 (11th Cir. 2021); *see also id.* at 1302 (noting that ascertainability is implicit in Rule 23). Ascertainability protects absent plaintiffs "by defining who is entitled to relief," and it protects defendants "by enabling a final judgment that clearly identifies who is bound by it." *In re Delta/AirTran Baggage Fee Antitrust Litig.*, 317 F.R.D. 675, 679 (N.D. Ga. 2016) (quoting 1 William B. Rubenstein, *Newberg on Class Actions* § 3:1 (5th ed. 2011)). Plaintiff's proposed class is not ascertainable for two reasons.

First, the class includes "all members of the United States Air Force who . . . have received *or will receive* a final denial of" their religious accommodation request. Mot. 3 (emphasis added). But there is no way to determine who "will receive a final denial" until that denial occurs. Indeed, Plaintiffs

themselves later clarify that the "final denial" of a class member's religious accommodation request is "the triggering event rendering someone a Class member." Pls' Mem. in Support of Mot. ("Mem.") 6, Dkt. 88-1. Because Plaintiffs' proposed class could be read to include service members who have not received a final denial, such class is not ascertainable.

Second, Plaintiffs propose an improper fail-safe class because its "membership can only be determined after the entire case has been litigated and the court can determine who actually suffered an injury." *Cordoba v. DIRECTV, LLC*, 942 F.3d 1259, 1276 (11th Cir. 2019). A fail-safe class "use[s] legal terminology whose application is linked to the ultimate merits of the case." *Russell v. Tyson Farms, Inc.*, No. 5:19-cv-1179, 2020 WL 3051241, at *1 (N.D. Ala. June 8, 2020) (quoting *Hurt v. Shelby Cnty. Bd. of Educ.*, No. 2:13-CV-230, 2014 WL 4269113, at *1 (N.D. Ala. Aug. 21, 2014)). Plaintiffs' proposed class includes Air Force service members who requested a religious accommodation "*based on a sincerely held religious belief*." Mot. 1 (emphasis added). Yet each service member must individually demonstrate that he or she "holds a belief, not a preference, that is sincerely held and religious in nature, not merely secular" or philosophical. *GeorgiaCarry.Org. Inc. v. Georgia*, 687 F.3d 1244, 1256 (11th Cir. 2012). There is thus no way to determine who belongs to the class until the merits of the case have been litigated.[2] Accordingly, the class is not ascertainable.

B. The Proposed Class Does Not Satisfy Rule 23(a) Requirements.

i. The Proposed Class Does Not Share Common Questions.

The highly individualized nature of RFRA claims means that the purported class will not share common questions sufficient to satisfy Rule 23(a)(2). Commonality under Rule 23(a)(2) is the existence of "questions of law or fact common to the class." Fed. R. Civ. P. 23(a)(2). This requires

[2] Indeed, thousands of service members have submitted religious accommodation requests—thousands more than have ever been requested for any other immunization requirement in military history. *See Navy SEAL 1 v. Austin*, No. 22-0688, 2022 WL 1294486, at *9 n.5 (D.D.C. Apr. 29, 2022), *appeal filed*, No. 22-5114 (D.C. Cir. May 5, 2022). That orders-of-magnitude increase suggests that many service members may have applied for religious exemptions based on something other than a sincerely held religious belief. *Id.*

not the literal raising of "common 'questions,'" but rather "the capacity of a class-wide proceeding to generate common *answers* apt to drive the resolution of the litigation." *Wal-Mart*, 564 U.S. at 350 (citation omitted). Thus, Plaintiffs must demonstrate not only that their claims depend on a "common contention," but that contention must be "capable of classwide resolution—which means that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Id.*; *see also Amgen Inc. v. Conn. Ret. Plans & Tr. Funds*, 568 U.S. 455, 468 (2013); *Sprague v. Gen. Motors Corp.*, 133 F.3d 388, 397 (6th Cir. 1998) ("It is not every common question that will suffice, however; at a sufficiently abstract level of generalization, almost any set of claims can be said to display commonality. What we are looking for is a common issue the *resolution* of which will advance the litigation." (emphasis added)).

This requires more than showing "merely that [class members] have all suffered a violation of the same provision of law." *Wal-Mart*, 564 U.S. at 350. This is because, "[q]uite obviously, the mere claim by employees of the same company that they have suffered [discrimination], or even [] disparate-impact [discrimination], gives no cause to believe that all their claims can productively be litigated at once." *Id.*; *see, e.g.*, *Vega v. T-Mobile USA, Inc.*, 564 F.3d 1256, 1272 (11th Cir. 2009) (holding plaintiff failed to show commonality under breach of contract claim because, without a common employment contract for all class members, the "mandatory elements of each class member's claim depend on [] individualized facts and circumstances").

Establishing commonality in a RFRA class action poses unique hurdles because RFRA "contemplate[s] an inquiry more focused than [a] categorical approach." *See Gonzales v. O Centro Espirita Beneficente Uniao do Vegetal*, 546 U.S. 418, 430–31 (2006). Resolving a RFRA claim necessarily requires individualized analysis of the particular burden on the individual's exercise of religion, the government's compelling interest in implementing a requirement, and the availability of less restrictive alternatives to each such application. *See id.*; *see also Hobby Lobby*, 573 U.S. 682. It "requires the

Government to demonstrate that the compelling interest test is satisfied through application of the challenged law 'to the person'—the particular claimant whose sincere exercise of religion is being substantially burdened." *Gonzales*, 546 U.S. at 430–31 (quoting 42 U.S.C. § 2000bb–1(b)). Indeed, this Court has emphasized the necessarily individualized nature of RFRA claims. *See, e.g.*, *Air Force Officer v. Austin*, ---F. Supp. 3d---, 2022 WL 468799, at *10 (M.D. Ga. Feb. 15, 2022) (requiring Defendants to "explain why they have a compelling interest in *Plaintiff* being vaccinated"). Accordingly, each service member in the putative class would require an individual "mini-trial[]" on his particular circumstances. *Truesdell v. Thomas*, 889 F.3d 719, 726 (11th Cir. 2018). Thus, the mere fact that the putative class members raise a RFRA claim as to the same policy does not establish commonality. *See Wal-Mart*, 564 U.S. at 350.

Instead, in a discrimination-type case, the putative class must establish that the *reasons* (in other words, the *answers* to the common questions) for adverse treatment are the same for each putative class member. *See id.* at 352 (explaining that when plaintiffs "wish to sue about literally millions of employment decisions at once," "[w]ithout some glue holding the alleged *reasons* for all those decisions together, it will be impossible to say that examination of all the class members' claims for relief will produce a common answer to the crucial question *why was*" each exemption request denied); *see also Truesdell*, 889 F.3d at 726 (holding that plaintiff failed to establish commonality because defendant's "reasons" for allegedly violating the relevant statute "may vary for each class member"). This standard applies both to Plaintiffs' RFRA claims and First Amendment claims. The Supreme Court in *Wal-Mart* explained that when a party seeks to certify a class under a theory of a pattern or practice of discrimination, it may establish the existence of common answers by showing either: (1) that the employer "used a biased testing procedure" common to the whole proposed class, or (2) "[s]ignificant proof that an employer operated under a general policy of discrimination" that would apply to the class. *Wal-Mart*, 564 U.S. at 353; *see also id.* at 347 (rejecting plaintiffs' argument that their "evidence

of commonality was sufficient to 'raise the common question whether Wal-Mart's female employees nationwide were subjected to a single set of corporate policies (not merely a number of independent discriminatory acts)'").

Plaintiffs' proposed class action fails to meet these requirements. First, Plaintiffs do not allege that Defendants used biased procedures common to the class. Regardless, Plaintiffs cannot make such a showing in light of the Air Force's individualized process to review and adjudicate religious exemption requests on a case-by-case basis. Ex. 1, Decl. of Major General Sharon R. Bannister ¶ 4; Decl. of Major Matthew J. Streett ¶¶ 4–16, Dkt. 38-16. "This is a fact- and labor-intensive analysis that is particular to the circumstances of the requestor." Ex. 1, Bannister Decl. ¶ 6 (explaining how each request is routed through every single commander in the requestor's chain of command). That process considers, individually for each requestor, the sincerity of the requestor's religious belief; whether the vaccine requirement imposes a substantial burden upon that belief; if so, whether that burden is required in furtherance of a compelling governmental interest; and whether there are any less restrictive means to achieve that interest. Streett Decl. ¶ 5, Dkt. 38-16.

Nor have Plaintiffs provided any evidence that the Air Force "operated under a general policy of discrimination." *Wal-Mart*, 564 U.S. at 353. "In this case, just as in *Walmart*, Plaintiffs do not allege that the [Air Force] ever had an *express* policy" of discrimination. *See In re Navy Chaplaincy*, 306 F.R.D. 33, 48 (D.D.C. 2014) (emphasis added). Rather, Plaintiffs summarily allege that the Air Force has secret "processes, policies, or practices of across-the-board denial of all religious accommodation requests." Second Amended Complaint ("SAC") ¶ 194. But Plaintiffs cannot rely on mere allegations for class certification; rather, they must prove "*in fact*" that they satisfy commonality. *Brown*, 817 F.3d at 1234 (quoting *Comcast*, 569 U.S. at 33); *see also* Mem. 8 ("This is precisely *what Plaintiffs have alleged*: a general policy of discriminating against religious service members[.]" (emphasis added)). Plaintiffs fail to show that the Air Force's religious accommodation request process is a sham. *See Roth v. Austin*,

No. 8:22CV3038, 2022 WL 1568830, at *2 (D. Neb. May 18, 2022) ("The Air Force has demonstrated that its process for consideration of religious exemptions was not simply 'theater' or 'a sham,' but was a process that adhered to the requirements of the law, most specifically RFRA.").

Plaintiffs argue that there must be a policy of discrimination against religious accommodation requests because only a small number of requests have been granted, and those that have been granted were eligible for administrative exemptions. Mem. 14–15. Preliminarily, only a small percentage of religious accommodation requests have been fully adjudicated on appeal across the Air Force. *See* DAF COVID-19 Statistics - May 17, 2022, https://perma.cc/RP9J-X6U8. Drawing any conclusions from the available data—and certainly any conclusion that accommodation requests are not being considered in good faith—is thus unwarranted. Regardless, mere "[s]tatistical disparities . . . are not proof that any particular plaintiff, must less the class as a whole, has been discriminated against." *In re Navy Chaplaincy*, 306 F.R.D. at 52; *see also In re Navy Chaplaincy*, No. 19-5204, 2020 WL 11568892, at *1 (D.C. Cir. Nov. 6, 2020) (per curiam), *cert. denied sub nom. Chaplaincy of Full Gospel Churches v. Dep't of the Navy*, 142 S. Ct. 312 (2021) (rejecting same evidence of statistical disparity in affirming district court's grant of summary judgment in favor of the Navy); *Wal-Mart*, 564 U.S. at 357 (holding that statistical disparity in pay or promotion was insufficient to show discrimination and does "not demonstrate that commonality of issues exist"). Simply put, statistics do not show *why* any particular religious accommodation request was denied or whether such a denial violated RFRA, let alone provide conclusive evidence of a policy of discrimination.

More importantly, the fact that many requests have been denied is consistent with the military's compelling interests in ensuring the health and safety of its service members. Ex. 2, Decl. of Lt. General Kevin B. Schneider ¶ 5 ("It is my professional military judgment that vaccination against COVID-19 is the most effective way to combat the disease and is necessary to ensure we maintain a credible fighting force able to deter our adversaries, protect our nation, and – if necessary – prosecute

our wars and other military operations."); Ex. 3, Decl. of Col. Artemio C. Chapa ¶ 3; DoDI 1332.45, https://perma.cc/G8D9-JEBB ("To maximize the lethality and readiness of the joint force" it is DoD policy that "all Service members are expected to be deployable."). "[W]hen evaluating whether military needs justify a particular restriction on religiously motivated conduct, courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest." *Goldman v. Weinberger*, 475 U.S. 503, 507 (1986). Such deference applies with equal force in the context of 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), and in the RFRA context, *see* S. Rep. No. 103-111, at 12, *reprinted in* 1993 U.S.C.C.A.N. 1892, 1901 (1993) (explaining that "the courts have always extended to military authorities significant deference in effectuating" the military's interest in maintaining good order, discipline, and security, and "[t]he committee intends and expects that such deference will continue under this bill"); *Navy SEAL 1*, 2022 WL 1294486, at *8 (deferring to "military and scientific expertise").

Plaintiffs may disagree with the Air Force's assessment of its compelling interest and least restrictive means, but such disagreement does not mean that Air Force leaders are operating in bad faith.[3] Plaintiffs' claim that the religious accommodation request process is a sham necessarily requires a finding that hundreds of military officials are acting in concert to issue indiscriminate and undifferentiated denials of each service member's request.[4] *Cf. Dodson v. Dep't of Army*, 988 F.2d 1199,

[3] Recent world events have confirmed the necessity of maintaining service members in a constant state of readiness. The United States responded to the Russian invasion of Ukraine by rapidly deploying aircraft, equipment, and thousands of Service members, many within only 24 to 48 hours of notification. Ex. 2, Schneider Decl. ¶ 7.

[4] The process for adjudicating a single service member's religious accommodation request involves review by: a chaplain; the service member's unit commander; a military physician; a Religious Resolution Team comprised of the commander, Senior Installation Chaplain, a public affairs officer, and a member of the Staff Judge Advocate's office; each commander in the chain of command, including (depending on the particular chain of command), squadron command, group command, wing command or delta commander, Numbered Air Force commander, and the MAJCOM (or equivalent) commander; and another Religious Resolution Team at the MAJCOM (or equivalent) level. Streett Decl. ¶¶ 9–13, Dkt. 38-16.

1204 (Fed. Cir. 1993) ("[M]ilitary administrators are presumed to act lawfully and in good faith like other public officers, and the military is entitled to substantial deference in the governance of its affairs."); *Doe 2 v. Shanahan*, 917 F.3d 694, 731 (D.C. Cir. 2019) (Williams, J., concurring) (noting that "the plausibility of such a scheme tends to unravel as we try to imagine the dozens of participants," including "Cabinet members and other officials," "who would have been needed for its realizatio n" (quotation marks omitted)); *see also* Ex. 1, Bannister Decl. ¶ 4 ("There is no blanket policy or practice of disapproving all religious accommodation requests.").

Plaintiffs' reliance on the Air Force's medical and administrative exemptions in support of class certification is misplaced. Mem. 17 (referencing "secular reasons" for exemption). These exemptions provide no basis for class certification because they are not comparable to religious accommodations. *Cf. Tandon v. Newsom*, 141 S. Ct. 1294, 1296 (2021) ("Comparability is concerned with the risks various activities pose"). In contrast to religious accommodations, medical exemptions serve the interest in military readiness: vaccinating a service member who has medical contraindications to the vaccine would harm the member's health, *detracting* from the military's interests in ensuring readiness and the health and safety of members. *See* Ex. 3, Chapa Decl. ¶¶ 12–13, 15, 19.[5] Likewise, administrative exemptions for members who are leaving the military are appropriate because requiring vaccination of individuals who will no longer be part of the force does not further the military's interest in ensuring readiness. Ex. 4, Decl. of Lt. Col. Nekitha M. Little ¶ 3; Ex. 5, Decl. of Lt. Col. Justin L. Long ¶ 5. Administrative exemptions are granted only to service

[5] *See also* Navy SEAL 1, 2022 WL 1294486, at *12 ("[T]he Navy grants medical exemptions only on a showing of a contraindication, i.e., upon a showing that vaccination would cause more medical harm than it would good."); *Mark Short v. Berger*, No. CV 22-1151, 2022 WL 1051852, at *8 (C.D. Cal. Mar. 3, 2022), *appeal filed* No. 22-55339 (9th Cir. Apr. 5, 2022); *Doe v. San Diego Unified Sch. Dist.*, 19 F.4th 1173, 1178 (9th Cir. 2021), *cert. and application for injunction denied*, 142 S. Ct. 1099 (2022); *Does 1–6 v. Mills*, 16 F.4th 20, 31 (1st Cir. 2021), *cert. denied*, *Does 1-3 v. Mills*, 142 S. Ct. 1112 (2022).

members on terminal leave, separating, or retiring from the Air Force.[6] Ex. 5, Long Decl. ¶¶ 4–5; Little Decl. ¶ 3. This effectuates the stated intent of Congress. *See* Joint Explanatory Statement to FY 2022 NDAA at 151, https://perma.cc/FL8K-PFUU ("We also expect the Department to include . . . exemptions [from mandatory COVID-19 vaccination] for servicemembers nearing separation and retirement in the development of uniform procedures relating to administrative exemptions."). Moreover, all medical and administrative exemptions are temporary—in contrast to the presumptive permanency of a sincerely-held religious belief opposing COVID-19 vaccination. Ex. 3, Chapa Decl. ¶¶ 13–14; Ex. 4, Little Decl. ¶¶ 3–4; Ex. 5, Long Decl. ¶ 5; *see also Mark Short*, 2022 WL 1051852, at *5 ("Only *permanent* medical exemptions are analogous to religious exemptions, because a religious belief is not likely to be temporary[.]"). Both medical and administrative exemptions have been steadily declining for months because medical exemptions require the service member to be vaccinated when their condition is resolved, *see* Ex. 3, Chapa Decl. ¶ 14, and administrative exemptions end when the recipient leaves the service, *see* Ex. 5, Long Decl. ¶ 5; Ex. 4, Little Decl. ¶ 3.[7]

Nor do medical and administrative exemptions provide a "golden ticket" for the recipient to continue as normal in their job duties as if they were vaccinated, as Plaintiffs here seek to do. Rather, "contrary to Plaintiffs' contentions, service members with medical, administrative, or religious exemptions to the COVID-19 vaccination mandate do not operate within the Air Force as if they were vaccinated." *Roth*, 2022 WL 1568830, at *20. Any service member who is not vaccinated is subject to the multiple deployment, assignment, and duty restrictions and limitations that Plaintiffs

[6] Some administrative exemptions are also granted to service members who are actively participating in COVID-19 vaccine clinical trials in the interest of furthering the efficacy of the vaccine itself. *But see* Ex. 3, Chapa Decl. ¶ 23 ("I am not personally aware of anyone that currently has an exemption from the COVID-19 vaccine because they are participating in a vaccine clinical trial.").

[7] *Compare* DAF COVID-19 Statistics - January 2022, https://perma.cc/BJ9D-7AJ4, *with* DAF COVID-19 Statistics - May 17, 2022, https://perma.cc/RP9J-X6U8. There are currently only 27 Active Duty and 92 Reservists with administrative exemptions; and 395 Active Duty and 182 Reservists with medical exemptions. DAF COVID-19 Statistics - May 17, 2022, https://perma.cc/RP9J-X6U8. Comparatively, the Air Force has granted 81 total religious accommodation requests. *Id.*

seek to avoid. Ex. 3, Chapa Decl. ¶ 16. Medical exemptions render a service member non-deployable and subject to additional restrictions, *id.* ¶¶ 15–17, and service members who remain non-deployable for more than 12 consecutive months are evaluated for whether they should be retained in military service, DoDI 1332.45 ¶ 1.2(b), https://perma.cc/G8D9-JEBB. Thus, medical and administrative exemptions do not provide any proof—much less definitive proof—that the Air Force is engaging in an intentionally discriminatory scheme such that class certification is appropriate.

Ultimately, Plaintiffs fail to show that the Air Force either "used a biased testing procedure" or "operated under a general policy of discrimination" that would apply to the whole class. *Wal-Mart*, 564 U.S. at 353. At best, Plaintiffs provide "statistical proof" and "anecdotal evidence," which are "too weak to raise any inference that all the individual, discretionary personnel decisions are discriminatory," *id.* at 358, and fail to show that any alleged discrimination "manifested itself . . . in the same general fashion" across each of the putative class members' unique religious accommodation requests, *id.* at 353. Rather, Plaintiffs' claims turn on the distinct contours of each putative class member's case—the individualized assessment of the vaccine mandate as applied to each "particular claimant." *Gonzales*, 546 U.S. at 430–31. Such an inquiry cannot be resolved on a classwide basis for either Plaintiffs' RFRA or First Amendment claims. Because Plaintiffs fail to establish a "common contention," the determination of which "will resolve an issue that is central to the validity of each one of the [RFRA and First Amendment] claims in one stroke," Plaintiffs have failed to establish commonality pursuant to Rule 23(a)(2). *Wal-Mart*, 564 U.S. at 350.

ii. The Named Plaintiffs Are Not Typical Of The Putative Class.

For related reasons, the named Plaintiffs cannot satisfy the typicality requirement of Rule 23(a)(3). Typicality and commonality "tend to merge," and both ultimately address "whether under the particular circumstances maintenance of a class action is economical and whether the named plaintiff's claim[s] and the class claim[s] are so interrelated that the interests of the class members will

be fairly and adequately protected in their absence." *Wal-Mart*, 564 U.S. at 349 n.5 (quoting *Gen. Tel. Co. of Sw. v. Falcon*, 457 U.S. 147, 157–58 n.13 (1982)). But where "commonality refers to the group characteristics of the class as a whole," "typicality refers to the individual characteristics of the named plaintiff[s] in relation to the class." *Piazza v. Ebsco Indus., Inc.*, 273 F.3d 1341, 1346 (11th Cir. 2001).

Under RFRA, each claim requires an individual analysis of relative burden to the service member's religion and whether there exist less restrictive means of furthering the government's compelling interest. Accordingly, differences in occupational duties, deployment tempo, and work environment all affect the RFRA analysis. Yet Plaintiffs' putative class includes service members across the entire possible range of Air Force occupations. With close to 10,000 pending religious accommodation requests in the Air Force, this putative class could include service members across approximately 3,300 squadrons, which each range in size from seven personnel to over 600 personnel. Ex. 1, Bannister Decl. ¶ 16. Traditional squadrons include "fighter squadrons, bomber squadrons, mobility squadrons, tanker squadrons, missile squadrons, intelligence squadrons, surveillance reconnaissance squadrons, command and control squadrons, and training squadrons," and operational support squadrons include "medical squadrons, aircraft maintenance squadrons, civil engineering squadrons, mission support squadrons, and security forces squadrons." *Id.* The roles and responsibilities of service members in these fields "differ vastly." *Id.* These occupations all require varying levels of proximity to other individuals, likelihood of deployment, likelihood of travel, and ability to telework. *See id.* ¶¶ 19, 22. Some service members who have requested religious accommodations "fly in a single-occupancy aircraft or fly in close proximity with multiple service members in a crew-type aircraft"; "some requestors are medical providers" who must work "in close proximity with individuals who are immuno-compromised or who have otherwise been unable to obtain public health vaccinations"; yet other requestors "may work more in an office setting or outdoors with less proximate physical contact to others." *Id.* ¶¶ 19–20. Thus, for the Court to

properly consider whether the Air Force wrongfully denied a particular religious accommodation request, the Court must take into account all of these individualized job circumstances—*i.e.*, a mini-trial for each of the 10,000 putative class members. *Cf. Murray v. Auslander*, 244 F.3d 807, 812 (11th Cir. 2001) (noting that even in challenge to the same allegedly illegal policy, "the need for complex, individualized hearings to determine [Medicaid] eligibility" under that policy would counsel against a finding of commonality and typicality).

Plaintiffs' putative class also includes service members with a broad variety of religious beliefs and, consequently, different reasons for objecting to the COVID-19 vaccine. These differences are essential in determining whether a particular vaccine places a substantial burden upon a service member's religion and whether there are available lesser restrictive means. For example, a service member requesting exemption from mRNA vaccines may not be substantially burdened if offered another type of vaccine, such as the Janssen (Johnson & Johnson) vaccine. A service member requesting exemption from vaccines with connections to abortion may not be substantially burdened if offered the Novavax or the Covaxin vaccines. The outcome of each request for a religious accommodation may vary based on such individual circumstances, as may the outcome of judicial review should a request be denied. Because of these essential differences, none of Plaintiffs' claims satisfy the typicality requirement of Rule 23(a)(3).

Each of the four named Plaintiffs also allege that vaccination is not the least restrictive means of furthering the Air Force's compelling interest in part because they have "natural immunity" from prior infection. SAC ¶¶ 97–103. Although Defendants argue that alleged natural immunity does not affect the Air Force's compelling interest in vaccinating a particular individual, *see infra* pp. 31–32, this Court has queried the relevance of natural immunity. *See Air Force Officer*, 2022 WL 468799, at *10 ("Plaintiff's natural immunity coupled with other preventive measures begs the question: Does a COVID-19 vaccine really provide more sufficient protection?"). Yet not each class member has

contracted COVID-19 and can allege "natural immunity." Thus, to the extent that natural immunity is indeed relevant, that consideration will differ across each putative class member, further rendering named Plaintiffs' claims atypical of the putative class.

Moreover, the four named Plaintiffs lack justiciable claims. "It should be obvious that there cannot be adequate typicality between a class and a named representative unless the named representative has individual standing to raise the legal claims of the class." *Prado–Steiman ex rel. Prado v. Bush,* 221 F.3d 1266, 1279 (11th Cir. 2000); *cf. TransUnion LLC v. Ramirez*, 141 S. Ct. 2190, 2208 (2021) ("Article III does not give federal courts the power to order relief to any uninjured plaintiff, class action or not.") (quoting *Tyson Foods, Inc. v. Bouaphakeo*, 577 U.S. 442, 466 (2016)). As explained in Defendants' Motion to Dismiss, Dkt. 92 at 12–14, AF Officer and AF NCO voluntarily retired and thus lack standing to challenge their retirements. AF Engineer and AF Special Agent have not exhausted their administrative remedies because the Air Force has not even begun administrative discharge proceedings or transfer to the Individual Ready Reserve ("IRR"). *Id.* at 14–19.[8]

Relatedly, the putative class includes service members in varying stages of exhaustion of their intra-military administrative remedies. Because the Air Force provides many opportunities for service members to present their arguments (depending on the service members' particular circumstances), putative class members are spread across the continuum of exhaustion. Streett Decl. ¶¶ 4–16, Dkt.

[8] AF Officer's claims lack typicality for the additional reason, as discussed in previous filings, that she lacks standing to serve as a class representative. *See* Mem. in Supp. of Mot. to Strike, Dkt. 60-1 at 5–9; Resp. in Opp'n to Mot. for Leave to File 2d Am. Compl., Dkt. 69 at 5–16. Because standing must be analyzed on a claim-by-claim basis, a proposed class representative must "demonstrate standing separately for each form of relief sought." *See I.L. v. Alabama*, 739 F.3d 1273, 1279 (11th Cir. 2014) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Svcs.,* 528 U.S. 167, 185 (2000)). As this Court has recognized, Dkt. 83 at 7, preliminary and permanent injunctive relief are separate forms of relief, *see Lermer Germany GmbH v. Lermer Corp.*, 94 F.3d 1575, 1577 (Fed. Cir. 1996); *Fin. Info. Techs., Inc. v. iControl Sys., USA, LLC*, No. 8:17-cv-190-T-23MAP, 2018 WL 3391379, at *10 (M.D. Fla. June 12, 2018). AF Officer has already received the preliminary injunctive relief that the class seeks. Accordingly, AF Officer lacks standing to seek preliminary injunctive relief on behalf of the class.

38-16; Ex. 6, Decl. of Col. Elizabeth M. Hernandez ¶¶ 3–17.[9] Moreover, some service members may opt to be vaccinated after the denial of a religious accommodation request and proceed with their service rather than pursuing litigation; some may choose to retire or to voluntarily separate as a possible alternative to vaccination. By including every active-duty and reserve service member in the Air Force who has submitted a religious accommodation request, Plaintiffs' putative class includes a range of members whose claims are nonjusticiable and at different stages of exhaustion. Joining all service members into a single class to litigate unexhausted claims is simply not appropriate.

Accordingly, Plaintiffs seek to litigate a class that includes different circumstances, religious objections, jobs in different locations with different responsibilities, and different outcomes. *See Jackson v. Motel 6 Multipurpose, Inc.*, 130 F.3d 999, 1006 (11th Cir. 1997) ("[P]laintiffs' claims will require distinctly case-specific inquiries into the facts surrounding each alleged incident of discrimination."). Yet each of these differences go to the heart of each putative class member's respective RFRA claim, because each purported class member requires an individual assessment of the sincerity of their religious beliefs, the alleged burden upon those beliefs, the compelling governmental interest, and the least restrictive means of achieving that interest. Plaintiffs thus fail to establish typicality.

iii. Plaintiffs And Their Counsel Have Not Shown They Will Fairly And Adequately Protect The Interests Of The Classes.

Under Rule 23(a)(4), the plaintiff must establish that "the representative parties will fairly and

[9] For active-duty members, many service members who have received a determination on appeal have not yet been subject to administrative action (*e.g.*, a Letter of Reprimand), or initiation of administrative discharge proceedings. Ex. 6, Hernandez Decl. ¶ 10. As noted in Defendants' Motion to Dismiss, there are multiple opportunities for a member subject to the initiation of administrative discharge proceedings to ultimately be retained. Dkt. 92 at 14–19. For reserve members, some who have received a determination on appeal have not yet have been subject to administrative action, such as a Letter of Reprimand; for those who have received a Letter of Reprimand, some have not yet have had their opportunity to consult with free defense counsel, provide a response and then receive a decision from the issuing authority, and some have not yet have appealed that decision. *Id.* ¶ 6. Even for those who have fully appealed, they may not have yet been placed in a no pay/no points status and reassigned to the IRR. Ex. 12, Decl. of Lt. Col. Ethel M. Watson ¶ 8; Ex. 8, Decl. of Col. Ashley Heyen ¶ 3. And the vast majority of putative members have not applied to the Air Force Board for Correction of Military Records to address any administrative or disciplinary action taken. *See* Ex. 6 ¶ 17.

adequately protect the interests of the class." Fed. R. Civ. P. 23(a)(4). This rule is particularly important in classes certified under Rule 23(b)(2), as Plaintiffs propose, because such classes are mandatory—any and every person within the class will be bound by this Court's judgment without the opportunity to opt out, either before or after judgment. *Cf. Cox v. Am. Cast Iron Pipe Co.*, 784 F.2d 1546, 1554 (11th Cir. 1986) ("The general rule in this Circuit is that absent members of (b)(2) classes have no automatic right to opt out of a lawsuit and to prosecute an entirely separate action."); *Chavez v. Plan Benefit Servs., Inc.*, 957 F.3d 542, 547 (5th Cir. 2020) ("[T]he existence of a class fundamentally alters the rights of present and absent members, particularly for mandatory classes such as the one here."). Accordingly, the Court must rigorously examine whether the proposed class representatives will adequately represent the interests of the absent class members. This requires "two separate inquiries: (1) whether any substantial conflicts of interest exist between the representatives and the class; and (2) whether the representatives will adequately prosecute the action." *Valley Drug Co. v. Geneva Pharms., Inc.*, 350 F.3d 1181, 1189 (11th Cir. 2003).

Plaintiffs fail to show how they can overcome fundamental conflicts between themselves and members of the proposed class. Putative class members have separately filed at least twelve lawsuits around the country challenging the COVID-19 vaccine requirements for members in the Air Force.[10] Three of those lawsuits purport to bring competing class action claims.[11] Plaintiffs in those lawsuits

[10] *See Bongiovanni v. Austin*, 3:22-cv-00237 (M.D. Fla.); *Coker v. Austin*, 3:21-cv-01211 (N.D. Fla.); *Crosby v. Austin*, 8:21-cv-02730 (M.D. Fla.); *Dunn v. Austin*, 2:22-cv-00288 (E.D. Cal.); *Navy SEAL 1 v. Austin*, 8:21-cv-02429 (M.D. Fla); *Poffenbarger v. Kendall*, 3:22-cv-00001 (S.D. Ohio); *Roth v. Austin*, 8:22-cv-03038 (Neb.); *Doster v. Kendall*, 1:22-cv-00084 (S.D. Ohio); *Crocker v. Austin*, 22-cv-00757 (W.D. La.); *Creaghan v. Austin*, 22-cv-00981 (D.D.C.); *Knick v. Austin*, 22-cv-01267 (D.D.C.); *Church v. Biden*, No. 1:21-cv02815 (D.D.C.).

[11] *See Navy SEAL 1 v. Austin*, 8:21-cv02429, Dkt. 35 at 1 (M.D. Fla) (seeking to certify class of "all United States Armed Forces servicemembers and civilian federal employees and contractors who are subject to Defendants COVID-19 Vaccine Mandate, have requested a religious exemption or accommodation from the Mandate based on sincerely held religious beliefs against receiving a COVID-19 vaccine, and been denied such exemption or accommodation"); *Poffenbarger v. Kendall*, 3:22-cv-00001, Dkt. 1 ¶ 32 (S.D. Ohio) (seeking to certify class of "persons who: (i) have been confirmed by Air Force Chaplains to have a sincerely held religious belief against the Air Force's vaccination requirements; (ii) have submitted paperwork demonstrating and seeking a religious accommodation; and (iii) have had their accommodation requests denied"); *Doster v. Kendall*, 1:22-cv-00084, Dkt. 21 at 4 (S.D. Ohio) (seeking to certify class of "All active-duty, and active reserve members of the

have chosen their own counsel and their own forums to press their claims, and to date, none has sought to consolidate with this present action. Several have already resulted in decisions (the majority of which have denied the respective requests for relief).[12] Given that these lawsuits all raise different issues—including claims not raised in this class action—managing a class action would be especially untenable. *See, e.g.*, *Coker v. Austin*, 3:21-cv-1211, Dkt. 47 (N.D. Fla.) (including claims under substantive due process and unconstitutional conditions doctrine and not RFRA); *Navy SEAL 1 v. Austin*, 8:21-cv-02429, Dkt. 49-1 (M.D. Fla.) (including claims under APA and FDCA). Plaintiffs proffer no explanation of how putative class members might choose which lawsuit to join. Other putative class members may choose to litigate their claim alone, or with different counsel, or may wish to raise different claims or arguments, or conceivably may wish not to seek legal redress at all—preferring to comply with a lawful order after their religious accommodation is decided and maintain their military service without litigation, or choose to leave or retire from the service. Yet all class members would be forced to have their claim adjudicated as part of this lawsuit. Indeed, where multiple plaintiffs challenge a government policy in many different forums, the Supreme Court has affirmed the importance of allowing individual lower courts to consider the issue. "Government litigation frequently involves legal questions of substantial public importance," and "[a]llowing only one final adjudication would deprive [the Supreme] Court of the benefit it receives from permitting

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United States Air Force who: (i) submitted a religious accommodation request to the Air Force from the Air Force's COVID-19 vaccination requirement, where the request was submitted or was pending, from September 1, 2021 to the present; (ii) were confirmed as having had a sincerely held religious belief by or through Air Force Chaplains; and (iii) either had their requested accommodation denied or have not had action on that request.").

[12] *See, e.g.*, *Dunn v. Austin*, No. 21A599, 2022 WL 1133402, at *1 (U.S. Apr. 18, 2022) (denying preliminary injunction pending appeal); *Creaghan v. Austin*, No. CV 21-0981 (CKK), 2022 WL 1500544, at *5 (D.D.C. May 12, 2022) (denying TRO and preliminary injunction motions); *Navy SEAL 1*, 2022 WL 1294486, at *8 (denying TRO and preliminary injunction motions); *Coker v. Austin*, 3:21-cv-01211, Dkt. 47 (N.D. Fla. Nov. 12, 2021) (denying preliminary injunction motions); *Crosby v. Austin*, 8:21-cv-02730, Dkt. 48 (M.D. Fla.) (denying TRO and preliminary injunction motions); *Church*, 2021 WL 5179215 (denying TRO and preliminary injunction motions); *Roth*, 2022 WL 1568830, at *2 (denying preliminary injunction motion).

several courts of appeals to explore a difficult question before this Court grants certiorari." *See United States v. Mendoza*, 464 U.S. 154, 160 (1984). Accordingly, Plaintiffs fail to establish that the prerequisites of Rule 23(a) are met.

C. Plaintiffs Fail to Show a Class That Can Be Maintained Under Rule 23(b) Because the Requested Relief is not Indivisible.

"In addition to satisfying Rule 23(a)'s prerequisites, parties seeking class certification must show that the action is maintainable under Rule 23(b)(1), (2), or (3)." *Amchem Prods., Inc. v. Windsor*, 521 U.S. 591, 614 (1997). As noted, Plaintiffs here seek to certify a class under Rule 23(b)(2), which applies when "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole." Fed. R. Civ. P. 23(b)(2). Rule 23(b)(2) classes are mandatory in that putative class members may not opt out of the class (nor even is the Court obliged to afford them notice of the action) because relief will necessarily "affect the entire class at once." *See Wal-Mart*, 564 U.S. at 362; *see also Casa Orlando Apartments, Ltd. v. Fed. Nat'l Mortg. Ass'n*, 624 F.3d 185, 198 (5th Cir. 2010) (explaining that Rule 23(b)(2) "seeks to redress what are really group as opposed to individual injuries," thus "render[ing] the notice and opt-out provisions of [Rule 23](b)(3) unnecessary"). Accordingly, to certify a Rule 23(b)(2) class, the requested relief must be "indivisible" such that "the conduct . . . can be enjoined or declared unlawful only as to all of the class members or as to none of them." *Wal-Mart*, 564 U.S. at 360.

Plaintiffs' requested relief is not "indivisible." *Id.*. Plaintiffs challenge the denials of their respective religious accommodation requests. *See* SAC ¶ 279 (seeking "a declaration that Defendants violated [Plaintiffs'] rights under RFRA to the free exercise of religion and an order restraining and enjoining Defendants from denying their requests for religious accommodation, from forcing them to retire or separate from the military, and from taking any other adverse action against them based on their unvaccinated status"); *see also* Mot. 2 (seeking an injunction preventing Defendants "from

taking any adverse action against Air Force NCO, Air Force Special Agent, Air Force Engineer, or any member of the Class on the basis of this lawsuit or of any Plaintiff's or Class member's request for religious accommodation related to the Mandates"). Because each religious accommodation request necessarily involves different underlying facts and circumstances, the Court cannot grant relief "only as to all of the class members or to none of them." *Wal-Mart*, 564 U.S. at 360; *see also id.* at 361 ("In none of the [racial segregation] cases cited by the Advisory Committee as examples of (b)(2)'s antecedents did the plaintiffs combine any claim for individualized relief with their classwide injunction"). Plaintiffs fail to establish the requirements for a mandatory class under Rule 23(b)(2).

Accordingly, Plaintiffs fail to show that "in fact" they meet class-certification requirements.

II. Plaintiffs Fail to Make the Extraordinary Showing Necessary for a Classwide Preliminary Injunction.

"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). Plaintiffs must establish by "*a clear showing*" 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); *Thompson v. DeWine*, 976 F.3d 610, 615 (6th Cir. 2020), *cert. denied*, 141 S. Ct. 2521 (2021). "Failure to show any of the four factors is fatal[.]" *ACLU of Fla., Inc. v. Miami-Dade Cnty. Sch. Bd.*, 557 F.3d 1177, 1198 (11th Cir. 2009).

Moreover, 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, *see Rostker v. Goldberg*, 453 U.S. 57, 66 (1981) (explaining that because of the "healthy deference to legislative and executive judgments in the area of military affairs," courts employ a relaxed scrutiny in reviewing military policy); *Aktepe v. United States,* 105 F.3d 1400, 1403 (11th Cir. 1997) ("[T]he political branches of government are accorded a particularly high degree of deference in the area of military affairs."); *see also Winck v. England*, 327 F.3d 1296, 1302–04

(11th Cir. 2003), *abrogated on other grounds by Santiago-Lugo v. Warden*, 785 F.3d 467 (11th Cir. 2015). Such deference extends to constitutional claims and military decisions about the health and welfare of the troops. *See, e.g.*, *Solorio*, 483 U.S. at 448; *Mazares*, 302 F.3d at 1385.

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

i. Plaintiffs' Claims Are Not Justiciable.

"Article III does not give federal courts the power to order relief to any uninjured plaintiff, class action or not." *See TransUnion*, 141 S. Ct. at 2208 (citation omitted). As discussed in Defendants' Motion to Dismiss, Dkt. 92 at 10–19, Plaintiffs have failed to establish that this Court has jurisdiction over their claims because Plaintiffs' claims are not ripe, Plaintiffs who chose to retire have no standing to challenge their retirements, and Plaintiffs have failed to exhaust administrative remedies.

First, a case is not ripe when the claim is "dependent on 'contingent future events that may not occur as anticipated, or indeed may not occur at all.'" *Trump v. New York*, 141 S. Ct. 530, 535 (2020) (citation omitted). The denial of a religious accommodation request, standing alone, does not cause injury. A service member faces substantial burden to his religion only upon the imposition of actual consequences—including separation or, for reservists, transfer to the IRR—for failing to receive the vaccine following the denial. *See Smith v. Harvey*, 541 F. Supp. 2d 8, 13 (D.D.C. 2008) (explaining that the military's "initiation of separation proceedings is a tentative action not fit for judicial review; one can only speculate as to the final outcome of any proceedings"); *see also Schlesinger v. Councilman*, 420 U.S. 738, 758 (1975) (explaining that simply being subject to military process with the prospect of some future punishment is not current harm and "the federal district courts *must* refrain from intervention, by way of injunction or otherwise" (emphasis added)). Neither named Plaintiffs nor most putative class members present ripe claims because "[w]hile [they] argue[] that [their] discharge [or transfer to the IRR] is likely, [they] ha[ve] not been discharged [or transferred] at this point." *Roberts*, 2022 WL 834148, at *4; *see also* DAF COVID-19 Statistics (May 17, 2022),

https://perma.cc/RP9J-X6U8 (noting that only 383 service members—out of Plaintiffs' 10,000-person putative class—have been administratively separating for refusal to vaccinate).

AF NCO's claim is unripe for the additional reason that he faces pending Medical Evaluation Board (MEB) processing. *See* Ex. 11, Decl. of Brig. Gen. William R. Kountz, Jr., ¶ 9. The MEB process will determine whether he is entitled to further evaluation for possible disability benefits due to a potentially medically-disqualifying, duty-interfering condition unrelated to his unvaccinated status. *See id.* This process will require, at a minimum, several months to complete, and AF NCO may be entitled to additional evaluation boards. *See id.* Depending on the result of this determination, AF NCO may be medically retired wholly unrelated to his unvaccinated status. *See id.*

Second, AF Officer and AF NCO voluntarily chose to retire from the military and thus do not have justiciable claims.[13] *See Hargray v. City of Hallandale*, 57 F.3d 1560, 1563 (11th Cir. 1995) (explaining that a voluntary resignation cannot form the basis of a statutory or constitutional claim). The Eleventh Circuit has emphasized the high bar one must meet to show that a resignation was involuntary. *See id.* at 1568 ("[T]he mere fact that the choice is between comparably unpleasant alternatives . . . does not of itself establish that a resignation was induced by duress or coercion, hence was involuntary." (quoting *Stone v. Univ. of Md. Med. Sys. Corp.*, 855 F.2d 167, 174 (4th Cir. 1988))). Neither AF Officer nor AF NCO meet that standard because they were given "alternative[s] to resignation" (including either taking the COVID-19 vaccine or facing military discipline), they "understood the nature" of that choice, they were "given a reasonable time" of five days[14] "in which to choose," and they were "permitted to select the effective date of the resignation." *See id.* at 1568

[13] As discussed, AF Officer requested to withdraw her retirement. *See* Dfs.' Mot. to Dismiss, Dkt. 92 at 12 n.5. For the same reasons discussed in Defendant's Motion to Dismiss, this does not affect the justiciability analysis.
[14] On December 6, 2021, AF Officer was initially given three days to choose. Following the December 7, 2021 memo providing service members with five days to choose, *see* Memorandum re: Supplemental Coronavirus Disease 2019 Vaccination Policy (Dec. 7, 2021), https://perma.cc/42DW-QQJW, AF Officer ultimately filed for retirement on December 11, 2021—five days after her initial notice, *see* Dkt. 92-5 (AF Officer's retirement application).

(providing factors for determining whether resignation was "obtained by coercion or duress"). Any of the putative class members who chose to retire also face this defect.

Third and finally, Plaintiffs have failed to exhaust available administrative remedies. As this Court explained, "the Eleventh Circuit recognized that judicial review of internal military matters should be 'forestall[ed]' until the administrative process is concluded." *Air Force Officer*, 2022 WL 468799, at *6 (citation omitted); s*ee also Winck*, 327 F.3d at 1303 n.4 (requiring a service-member plaintiff to exhaust "*all* available military remedies" (emphasis added)). Several courts have denied relief to service-member plaintiffs who had received a final decision on a religious accommodation request and pursued RFRA and First Amendment claims before exhausting their discipline or separation remedies. *See Church*, 2021 WL 5179215, at *10–11; *Mark Short*, 2022 WL 1051852, at *4 ("Although he has received a decision on his appeal, he still must undergo separation proceedings before any permanent adverse consequences are imposed."); *cf. Roberts*, 2022 WL 834148, at *4. No named Plaintiff has even been subject to final discipline, *see* Holmes Decl. ¶ 4, Dkt. 92-2; Bullard Decl. ¶ 5, Dkt. 92-3; Rigsbee Decl. ¶¶ 5–6, Dkt. 92-4,[15] much less exhausted available administrative remedies with the Air Force Board for Correction of Military Records ("BCMR"), *see Rucker v. Sec'y of the Army*, 702 F.2d 966, 970 (11th Cir. 1983) (explaining that exhausting all military remedies involves everything up to and including "petitioning to the [BCMR] [to] request[] the relief sought in th[e] action" and subsequently "receiving [the] adverse determination"); *see also Bois v. Marsh*, 801 F.2d 462, 468 (D.C. Cir. 1986) ("'[T]he salutary rule [is] that 'an aggrieved military officer must first exhaust his administrative remedies with his particular service's [BCMR] prior to litigating his claims in a federal court.'") (quoting *Knehans v. Alexander*, 566 F.2d 312, 315 (D.C. Cir. 1977)). Similarly, any putative class members who failed to exhaust their administrative remedies also present non-justiciable claims.

[15] Defendants' Motion to Dismiss mistakenly implied that AF Special Agent may be subject to discharge proceedings and entitled to a Board of Inquiry. Dkt. 92 at 17. Rather, AF Special Agent is an enlisted reservist who faces reassignment to the IRR rather than discharge.

Accordingly, Plaintiffs are unlikely to succeed on the merits of their claims because named Plaintiffs and putative class members do not present justiciable claims.

ii. Plaintiffs Are Unlikely to Succeed on the Merits of their RFRA or First Amendment Claims.

Plaintiffs are unlikely to succeed on the merits of their RFRA claim.[16] Military orders to vaccinate do not violate RFRA if the government "demonstrates that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest." 42 U.S.C. § 2000bb-1(b). Requiring Plaintiffs to be vaccinated furthers the compelling interests in military readiness and health of service members, and is the least restrictive means of advancing those interests. "[A] majority of the Supreme Court has already held . . . that the Government is likely to succeed on the merits on the same claims brought by Navy SEALs," and although this decision may not be formally binding, "it is the most persuasive authority on which a District Court may rely." *Navy SEAL 1*, 2022 WL 1294486, at *4.

1. Vaccinating Plaintiffs and the Putative Class Against COVID-19 Furthers the Government's Compelling Interest.

This Court has recognized that "[i]t would be a waste of time and wrong to state that '[s]temming the spread of COVID-19' isn't a compelling interest—the Supreme Court has already decided it is." *Air Force Officer*, 2022 WL 468799, at *9 (quoting *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 67 (2020)); *see also Roth*, 2022 WL 1568830, at *17 (quoting *Air Force Officer* for the proposition that the government has a compelling interest in stemming the spread of COVID-19); *see Roth*, 2022 WL 1568830, at *17 ("[T]he Air Force has also narrowly or specifically framed its interest as preventing COVID-19 from impairing the readiness and health of its forces, including individual service members like Plaintiffs, which the COVID-19 vaccination mandate is intended to further.").

[16] There is no need for the Court to address Plaintiffs' First Amendment claim separately. If the Government prevails on Plaintiffs' RFRA claim, then the Government necessary prevails under Plaintiffs' First Amendment claim. Conversely, if Plaintiffs prevail under RFRA, the Court need not reach the constitutional theory.

Requiring named Plaintiffs and the putative class to be vaccinated against COVID-19 furthers that compelling interest, especially when evaluated against the backdrop of the substantial deference that courts have always given to military operational decisionmaking. *See Mark Short*, 2022 WL 1051852, at *7 ("[W]hen evaluating whether military needs justify a particular restriction on religiously motivated conduct, courts must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest." (quoting *Goldman*, 475 U.S. at 507)); *see also Orloff v. Willoughby*, 345 U.S. 83, 94 (1953) ("Orderly government requires that the judiciary be as scrupulous not to interfere with legitimate [military] matters as the [military] must be scrupulous not to intervene in judicial matters."); *Bryant v. Gates*, 532 F.3d 888, 899 (D.C. Cir. 2008) ("[I]nterfere[nce] with the military's pursuit of its critical mission and involve[ment of] the courts in military decisions . . . are well beyond the competence of judges.") (Kavanaugh, J., concurring); *Kreis v. Sec'y of Air Force*, 866 F.2d 1508, 1511 (D.C. Cir. 1989). The Supreme Court has repeatedly emphasized that the government's interest in "maximum efficiency" of military operations is paramount, *cf. United States v. O'Brien*, 391 U.S. 367, 381 (1968), and that "[f]ew interests can be more compelling than a nation's need to ensure its own security," *Wayte v. United States*, 470 U.S. 598, 611 (1985). Congress expressly recognized these long-standing principles of military deference in enacting RFRA. *See* S. Rep. No. 103-111, at 12 ("The courts have always recognized the compelling nature of the military's interest in [good order, discipline, and security] in the regulations of our armed services . . . [and] have always extended to military authorities significant deference in effectuating these interests. The committee intends and expects that such deference will continue under this bill."); H.R. Rep. No. 103-88, at 8 (1993).

After consulting with "medical experts and military leadership," including the "Chairman of the Joint Chiefs of Staff, the Secretaries of the Military Departments, [and] the Service Chiefs," the Secretary of Defense "determined that mandatory vaccination against [COVID-19] is necessary to

protect the Force and defend the American people." Sec'y of Def. Mem. (Aug. 24, 2021), https://perma.cc/N759-S758; Sec'y of Def. Mem. (Aug. 9, 2021), https://perma.cc/S4R3-2VZW. The Secretary of the Air Force likewise found that COVID-19 vaccination of each service member is necessary to ensure military readiness and the health and safety of airmen. *See* Sec'y of Air Force Mem. at 1 (Sept. 3, 2021), https://perma.cc/6E2W-3EQM; *see also* Ex. 2, Schneider Decl. ¶ 6; *Creaghan*, 2022 WL 1500544, at *9 (explaining that "logic alone" dictates that "the military's general compelling interest in ensuring the health of its servicemembers . . . distill[s] to a compelling interest in ensuring that [each individual service member] remains healthy enough to accomplish her duties"). The Court must "give great deference" to these "professional military judgments" when it comes to what is needed to ensure military readiness and the welfare of service members. *Winter*, 555 U.S. at 24–25 (quoting *Goldman*, 475 U.S. at 507; *Gilligan*, 413 U.S. at 10). Especially "when executive officials 'undertake to act in areas fraught with medical and scientific uncertainties,'" courts should not "second-guess[]" their "public health" assessments. *Mark Short*, 2022 WL 1051852, at *5 (quoting *S. Bay United Pentecostal Church v. Newsom*, 140 S. Ct. 1613, 1613–14 (2020) (Roberts, C.J., concurring)); *see also Creaghan*, 2022 WL 1500544, at *8 ("[T]he military's technical, *scientific* findings supporting the wisdom of a particular, generally applicable military order may be due some regard greater than those resting on no such findings.").

As to named Plaintiffs in particular, the Air Force conducted a "to the person" analysis, 42 U.S.C. § 2000bb-1(b), that considered each individual Plaintiff's job duties and the resulting risk to operational impact, *see, e.g.*, *Roth*, 2022 WL 1568830, at *15 ("Defendants made individualized determinations of the harm to the Air Force's compelling interests in readiness and health and safety of service members, including the individual applicants, of granting specific exemptions to particular religious claimants."); *see generally* Exs. 14–17 (Plaintiffs' Religious Accommodation Request Administrative Records ("ARs")). First, with regard to AF Engineer, the Approval Authority

concluded that he "manage[s] civil engineer personnel, programs and projects, and [is] subject to short-notice deployment," thus "being unvaccinated restricts [his] role and increases the impact on the rest of [his] team." Ex. 15, AF Engineer AR at 23. This determination was prescient: AF Engineer was selected to deploy in February, but was unable to fulfill the requirement due to his unvaccinated status. Ex. 9, Decl. of Col. Philip A. Holmes ¶ 5 & pp. 5 n.5. This inability to deploy "places additional burdens on other service members who may have to deploy more often" and "can result in delays identifying, preparing, and deploying a replacement, which can negatively impact the [] mission." *Id.* The Surgeon General, in denying AF Engineer's appeal, further emphasized AF Engineer's "leadership role" and "frequent contact with others," and noted that his "unit has high-risk personnel that have an elevated potential for severe illness or death, if they were infected." Ex. 15, AF Engineer AR at 11.

Second, the Surgeon General denied AF Special Agent's appeal in light of his "intermittent to frequent contact with others" and his "required in-person meeting attendance includ[ing] prolonged, intermittent contact with multiple individuals." Ex. 17, AF Special Agent AR at 58. AF Special Agent is an investigator with the Air Force Office of Special Investigations, where "he is responsible for felony-level criminal investigations and national security investigations." Ex. 10, Decl. of Brig. Gen. Terry L. Bullard ¶ 4. The nature of this work "require[s] a hands-on approach" and involves "physical contact with service members [and] the public." *Id.* ¶ 5. For example, AF Special Agent must conduct in-person interviews (for which remote conference may undermine the investigation); respond to crime scenes; work in close coordinate with local, state, and federal law enforcement agencies; execute search warrants; and testify in judicial proceedings. *Id.* He must also remain ready to deploy. *Id.* ¶ 8.

Third, the Surgeon General denied AF NCO's appeal given his "present duty assignment as a Functional Area Manager," which requires "intermittent to frequent contact with others," travel, and possible deployment. Ex. 16, AF NCO AR at 42. AF NCO is the primary program manager of the

Reserve Phoenix Raven Program, which "provides security to Air Force aircraft transiting in high terrorist and criminal threat areas." Ex. 11, Kountz Decl. ¶ 4.[17] He is responsible for ensuring that individual reserve units meet training and standards. *Id.* Indeed, Plaintiffs themselves recognize that AF NCO's "work unit is understaffed and task-saturated, and none of the already limited personnel there is currently able or qualified to effectively take over his position." SAC ¶ 147. Thus, should AF Engineer, AF Special Agent, or AF NCO contract COVID-19—especially a more serious case that requires longer absence—their units would be substantially harmed. *See* Ex. 15, AF Engineer AR at 11; Ex. 17, AF Special Agent AR at 58; Ex. 16, AF NCO AR at 42.

These professional military judgments are amply supported by evidence showing COVID-19's harmful impact on the military and military readiness. COVID-19 has "impacted all elements of DoD simultaneously," including exercises, deployments, redeployments, and other global force management activities, Stanley Decl. ¶¶ 4, 6–8, Dkt. 38-11; caused the cancellation of numerous significant preparedness and readiness events, *id.* ¶ 9; suspended operations and resulted in inoperability of aircraft carriers for months in strategically significant areas, *id.* ¶ 8; and infected hundreds of thousands of service members, hospitalized thousands, and tragically caused the loss of 96 service members, *see* Ex. 7, Decl. of Col. Tanya Rans. ¶ 12; *see also* Ex. 2, Schneider Decl. ¶ 26. In the Department of the Air Force alone, over 98,000 service members have been infected, resulting in significant loss of time and readiness. DAF COVID-19 Statistics - May 17, 2022, https://perma.cc/RP9J-X6U8. These harms have real effects on mission efficiency.

The Air Force's professional military judgments are also supported by the positive effects that COVID-19 vaccination has had on military readiness and service member health. Vaccinations have unquestionably reduced the risk of infections, hospitalizations, and deaths of service members. *See,*

[17] AF NCO is not currently on base level, but when he is, his duties include "tactical leadership" of "installation security, gate operations, and responding emergency situations." Ex. 11, Kountz Decl. ¶ 3.

e.g., Stanley Decl. ¶¶ 16–18, Dkt. 38-11; Ex. 7, Rans Decl. ¶ 8, 11–12; Decl. of Col. James R. Poel ¶ 9, Dkt. 38-13; Ex. 15, Engineer AR at 23; *see also Church*, 2021 WL 5179215, at *18 (requiring vaccination is "supported by a lengthy record replete with data demonstrating the necessity of a general vaccine mandate"); *Mark Short*, 2022 WL 1051852, at *7 (noting "the empirical evidence in the record of the vaccine's efficacy" and the military's "evidence-based approach in its reliance on vaccination"); *Oklahoma v. Biden*, ---F. Supp. 3d---, 2021 WL 6126230, at *14 (W.D. Okla. Dec. 28, 2021) (stressing that the vaccine "has been shown to be remarkably effective in mitigating the effects of the pandemic which has affected . . . thousands of service members"). Vaccination also clearly reduces the severity of COVID-19 infection, including the chances of death and hospitalization. Ex. 15, Engineer AR at 23. The overwhelming percentage of service members who have died from COVID-19 were unvaccinated. Stanley Decl. ¶ 3, Dkt. 38-11; Ex. 7, Rans Decl. ¶ 12. Likewise, "[b]etween July and November of 2021, non-fully-vaccinated active-duty service members had a 14.6-fold increased risk of being hospitalized when compared to fully vaccinated active-duty service members," and "[i]n December 2021 unvaccinated adults were 16-times more likely to be hospitalized than vaccinated adults." *Id.* ¶ 18; *see also* Poel Decl. ¶ 9, Dkt. 38-13. A recent study published by the CDC confirmed mRNA vaccine effectiveness against invasive mechanical ventilation or death during the Omicron-predominant period, CDC, Morbidity and Mortality Weekly Report (Mar. 18, 2022), https://perma.cc/HJH3-PEN4; *see also* Poel Decl. ¶ 9, Dkt. 38-13. Vaccinations also have reduced the number of service members required to quarantine, permitted the military to return to higher levels of occupancy in DoD facilities and hold in-person training, and allowed service members to participate in joint training exercises with countries that have vaccination requirements. Stanley Decl. ¶ 14, Dkt. 38-11. Vaccinations also provide necessary protection to service members in deployed environments, where access to healthcare may be limited. Poel Decl. ¶ 6, Dkt. 38-13; Ex. 9, Holmes Decl. ¶ 14–15; Ex. 10, Bullard Decl. ¶ 8; Ex. 11, Kountz Decl. ¶¶ 11–13. In short, "[g]iven the tangible protection

the vaccines afford service members against infection, serious illness, hospitalization, and death, it is clear that COVID-19 vaccines improve readiness and preserve the DoD's ability to accomplish its mission." Stanley Decl. ¶ 20, Dkt. 38-11.

Plaintiffs cannot rely on medical and administrative exemptions to undermine the government's compelling interest in vaccinating either named Plaintiffs or the entire putative class. As discussed above, medical exemptions serve the interest in military readiness by avoiding vaccination of those with medical contraindications, and administrative exemptions are provided when the service member is leaving the force and thus vaccination would not serve the interest in military readiness. *See supra* pp. 11–13. Moreover, both medical and administrative exemptions are temporary, are steadily declining, and do not permit an unvaccinated person to continue serving without restriction. *See id.*

Nor can Plaintiffs rely on their alleged "natural immunity" from prior infection. SAC ¶ 234. While a prior infection can provide some protection against another infection for some amount of time, the available medical evidence leaves much unknown about the strength, consistency, and duration of that protection. *See* Poel Decl. ¶¶ 22–23, Dkt. 38-13; Ex. 7, Rans Decl. ¶¶ 20–22, 24, 30; Ex. 13, *Dunn v. Austin*, No. 22-cv-00288 (E.D. Cal. Feb. 22, 2022) ("*Dunn* Op.") at 39–40 ("[I]t's not well established that a natural immunity is effective, more effective or as effective as the vaccine"); *Roth,* 2022 WL 1568830, at *26 ("in light of Col. Poel's evidence, the Court cannot in good conscious . . . conclude that natural immunity is superior to COVID-19 vaccination in furthering the Air Force's compelling interest."). Contrary to Plaintiffs' declaration of immunity, there is no scientific consensus on the amount of antibodies that would indicate protection from reinfection, or for how long or to what degree such protection would exist. *See* Poel Decl. ¶¶ 22–23, Dkt. 38-13; Ex. 7, Rans Decl. ¶¶ 20–22, 30; *see also* FDA, *Antibody Testing Is Not Currently Recommended to Assess Immunity After COVID-19 Vaccination: FDA Safety Communication* (May 19, 2021), https://perma.cc/X8GQ-TNHQ ("Be aware that a positive result from an antibody test does not mean you have a specific amount of

immunity or protection from SARS-CoV-2 infection."); FDA, *Antibody (Serology) Testing for COVID-19: Information for Patients and Consumers* (Feb. 24, 2022), https://perma.cc/WY9T-6LSG ("Antibody tests do not tell you whether or not you can infect other people with SARS-CoV-2."). And evidence shows that protection from a prior infection increases following vaccination. *See* Ex. 7, Rans Decl. ¶ 21; Poel Decl. ¶ 23, Dkt. 38-13; *see also Bauer v. Summey*, --- F. Supp. 3d ---, 2021 WL 4900922, at *12 (D.S.C. Oct. 21, 2021) (citing "evidence that vaccines provide more robust protection than antibodies from a previous COVID-19 infection"). The Department of the Air Force has therefore determined, consistent with guidance from the CDC, that vaccination is the best way to minimize the risk posed by COVID-19 to military readiness. *See* Poel Decl. ¶ 23, Dkt. 38-13; *see also* DoDI 6205.02 ¶ 1.2 (effective July 23, 2019), https://perma.cc/8HLA-AXQB (mandating vaccination in accordance with the CDC's recommendations); CDC, *Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States* (last updated Apr. 21, 2022), https://perma.cc/3646-DC3S (recommending COVID-19 vaccination for individuals five and over "regardless of a history of symptomatic or asymptomatic [COVID-19] infection," and "serologic testing to assess for prior infection is not recommended for the purpose of vaccine decision-making"); *cf. Biden v. Missouri*, 142 S. Ct. 647, 653–54 (2022) (concluding that it was rational for an agency to rely on CDC guidance in requiring vaccination even for individuals with "natural immunity" from prior COVID-19 illness); *Norris v. Stanley*, No. 1:21-cv-756, 2022 WL 557306, at *4 (W.D. Mich. Feb. 22, 2022) (similar), *appeal filed*, No. 22-1200 (6th Cir. Mar. 14, 2022); *Valdez v. Grisham*, 559 F. Supp. 3d 1161, 1770 (D.N.M. 2021) (rejecting argument that the government should have accepted plaintiff's account that "Covid-recovered individuals have equal to or better immunity response than vaccinated individuals" (citation omitted)), *appeal filed*, No. 21-2105 (10th Cir. Sept. 15, 2021).

Plaintiffs also mistakenly imply that the Department's compelling interest in ensuring the health of its service members is decreased with "the passage of time." Mem. 19. "To the contrary,

continued vaccination remains essential to protecting against serious illness, hospitalization, and death; is key to limiting the opportunities for the virus to mutate (thus causing new variants); and is necessary in reducing public risks that could require future safety measures such as travel restrictions and reinstituting public health measures." Ex. 7, Rans Decl. ¶ 44. The country as a whole still has only a 66.5% vaccination rate. *Id.* ¶ 44. Just the past few weeks have seen another increase in COVID-19 infections. *See id.* ¶ 44; *see also id.* ¶ 45 (noting that data from mid-April shows that medium and high COVID-19 community levels are increasing). Indeed, on April 12, 2022, the Secretary of Health and Human Services renewed the determination that a public health emergency still exists. *Id.* ¶ 45. Thus, any suggestion that vaccination is less important merely because the world has loosened certain COVID-19 restrictions ignores the reality that that COVID-19 remains a significant public health risk.

2. Vaccinating Plaintiffs and the Putative Class Against COVID-19 Is the Least Restrictive Means of Furthering the Government's Compelling Interests.

As other courts have found in non-military settings, a uniform practice of vaccination is the least restrictive means for accomplishing the government's interest in preventing the spread of infectious diseases in the workforce. *See, e.g.*, *We The Patriots USA, Inc. v. Hochul*, 17 F.4th 266 (2d Cir. 2021) (health-care workers), *application for injunction denied*, 142 S. Ct. 552 (2021); *Does 1–6*, 16 F.4th 20 (same); *Doe*, 19 F.4th 1173 (students); *see also Hobby Lobby*, 573 U.S. at 733 (recognizing that vaccines "may be supported by" the government's compelling interest in "the need to combat the spread of infectious diseases"). This reasoning has greater force in the military setting, where health of service members is paramount to military readiness, and where the acceptable level of risk to the mission must be a military, not judicial, judgment. *See Navy SEALs 1–26*, 142 S. Ct. at 1302 (Kavanaugh, J., concurring) (cautioning that a court may not "insert[] itself into the [military's] chain of command, overriding military commanders' professional military judgments"); *Mark Short*, 2022 WL 1051852, at *7 (emphasizing deference to military judgments and adding that "[t]his deference is layered on top of

the deference that courts must give to expert policymakers on matters involving complex medical or scientific uncertainties"); Ex. 13, *Dunn* Op. at 37–42 (finding vaccination of an Air Force officer to be the least restrictive means, including because of the necessary deference afforded to military assessments and because "judges aren't scientists"); *Navy SEAL 1*, 2022 WL 1294486, at *8 ("[V]accinations require a higher degree of deference because they 'improve the readiness of the force,' the military generally has not granted religious exemptions from immunizations in the past, and the military relies on complex scientific data to promulgate immunization and medical requirements."); *Creaghan*, 2022 WL 1500544, at *8 ("[T]he military's technical and scientific conclusions should receive due regard in determining whether those technical and scientific judgments are *in fact* the least restrictive means to accomplish the military interest at issue as to a particular military claimant.").

It is not possible to evaluate availability of lesser restrictive means for the entire putative class, since the analysis necessarily requires consideration of each individual service members' circumstances. However, after careful consideration of each of the three new named Plaintiffs' requests for a religious accommodation and their appeals, the Air Force Surgeon General—the most senior medical professional in the Air Force—concluded that no lesser restrictive means sufficiently serve the Air Force's compelling interests in readiness and ensuring the health and safety of all service members. The Air Force is not required to use an alternative that does not serve its compelling interests "equally well" relative to vaccination. *See Hobby Lobby*, 573 U.S. at 731 (examining whether alternative served stated interest "equally well"); *Kaemmerling v. Lappin*, 553 F.3d 669, 684–85 (D.C. Cir. 2008) (rejecting RFRA and constitutional challenges against DNA Act, where "[a]ny alternative method of identification would be less effective" in furthering the government's compelling interests).

For instance, the Air Force considered whether telework or remote work could provide a less restrictive alternative, but concluded that none of the three new named Plaintiffs can complete their duties remotely. The Surgeon General concluded that although some of AF Engineer's duties could

be accomplished remotely, "institutionalizing remote completion of those duties permanently would be detrimental to readiness, good order and discipline, and unit cohesion." Ex. 15, Engineer AR at 11. AF Engineer's in-person presence is also needed to supervise his in-person subordinates. Ex. 9, Holmes Decl. ¶ 11. Moreover, AF Engineer's has "a high ops tempo or deployment tempo," meaning he must remain ready to deploy at a moment's notice. *Id.* AF NCO, as primary program manager of the Reserve Phoenix Raven Program, is responsible for in-person inspections at 37 separate locations. Ex. 11, Kountz Decl. ¶ 4. His duties "cannot get accomplished remotely." Ex. 16, NACO AR at 23. Similarly, AF Special Agent's criminal and national security investigation work "preclude[s] [him] from being able to accomplish his duties remotely or via telework." Ex. 10, Bullard Decl. ¶ 4.

Likewise, the Air Force evaluated the feasibility and effectiveness of masking and distancing but concluded that those measures are not as effective as vaccination. *See, e.g.*, Ex. 15, Engineer AR at 23. Unlike vaccination, masking and distancing provide no protection to an infected individual from severe illness or death. Poel Decl. ¶¶ 11–14, 24–25, Dkt. 38-13; *see also Roth*, 2022 WL 1568830, at *23 ("It should be obvious that masks and social distancing provide no protection to a service member who is infected with COVID-19, but COVID-19 vaccination does."). The effectiveness of masking and distancing also fluctuate based on human behavior. *Id.* And distancing ignores the fact that the three new named Plaintiffs share workspaces and that aspects of their work require close contact with other individuals. Ex. 9, Holmes Decl. ¶¶ 6, 11; Ex. 10, Bullard Decl. ¶¶ 4–5; Ex. 11, Kountz Decl. ¶¶ 3–4, 14; *see also United States v. Elder*, ---F. Supp. 3d---, 2022 WL 836923, at *9 (E.D.N.Y. Mar. 21, 2022) ("By themselves, face masks, social distancing, and similar measures may be effective for small groups over short periods of time, but fail to ensure the safety of large groups in close contact for sustained periods.").

Plaintiffs propose that the Air Force rely on "regular testing" in lieu of vaccination. SAC ¶ 257. But although "[s]erial testing will curtail the exposure in the unit after the infection is detected,"

it "is not as effective as preventing the original infection." Poel Decl. ¶ 20, Dkt. 38-13; *see also* Ex. 15, Engineer AR at 23. The military experienced multiple COVID-19 outbreaks when it merely required service members to undergo routine testing requirements, rather than requiring vaccination. Stanley Decl. ¶¶ 7–8, Dkt. 38-11; *see Does 1-6*, 16 F.4th at 33 (noting same was true of Maine). Nor does testing prevent a service member who tests positive from suffering serious health outcomes, such as long COVID, hospitalization, and death. Poel Decl. ¶ 20, Dkt. 38-13. Moreover, the "virus can be easily transmitted to others prior to symptom development and therefore may infect significant numbers before being identified." Ex. 7, Rans Decl. ¶ 10; Poel Decl. ¶¶ 18–19, Dkt. 38-13. Especially "[i]n light of the Air Force's scientific evidence, the Court cannot conclude that testing is a less restrictive but *equally* effective means compared to vaccination for furthering the Air Force's compelling interest in preventing COVID-19 from impairing the readiness and health of its forces, including individual service members like Plaintiffs." *Roth*, 2022 WL 1568830, at *24 (emphasis added).

Plaintiffs argue that "the alternative precautions the Air Force makes available and deems sufficient for its service members with medical or administrative exemptions are plainly available to the three new Plaintiffs as well." Mem. 24. But as discussed above, service members with medical and administrative exemptions do not receive a "golden ticket" to continue as normal in their job duties as if they were unvaccinated. *See supra* pp. 12. Rather, any service member who is not vaccinated is subject to the multiple deployment, assignment, and duty restrictions and limitations that Plaintiffs seek to avoid. Ex. 3, Chapa Decl. ¶ 16.

B. Plaintiffs Do Not Face Irreparable Harm.

Plaintiffs, unable to identify particularized harm for the class as a whole, rely solely on the notion that the rights of the class are compromised under RFRA and the First Amendment. Mem. 21. But Plaintiffs fail to establish likelihood of success on the merits, so infringement is neither

"threatened [nor] occurring." *Elrod v. Burns*, 427 U.S. 347, 374 (1976); *see, e.g.*, *Archdiocese of Wash. v. Wash. Metro. Area Transit Auth.*, 897 F.3d 314, 334 (D.C. Cir. 2018) (explaining that to show irreparable harm based on loss of constitutional rights, movant must "show a likelihood of success on the merits"), *cert. denied*, 140 S. Ct. 1198 (2020); *Bellinger v. Bowser*, 288 F. Supp. 3d 71, 88–89 (D.D.C 2017) (denying preliminary injunction, "even assuming that every [constitutional] allegation constitutes an irreparable injury," where the other factors "weigh so heavily against Plaintiffs that they cannot prevail"); *Mark Short*, 2022 WL 1051852, at *9 ("[B]ecause this Court has found that Plaintiff failed to demonstrate a sufficient likelihood of success on the merits of his religious freedom claims, there is no presumption of irreparable harm."); Ex. 13, *Dunn* Op. at 45; *Thomas Short v. Berger*, No. CV-22-00444, 2022 WL 1203876, at *7-8 (D. Ariz. Apr. 22, 2022), *appeal filed*, No. 22-15755 (9th Cir. May 18, 2022); *Creaghan*, 2022 WL 1500544, at *10 ("A mere 'possibility of irreparable harm' is not enough[.]").

Moreover, there is no broad excision of the irreparable harm requirement any time a plaintiff asserts a colorable constitutional claim. This case is much different than cases where "the plaintiffs were literally prevented from exercising their religion in group settings." *Doe*, 19 F.4th at 1181. For example, in *Tandon v. Newsom*, the Supreme Court held that closing places of worship is irreparable because it prevented individuals from group worship. 141 S. Ct. at 1297. That holding echoed the conclusion of at least five Justices in *South Bay United Pentecostal Church v. Newsom* that "California's prohibition on singing and chanting during indoor services" could constitute irreparable harm. 141 S. Ct. 716, 717 (2021) (Barrett, J., concurring).

Here, in contrast, no such harm is "threatened [or] occurring" given that Plaintiffs' claims are unripe and they have failed to exhaust their administrative remedies. *Elrod*, 427 U.S. at 374; *see also supra* Part I.A.i. And in any event, Plaintiffs "may exercise [their] religion by declining to receive the vaccination." *Id.*; *see also Navy SEAL 1*, 2022 WL 1294486, at *16 (concluding that "no government actor is preventing" service members in this situation "from exercising [their] alleged religious

conviction against COVID-19 vaccination" because service members "remain[] free to depart the military" in lieu of vaccination and to worship as they desire); *Thomas Short*, 2022 WL 1203876, at *8 ("Because Major Short may continue to 'exercise [his] religion by declining to receive the vaccination,' [applying *Doe*], he has not suffered an irreparable injury under Ninth Circuit law." (citation omitted)). And while declining to receive the vaccination could result in punitive action, this Court has noted that such action is not irreparable harm. *See Air Force Officer*, 2022 WL 468799, at *12 ("While it is true that Plaintiff has 'gradually [been] stripped of her duties, benefits, and pay, and forced into early retirement' . . . these harms are redressable as monetary damages and therefore insufficient to obtain injunctive relief." (citation omitted)).

Accordingly, "even if Plaintiffs establish a likelihood of success on the merits, the absence of a substantial likelihood of irreparable injury would, standing alone, make preliminary injunctive relief improper." *Siegel v. LePore*, 234 F.3d 1163, 1176 (11th Cir. 2000).

C. The Balance of Equities and the Public Interest Support Denying the Motion.

The third and fourth requirements for issuance of a preliminary injunction—the balance of harms and whether the requested injunction will disserve the public interest—"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 here—both for the three new named Plaintiffs and especially for the entire 10,000-person putative class.

This Court previously recognized the paramount public interest in national defense and military readiness. *See Air Force Officer*, 2022 WL 468799, at *12; *see also Winter*, 555 U.S. at 24–26 (vacating preliminary injunction where the balance of equities and public interest, with deference to military judgments, "tip strongly in favor of the Navy"); *North Dakota v. United States*, 495 U.S. 423, 443 (1990); *Mark Short*, 2022 WL 1051852, at *5 (explaining that deciding the potential harm to the national defense "necessarily involves 'complex, subtle, and professional decisions as to the

composition, training, equipping, and control of a military force[, which] are essentially professional military judgments"' (quoting *Gilligan*, 413 U.S. at 10)). This Court ultimately found that the harm of forgoing vaccination of a single individual did not outweigh the harm to that military. *Air Force Officer*, 2022 WL 468799, at *12.

But Plaintiffs now return to this Court seeking to forgo vaccination not of a single service member, but of the 10,000 putative class members. Allowing 10,000 service members to remain unvaccinated would be nearly ten times the amount of current medical and administrative exemptions in the entire Air Force. And unlike service members with medical and administrative exemptions, Plaintiffs seek to remain in their current posts without any changes to their duties. Such an injunction, covering such a huge swath of the Air Force, would "creat[e] significant and irreparable harm to good order and discipline, force health protection, and military readiness," which would "seriously danger[] the Department of the Air Force's ability to decisively execute its mission." Ex. 2, Schneider Decl. ¶ 8. It would also be contrary to the stay entered by the Supreme Court allowing the military to determine assignments of unvaccinated personnel while litigation is pending. *See U.S. Navy SEALs 1–26*, 142 S. Ct. at 1301. The public and national security interests of the United States depends on these 10,000 service members and their collective abilities to execute their military duties and maintain necessary readiness to deploy. *See Qualls v. Rumsfeld*, 357 F. Supp. 2d 274, 286 (D.D.C. 2005) ("In evaluating the harm to the [military], the court must consider the aggregate harm of all these possible claims."); *Bors v. Allen*, 607 F. Supp. 2d 204, 212 (D.D.C. 2009) ("[I]nterference in military personnel decisions [causes] great harm to the military because of the potential cumulative effect of multiple injunctions."); *Parrish v. Brownlee*, 335 F. Supp. 2d 661, 669 (E.D.N.C. 2004) (assessing "the possibility of substantial disruption and diversion of military resources" presented by the proliferation of claims "in the aggregate" in denying preliminary injunction). The Air Force's judgment that it cannot accept avoidable risk to the health and readiness of its fighting forces serves the public interest, outweighs

any interests that Plaintiffs or the putative class may have in premature preliminary relief, and deserves this Court's deference. *See Navy SEAL 1*, 2022 WL 1294486, at *16–17 (denying preliminary injunction); *Church*, 2021 WL 5179215, at *18–19 (same); *Mark Short*, 2022 WL 1051852, at *9–10 (same); Ex. 13, *Dunn* Op. at 46–47 (same); *cf. Dunn*, 2022 WL 1133402 (same).

Moreover, the national defense depends on service members' compliance with lawfully issued orders. No military can successfully function where members feel free to define the terms of their own military service and which orders they will choose to follow. *See, e.g.*, *Stein v. Mabus*, No. 3:12-cv-00816, 2013 WL 12092058, at *7–8 (S.D. Cal. Feb. 14, 2013) (noting that "[m]ilitary officers are better suited than civilian courts to determine" whether a service member's refusal to "follow all orders from" the Commander-in-Chief "disrupted good order and discipline"); *United States v. Stark*, No. NMCM200000243, 2000 WL 1456299, at *2 (N-M. Ct. Crim. App. Aug. 31, 2000) (concluding that, upon receiving an order to take the anthrax shot, the service member could not "pick and choose which immunizations he should receive"); *cf. United States. v. Hardy*, 46 M.J. 67, 74 (C.A.A.F. 1997) ("[The notion] that service members need not obey unpopular, but lawful, orders from either their civilian or military superiors . . . would be antithetical both to the fundamental principle of civilian control of the armed forces in a democratic society and to the discipline that is essential to the successful conduct of military operations"). Plaintiffs' requested class-wide injunction would also harm the public interest in a strong and ready national defense by interfering with the military's clear discretion to handle matters of good order and discipline, to the detriment of military effectiveness and trust between commanding officer and subordinate. *See Chappell v. Wallace*, 462 U.S. 296, 300 (1983); *Orloff*, 345 U.S. at 95.

CONCLUSION

For the foregoing reasons, Plaintiffs' motions for class certification and class-wide preliminary injunctive relief should be denied.

Dated: May 24, 2022

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 24, 2022, I electronically filed the foregoing paper with the Clerk of Court using this Court's CM/ECF system, which will notify all counsel of record of such filing.

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Table of Exhibits

Exhibit Number	Exhibit Description
1.	Declaration of Major General Sharon R. Bannister
2.	Declaration of Lieutenant General Kevin B. Schneider
3.	Declaration of Colonel Artemio C. Chapa (May 23, 2022)
4.	Declaration of Lieutenant Colonel Nekitha M. Little
5.	Declaration of Colonel Justin L. Long
6.	Declaration of Colonel Elizabeth M. Hernandez
7.	Declaration of Colonel Tonya Rans (May 24, 2022)
8.	Declaration of Colonel Ashley Heyen
9.	Declaration of Colonel Philip A. Holmes (May 24, 2022)
10.	Declaration of Brigadier General Terry L. Bullard (May 20, 2022)
11.	Declaration of Brigadier General William R. Kountz Jr. (May 24, 2022)
12.	Declaration of Lieutenant Colonel Ethel M. Watson (May 24, 2022), with attachments
13.	*Dunn v. Austin*, No. 22-cv-00288 (E.D. Cal. Feb. 22, 2022)
14.	Air Force Officer Religious Accommodation Request Administrative Record [filed under seal]
15.	Air Force Engineer Religious Accommodation Request Administrative Record [filed under seal]
16.	Air Force NCO Religious Accommodation Request Administrative Record [filed under seal]
17.	Air Force Special Agent Religious Accommodation Request Administrative Record [filed under seal]

Exhibit 1

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF MAJOR GENERAL SHARON R. BANNISTER

I, Sharon R. Bannister, hereby state and declare as follows:

1. I am a Major General in the United States Air Force currently assigned as the Director of Medical Operations at the Department of the Air Force Office of the Surgeon General. I have been in this position since June 10, 2021. As a part of my duties, I am responsible for ensuring a medically ready force, which includes oversight of the Headquarters-level Religious Resolution Team for the Department of the Air Force (HAF/RRT).

2. I am generally aware of the various lawsuits filed throughout the United States concerning the Secretary of Defense and Secretary of the Air Force mandates requiring that all service members, including Active Duty and Reserve Components, receive vaccinations against the COVID-19 virus. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as the Director overseeing the HAF/RRT and based upon my personal knowledge and information that has been provided to me in the course of my official duties.

3. Religious accommodation requests for exemption from an immunization requirement are reviewed and resolved in accordance with Department of the Air Force Instruction (DAFI) 52-

201, *Religious Freedom in the Department of the Air Force*, dated 23 June 2021, and Air Force Instruction (AFI) 48-110_IP, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, dated 7 October 2013 (certified current 16 February 2018). Religious Resolution Teams (RRT) aid and advise the initial approval level decision authority. The initial approval authority is the member's Major Command (MAJCOM), Field Command (FIELDCOM), Direct Reporting Unit (DRU), or Field Operating Agency (FOA) commander.[1] The appeal authority is the Air Force Surgeon General.[2] If an appeal is made from the initial decision, a separate RRT assists and advises the appellate authority. At the initial level (installation level), the RRT will be comprised of, at a minimum: the commander (or designee), Senior Installation Chaplain (or equivalent), Public Affairs Officer, Judge Advocate, and medical provider.[3] At the appeal level, the RRT comprises, at a minimum: a Chaplain, Judge Advocate, medical provider, member from Public Affairs, and member from the office of the Deputy Chief of Staff for Manpower, Personnel, and Services.[4] The Air Force Surgeon General, as the appeal authority, provides an individualized review of each request and is not required to rely on the determinations made by the approval authority. Additionally, the appeal authority is not limited to the documentation submitted by the approval authority. If necessary, the appeal authority can and will request additional information from the approval authority or others in requestor's chain of command in order to make an informed decision. The Surgeon General may deny the religious accommodation request or overrule the initial disapproval and grant the religious accommodation request in full or in part. I am familiar with the religious accommodation

[1] DAFI 52-201, paragraph 6.6.1.
[2] DAFI 52-201, Table 6.1.
[3] DAFI 52-201, paragraph 3.8.1.1.
[4] DAFI 52-201, paragraph 3.8.1.2.

process for exemption from an immunization requirement and the RRT as it falls within the scope of my official duties.

4. There is no blanket policy or practice of disapproving all religious accommodation requests. Every religious accommodation request is unique. Each request is reviewed individually—by both the initial approval level decision authority and the appellate authority, if applicable—to determine (1) if an individual has a sincerely held religious belief, (2) if the vaccination requirement substantially burdens that individual's sincerely held religious belief, and if so, (3) whether there is a compelling government interest in requiring that specific requestor to be vaccinated, and (4) whether there are less restrictive means in furthering the compelling government interest in that individual's vaccination.[5]

5. Several members of the Air Force have not limited their request to the new COVID-19 vaccine, but request exemption from multiple (or all) DoD vaccination requirements. Each aspect of the requested exemption must be considered separately since the compelling government interest and possible less restrictive means may differ for each vaccine.

6. This is a fact- and labor-intensive analysis that is particular to the circumstances of the requestor. To aid in this endeavor, a religious accommodation package includes a written request from the service member,[6] a memorandum from a chaplain who interviewed the member, counseling memoranda from both a medical provider and the member's commander, a recommendation from the RRT, and then recommendations from every commander in the service member's chain of command. The recommendations from the chain of command discuss whether there is a compelling government interest in vaccinating that member, the impact on

[5] DAFI 52-201, paragraphs 2.2 – 2.10.
[6] The request may also include letters from ecclesiastical leaders or others in support of the sincerely held religious belief.

mission accomplishment if the member is not vaccinated, and whether there are less restrictive means. Other pertinent information for resolving the request may also be included. It is common practice for the Religious Resolution Team for the Appeal Authority to send requests, as needed, for additional information about the individual requestor's particular circumstances, such as additional facts about the requestor's career field, duties, and work environment. To date, the Religious Resolution Team has submitted requests for additional information in more than a third of cases reviewed.

Sincerely Held Religious Beliefs

7. As noted above, religious accommodation requests are not all the same. One request is not representative of another. As an initial matter, requests must be reviewed to determine if the beliefs are sincerely held and if they are religious in nature. Some requests do not provide support showing that the belief is religious in nature. Some members have also asserted expressly non-religious reasons, such as medical concerns, within their religious exemption requests. For example, some question the safety of the vaccine or the speed with which it was approved by the Food and Drug Administration (FDA). Others have expressed a concern that the vaccine will be used to implant a surveillance chip. These non-religious bases may be the only justification given or may be intermixed with beliefs of a more religious nature.

8. Requestors have presented a wide range of religious beliefs. Some have stated a religious-based opposition to abortion and the use of aborted fetal stem cells in the development and testing of vaccines. Others have asserted a religious-based opposition to putting contaminants into their body. Some have asserted that an mRNA-vaccine alters what the DNA does, thus violating their religious beliefs.

9. The approval and appeal authority may still consider whether the belief is sincerely held. This analysis involves looking at, among other things, how the individual demonstrates adherence to that belief. For example, an individual who requests a religious accommodation based on opposition to contaminants may raise questions as to how their belief system defines a contaminant and how they have adhered to that system in the past and present. An approval authority or the appeal authority may assume, without deciding, there is a sincerely held belief and focus the analysis on the other factors.

Substantial Burden

10. Identifying the sincerely held religious belief is necessary for determining whether there is a substantial burden on that belief. For instance, a service member requesting an exemption from COVID-19 vaccinations that used aborted fetal cells in the testing of the vaccine may not be substantially burdened if offered a vaccine that was not tested in this fashion. Similarly, a member requesting exemption from mRNA vaccines may not be substantially burdened if offered another type of vaccine, such as the Janssen (Johnson & Johnson) vaccine.

11. In addition, the substantial burden to a service member's religion may be temporal in nature. Certain immunization requirements are only due at certain times or under certain conditions. For example, the Tetanus-diphtheria (Td) booster is only required every 10 years.[7] A request to be exempt from these types of vaccines requires an analysis to determine whether there is a substantial burden at this time for that member. A substantial burden may not exist for a member requesting exemption from Td if that member is not due to receive the booster for an extended period. If a substantial burden does not exist due to such timing, the member may need to resubmit a religious accommodation request at a later date.

[7] AFI 48-110_IP, paragraph 4-16(c).

12. Similarly, certain vaccines are only required if a particular assignment or duty would expose the member to the risk, such as a deployment or relocation to certain geographic locations. For example, a member is required to vaccinate against smallpox only if warranted based on duties (e.g., medical teams at hospitals/clinics), geographical locations that pose a higher risk, or in designated occupational roles.[8] Accordingly, a member requesting exemption from smallpox may not be substantially burdened if the member is not required to take the relevant vaccine anyway based on that member's circumstances.

13. In both types of scenarios—the vaccine is not required for an extended period of time or not yet required based on the member's individual circumstances—there is no substantial burden and the Department of the Air Force cannot properly review the compelling government interest and less restrictive means until closer in time to when the vaccine is actually required. This is because the service member's circumstances—physical, geographic, occupational, and otherwise—may change drastically between when the member initially request an exemption request and when the vaccine would otherwise be required.

14. Given the global nature of COVID-19 and the danger that the disease presents to military readiness, the Department of Defense and the Air Force have determined that vaccination against COVID-19 is required worldwide. To satisfy that requirement, service members must take a COVID-19 vaccine that received full licensure from the Food and Drug Administration. Service members may also satisfy the vaccination requirement by voluntarily receiving a COVID-19 vaccine under FDA Emergency Use Authorization or World Health Organization Emergency Use Listing in accordance with the applicable dose requirements.

[8] AFI 48-110_IP, paragraph 4-15(g).

Compelling Government Interest

15. The Department of the Air has a compelling interest in preventing and minimizing the impact of infectious disease that affects "military readiness, unit cohesion, good order and discipline, and health and safety for both the member and the unit."[9] The Department of the Air Force, along with the rest of the Department of Defense, maintains robust vaccination requirements for its members including both routine vaccinations and risk-based or occupation-related vaccinations. In the event of a request for exemption from a particular vaccination, the Air Force's determination is made on an individualized basis. As previously noted, commanders within a member's chain of command provide recommendations and input on the circumstances of the requestor, including the impact approving the accommodation would have on the requestor's unit and the accomplishment of its mission.

16. Some considerations for a religious accommodation request are unique to the Department of the Air Force itself. Even within the Department of the Air Force, the roles and responsibilities of individual Airmen and Guardians may differ vastly. The Air Force has approximately 3,300 different squadrons with different types of missions. Squadrons come in sizes ranging from seven personnel to over 600 personnel and may have a specialized tactical or functional mission. The traditional squadrons include fighter squadrons, bomber squadrons, mobility squadrons, tanker squadrons, missile squadrons, intelligence squadrons, surveillance reconnaissance squadrons, command and control squadrons, and training squadrons. These specialized squadrons, along with an operational support squadron, usually make up the operational group on any specific base. Other squadrons include medical squadrons, aircraft

[9] DAFI 52-201, paragraph 2.1.

maintenance squadrons, civil engineering squadrons, mission support squadrons, and security forces squadrons.

17. There are nine Major Commands (MAJCOMs), three Field Commands (FIELDCOMs), and approximately 20 Direct Reporting Units (DRUs) or Field Operating Agency (FOA) in the Department of the Air Force. Each has their own unique mission and requirements, which support the overall mission of the Department of the Air Force in defending national security. The vast majority of commanders (i.e., approval authorities) for the MAJCOMs and FIELDCOMs are three- and four-star General Officers.

18. There are multiple factors that could impact the Air Force's interest in requiring a vaccination for a particular service member, including the member's career field, the proximity and amount of time they must work with other individuals, the likelihood of the member being required to travel with little or no notice, the requirement for all service members to be medically ready and deployable (which requires vaccination), whether the member is leaving service, and the impact to the mission if that member contracted a disease, such as COVID-19, or infected another member with the disease either in garrison or while deployed. These individualized factors are considered in connection with requests for religious exemption from the COVID-19 vaccine requirement.[10]

19. The primary mission of the U.S. Air Force is "Fly, fight, and win – airpower anytime, anywhere."[11] Thus, Airmen and Guardians are expected to maintain a high state of readiness – physical, mental, and occupational – to perform both the duties they typically train for in their respective career fields and as augmentees in other military duties such as disaster and relief

[10] While addressing COVID-19 in the example, the same analysis may apply for other vaccines from which a particular member may request exemption.
[11] U.S. Air Force Mission, https://www.airforce.com/mission, last visited November 19, 2021.

operations or physical security for Air Bases or Garrisons. Some requestors' primary duties in the Department of the Air Force involve flight or space operations. Other requestors fulfill the Air Force's mission through intelligence operations, logistics support, aircraft maintenance, finance, and medical support, to name a few. Depending on the specialty, service members requesting an exemption may fly in a single-occupancy aircraft or fly in close proximity with multiple service members in a crew-type aircraft. The impact to mission accomplishment if a member in a single occupancy aircraft contracted COVID-19 may be different than the impact if a member of an aircrew contracted COVID-19 and the entire crew was exposed. The approval or appeal authority may find there is a compelling government interest in both scenarios, or it might find otherwise, but the discrete facts are relevant and reviewed separately.

20. Likewise, some requestors are medical providers, working with service members and their dependent family members. Accordingly, they may come in close proximity with individuals who are immuno-compromised or who have otherwise been unable to obtain public health vaccinations. Other service members may work more in an office setting or outdoors with less proximate physical contact to others. With over 10,000 religious accommodation requests pending in the Department of the Air Force (including routing for initial approval authority action or routing for appeal authority action), the types of situations that may be presented are as diverse as the career fields and assignments the Department of the Air Force has to offer. Our Approval and Appeal Authorities review each fact scenario on an individualized case-by-case basis in determining whether there is a compelling government interest.

Less Restrictive Means

21. Whether there are less restrictive means available that are as effective as vaccination in furthering the compelling government interest is fact-dependent as well. For one, a potentially

less restrictive means available for one service member may not be reasonable for another service member in a different career field, at a different geographic location, or in different work circumstances that would compel the service member's physical presence. Pilots and other aircrew, for example, cannot telework. Other positions may be able to telework, but only in a degraded capacity or at the risk of losing unit cohesion, and may still be at risk themselves due to exposure in the local community or through family and friends. Service members remaining in service cannot telework while deployed. The Air Force has a deadline for all personnel to be vaccinated for COVID-19 because approving an accommodation conditioned on future vaccination may not be feasible to address mission needs. For example, even if a deployable service member could sometimes telework without degrading the mission at their primary duty location (i.e., home station), that member may still need to be fully vaccinated because the nature of military operations can make the need to deploy or otherwise travel unpredictable. When the Air Force needs its forces to travel immediately to meet an evolving threat, there is not enough time to wait for the member to reach a fully vaccinated status in two, three, or four weeks. An Approval or Appeal Authority often has to weigh multiple factors like these to determine whether or not the facts warrant an accommodation.

22. The availability of a less restrictive means may also depend on the sincerely held religious belief. A less restrictive means for a member who requested an exemption based on how the vaccine was developed may involve permitting them to take a vaccine that was not developed the same way. A service member with limited time remaining in service may be able to be accommodated differently than a member who has a four- to six-year service commitment.

23. The Air Force does not apply a "blanket" rule that no less restrictive means of protecting the force exists other than a vaccination. The Approval and Appeal Authority must look at

numerous factors that vary by individual. The Department of the Air Force strives to make sure full and appropriate consideration is given to each request. Where an accommodation can be granted without adversely impacting the compelling government interest in mission accomplishment, it will be.

24. COVID-19 is no exception, but presents some unique challenges. The spread of the disease has been difficult to control and the disease has already demonstratively adversely impacted mission accomplishment and military effectiveness. There has been a surge of accommodation requests to be exempt from the vaccine that is unprecedented. Identifying the situation where less restrictive alternatives to the vaccine would not adversely impact mission accomplishment requires an individualized analysis.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 23d day of May 2022.

BANNISTER.SHARON.RUSCH.1102715019

Digitally signed by BANNISTER.SHARON.RUSCH.1102715019
Date: 2022.05.23 12:20:28 -04'00'

SHARON R. BANNISTER, Maj Gen, USAF
Director of Medical Operations

Exhibit 2

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF GEORGIA
MACON DIVISION

AIR FORCE OFFICER,

Plaintiff,

v.

LLOYD J. AUSTIN, **III**, individually and in his official capacity as Secretary of Defense; **FRANK KENDALL**, **III**, individually and in his official capacity as Secretary of the Air Force; and **ROBERT I. MILLER**, individually and in his official capacity as Surgeon General of the Air Force,

Defendants.

Case No. 5:22-cv-00009-TES

DECLARATION OF LIEUTENANT GENERAL KEVIN B. SCHNEIDER

I, Kevin B. Schneider, hereby state and declare as follows:

1. I am a Lieutenant General[1] in the United States Air Force currently assigned as the Director of Staff for the Headquarters of the Air Force, located in the Pentagon, Arlington, Virginia. I have served in this position since August 2021.

2. I am generally aware of the various lawsuits – and kept apprised of new lawsuits – filed throughout the United States concerning the Coronavirus Disease 2019 (COVID-19) vaccination mandates issued by the Secretary of Defense and the Secretary of the Air Force, that require all Department of the Air Force Service members on active duty, in the Air Force Reserve, and Air National Guard, to be fully vaccinated against COVID-19. I make this declaration in support of the Government to address the impact COVID-19 has had within the Department of the Air Force,[2] and the impact that granting thousands of religious accommodations would have on the mission, and the harm posed by a preliminary injunction exempting a single Plaintiff from being vaccinated – let alone an injunction covering thousands of Service members. The statements made in this declaration are based upon my personal knowledge, my military judgment and experience, and upon information that has been provided to me in my official duties.

Air Force Background and Experience

3. I am a 1988 graduate of the U.S. Air Force Academy and have continuously served in the U.S. Air Force for nearly 34 years. My experience includes multiple assignments in senior leadership and operational positions. As Commander of the 380th Air Expeditionary Wing, I led

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[1] The rank of "Lieutenant General" is the second highest military rank in the Department of the Air Force, and is sometimes referred to as a "Three-Star General." The term "general" is also frequently referred to as "general officers." General officers include the ranks of Brigadier General, Major General, Lieutenant General, and General. General Officers comprise the most senior levels of uniformed leadership in the Department of the Air Force.

[2] The Department of the Air Force is comprised of two distinct military services: the U.S. Air Force and the U.S. Space Force.

one of the most diverse combat wings in the U.S. Air Force and conducted combat operations to include close air support and strike missions as well as intelligence, surveillance, reconnaissance, and aerial refueling. In my duties as Assistant Deputy Commander of U.S. Air Forces Central Command and Vice Commander of the 9th Air Expeditionary Task Force, I was responsible for the command and control of all air operations in a 20-nation area of responsibility covering Central and Southwest Asia. While serving as the Chief of Staff for the Headquarters of the Pacific Air Force, I coordinated a command staff directing 46,000 personnel across sixteen time zones. As Chief of Staff for the U.S. Indo-Pacific Command, I coordinated a joint force staff providing combat capabilities to the Secretary of Defense across 52% of the globe. Most recently, as Commander of U.S. Forces Japan and the 5th Air Force, I was responsible for overseeing joint and bilateral exercises and improving combat readiness for 54,000 military and Department of Defense civilian personnel. I am also a command pilot with more than 4,000 flying hours in the F-16C *Fighting Falcon*, F-15E *Strike Eagle*, T-38C *Talon*, and UH-1N *Iroquois*; which includes 530 combat flying hours, serving in Operations SOUTHERN WATCH, ENDURING FREEDOM, IRAQI FREEDOM, and INHERENT RESOLVE.

4. I currently serve as the Director of Staff for the Air Force Headquarters. In that role, I assist the Secretary of the Air Force in his statutory duties and responsibilities as they pertain to the U.S. Air Force. Under 10 U.S.C. § 9032, those duties include "prepar[ing] for such employment of the Air Force" and "recruiting, organizing, supplying, equipping . . . , training, servicing, mobilizing, demobilizing, administering, and maintaining of the Air Force." Additionally, I synchronize and integrate policy, plans, positions, procedures, and cross functional issues for the headquarters staff. In that role, I work with my counterpart in the U.S. Space Force, Lieutenant General Nina M. Armagno, and am aware of the overall impact of

COVID-19 on both the U.S. Air Force and U.S. Space Force. Specifically, as related to COVID-19, I am responsible for providing oversight to the Air Force COVID-19 Team, which has implemented the Secretary of Air Force vaccination mandate across both services within the Department of the Air Force.

Preliminary Statement

5. I have reviewed the Declaration of Admiral Daryl Caudle, Commander, United States Fleet Forces Command, filed in *U.S. Navy SEALs 1-26 v. Austin et. al.*, N.D. TX, Case 4:21-CV-01236-O. I agree with his assessment regarding the importance of having a fully vaccinated Force to blunt the impact of COVID-19 and the significant harm that would come from allowing a subset of that Force to remain unvaccinated. Unvaccinated or partially vaccinated Service members are at a higher risk of contracting COVID-19 and substantially more likely to develop severe symptoms resulting in hospitalization or death. Not only does this increase risks to the health and safety of vaccinated Service members, and the communities in which they live, it adversely impacts our ability to execute the mission. It is my professional military judgment that vaccination against COVID-19 is the most effective way to combat the disease and is necessary to ensure we maintain a credible fighting force able to deter our adversaries, protect our nation, and – if necessary – prosecute our wars and other military operations.

6. Not only does the Department of the Air Force have a compelling interest in the health and mission readiness of the U.S. Air Force and U.S. Space Force as a whole, we have a compelling interest to ensure the health and mission readiness of each and every Service member. This is because we cannot ensure the collective health or readiness of the Force unless we ensure the health and readiness of each member who composes that Force. In my opinion, if a large number of Department of the Air Force Service members were to be exempt from the

COVID-19 vaccine mandate, it would pose a significant and unprecedented risk to military readiness and our ability to defend the nation.

7. Observing the current state of global affairs verifies that we are operating in a volatile, uncertain, and complex environment. In this environment, the need for constant vigilance and defense preparation cannot be overstated. This requires our Service members to be in a constant state of readiness. Recently, our nation responded to the Russian invasion of Ukraine by rapidly deploying aircraft, equipment, and thousands of Service members, many within only 24 to 48 hours of notification. Currently, there are hundreds of aircraft and tens of thousands of Department of the Air Force personnel deployed in support of operations furthering our nation's interests throughout the world. Those personnel must be medically ready to deter conflict and aggressively execute the mission. In my opinion, it would be a failure of leadership to allow Service members who are not fully vaccinated against COVID-19 to deploy without regard to the risk they pose to themselves, others, and the mission. For this reason, such decisions, and the appropriate balance of risks associated with them, should be left to the judgment of the military chain of command.

8. A preliminary injunction that prevents the Department of the Air Force from enforcing the COVID-19 vaccination mandate on even a single plaintiff would result in that plaintiff not being medically ready to support military operations to defend the nation. Similarly, an injunction expanded to apply to 10,000 or more Service members seeking a vaccination exemption would amplify this outcome across the Force, creating significant and irreparable harm to good order and discipline, force health protection, and military readiness; seriously endangering the Department of the Air Force's ability to decisively execute its mission.

Specific Functions of the Department of the Air Force

9. The U.S. Air Force and U.S. Space Force comprise the Nation's principal Air and Space Forces. Their mission is to "provide the Nation with global vigilance, global reach, and global power in the form of in-place, forward-based, and expeditionary forces possessing the capacity to deter aggression and violence by state, non-state, and individual actors to prevent conflict, and, should deterrence fail, prosecute the full range of military operations in support of U.S. national interests."[3]

10. The Department of the Air Force is tasked to "organize, train, equip, and provide air, space, and cyberspace forces for the conduct of prompt and sustained combat operations, military engagement, and security cooperation in defense of the Nation, and to support the other military services and joint forces."[4] These forces include pilots, aircraft maintainers, aircrew, chaplains, security forces, medical providers, personnel specialists, and more. Providing fully trained and combat ready Service members to Combatant Commanders[5] is vital to ensuring the security of our nation and operational success. Whether tasked to stand as ever-ready sentinels of freedom at outposts throughout the world, provide humanitarian aid, or engage in armed conflict with our adversaries, our Service members must be medically and physically ready to accomplish the mission under inhospitable conditions and in hostile environments.

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[3] Department of Defense Directive (DoDD) 5100.01, *Functions of the Department of Defense and Its Major Components*, Change 1, Sep. 17, 2020, Encl. 6, ¶ 6.a.

[4] Ibid.

[5] The military services provide forces to combatant commanders who then exercise authority, direction and control over the commands and forces assigned to them and employ those forces to accomplish missions assigned to the combatant commander within their area of operation. Department of Defense Directive (DoDD) 5100.0 I, Change I, 09/17/20, Encl. 5, ¶ 1.a through d. The operational chain of command runs from the President of the United States to the Secretary of Defense to the Combatant Commanders. There are 11 combatant commands, each of which provides command and control of military forces, regardless of branch of service, in peace and war. Some combatant commands are geographic, such as Central Command (CENTCOM), whose area of responsibility includes the Middle East. Others are functional, such as Special Operations Command (SOCOM), which utilizes the special operations units within the services to carry out special operations world-wide.

11. The U.S. Air Force protects U.S. interests and defends the nation through its five core missions: (1) Air and Space Superiority; (2) Intelligence, Surveillance, Reconnaissance (ISR); (3) Rapid Global Mobility; (4) Global Strike; and (5) Command and Control.[6] Air and space superiority are crucial to ensuring the safety of our Service members. It is axiomatic that "whoever controls the air generally controls the surface."[7] Air and Space Superiority: the U.S. Air Force brings the ability and capability to conduct offensive and defensive operations to gain and maintain air superiority in support of U.S. and allied forces in the domains of land, sea, air, and space. This includes the ability to engage in offensive operations within our adversaries' airspace, as well as defensive operations to protect our own airspace. ISR: the U.S. Air Force provides the ability to gather real-time intelligence for warfighters and policymakers through manned and unmanned aircraft, space, and other technology. Rapid Global Mobility: the U.S. Air Force rapidly moves personnel and equipment around the world, enabling operational success. This includes providing aerial refueling to truly make global deployment possible and aeromedical transport to ensure the prompt treatment of injured troops. Global Strike: through bombers, fighters, and missiles, the U.S. Air Force provides the ability to attack targets, worldwide, in support of U.S. interests and in the defense of our nation. In addition to conventional ordnance, the U.S. Air Force mission includes two of the three legs of the nuclear deterrence triad – nuclear-capable bombers, and intercontinental ballistic missiles (ICBMs). Command and Control: finally, through various means, including air, space, and cyberspace platforms, the U.S. Air Force provides and defends the systems necessary to ensure a clear operational picture and means of communicating with our forces throughout the world.

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[6] Congressional Research Service, *Defense Primer: The United States Air Force*, Oct. 26, 2021, available at https://crsreports.congress.gov.
[7] Col Philip S. Meilinger, *Ten Propositions Regarding Airpower*, 1995.

12. Similarly, the U.S. Space Force protects U.S. interests and defends the nation through its missions: (1) Space Security; (2) Combat Power Projection; (3) Space Mobility and Logistics; (4) Information Mobility; and (5) Space Domain Awareness.[8] Space Security: controlling space has become increasingly important to ensure successful military operations and the U.S. Space Force protects U.S. military, civilian, and commercial space assets from danger or hostile actions. Combat Power Projection: the U.S. Space Force ensures U.S. and allied forces are able to operate freely in space by employing offensive and defensive capabilities designed to reduce the effectiveness of threats to space capabilities. Space Mobility and Logistics: the ability to sustain our space assets is crucial to sustaining continued space technology and operational advantages. The U.S. Space Force ensures the continued ability to launch and recover space assets vital to the protection of our nation. Information Mobility: U.S. Space Force technology allows for the rapid collection and dissemination of information globally in support of military operations. This capability ensures, communications, ISR, missile warning, and nuclear detonation detection, and other important capabilities. Space Domain Awareness: finally, the U.S. Space Force effectively monitors space, and objects in the space domain, analyzing potential impacts to military operations, and the safety and security of U.S. interests.

13. As of March 14, 2022, the Department of the Air Force had approximately 501,000 uniformed Service members – including 326,000 active duty, 68,000 Reserve, and 107,000 Air National Guard personnel – and 5,800 aircraft to support the mission. Regardless of the career field, rank, or duty status, every Service member plays an important role in accomplishing the mission and must be ready to perform their duties when called upon anytime, anywhere.

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[8] Space Capstone Publications, *Space Power: Doctrine for Space Forces*, June 2020, available at https://www.spaceforce.mil/Portals/1/Space%20Capstone%20Publication_10%20Aug%202020.pdf.

Mandatory Vaccination Requirements for COVID-19

14. On August 24, 2021, the Secretary of Defense directed the Secretaries of the Military Departments to immediately begin full vaccination of all members of the Armed Forces, including Service members on active duty or in the Ready Reserve, including the National Guard. The Secretary of Defense found that "[t]o defend the nation, we need a healthy and ready force" and "[a]fter careful consultation with medical experts and military leadership, and with the support of the President . . . vaccination against the coronavirus disease 2019 (COVID-19) is necessary to protect the Force and defend the American people."[9] The Secretary of the Air Force directed implementation via Department-wide memorandum on September 3, 2021. The memorandum applies to both services within the Department of the Air Force, the U.S. Air Force and the U.S. Space Force. It requires all active duty Service members, unless exempted, to be fully vaccinated with an FDA-approved COVID-19 vaccine[10] by November 2, 2021. It further requires, unless exempted, all Service members in the Ready Reserve, to include the Air National Guard, to be fully vaccinated by December 2, 2021. Like other orders in the United States military, the COVID-19 vaccination mandate constitutes a lawful order under Article 92 of the Uniform Code of Military Justice and failure to comply may result in administrative and/or disciplinary action. On the same date, the Department of the Air Force also issued implementation guidance, outlining the policy, administration and reporting requirements, and general guidance related to logistics and distribution of vaccines.

[9] Secretary of Defense memorandum, *Mandatory Coronavirus Disease 2019 Vaccination of Department of Defense Service Members* (August 24, 2021).

[10] Although only FDA-approved vaccines are mandated by the order, Service members may voluntarily receive a vaccine that has obtained an FDA Emergency Use Authority or is included on the World Health Organization's Emergency Use Listing.

15. On December 7, 2021, the Secretary of the Air Force issued supplemental guidance that reiterates the requirement to be vaccinated against COVID-19 unless the Service member has an approved or pending medical, religious, or administrative exemption. It also implements and outlines options for Service members if they are notified that their exemption request is denied, providing opportunities for Service members to request a voluntary separation or retirement, if eligible, in lieu of vaccination. If approved in accordance with the applicable separation or retirement regulations, and they meet other conditions (e.g., separating within established timelines), they would be temporarily exempt from the vaccination requirement for the brief period of their remaining service. The guidance provides options that are adapted to active duty, various types of Reserve, and Air National Guard situations.

16. The COVID-19 vaccination requirement is not unique. The Department of Defense has a well-established "Individual Medical Readiness" requirement for all Service members – whether on active duty or in the Reserves – to ensure each Service member is physically and medically fit to perform their duties and to mobilize in support of our national defense. Among other things, Service members are required to undergo required physical health assessments and dental examinations to ensure the member is medically ready for operational needs.[11] Included in that requirement are a number of vaccines that all Service members are required to receive, including communicable diseases – such as influenza, hepatitis A & B, measles, mumps, and rubella – and non-communicable diseases – such as tetanus. These required based on the professional judgment of Department of Defense military and civilian leadership, that the vaccinations are

[11] While not intuitive, dental care is an important component of operational readiness. A deployed Service member with a dental emergency (e.g., abscessed or cracked tooth) may be unable to perform their duties – limiting the unit's ability to complete its mission – and may require a medical evacuation to ensure they are able to receive the care they need. This can be a drain on operational capabilities as resources are diverted from their original tasking to evacuate the member. Annual dental examinations and follow-up care is a DoD requirement to reduce the operational risks.

necessary to medically protect our Service members and to maintain a combat ready force. Diseases can be a serious threat to the ability of our Service members to perform their duties, and especially dangerous for Service members who are mobilized in support of combat operations. Vaccination is the most effective way to minimize the risk of disease in Service members which allows us to maximize our operational capabilities and mission effectiveness.

17. Service members who fail to meet medical readiness requirements are typically non-deployable. While Service members may go through brief periods where they are non-deployable, all members are expected to return to and maintain a deployable status. Reserve Component Service members are required to maintain the same physical and medical readiness as active duty Service members. The purpose of the Reserve Component is to provide fully trained and qualified personnel to support the military mission as necessary. In fact, medical readiness is a long-standing pre-requisite for active participation in the Air Force Reserve and Air National Guard.[12]

18. It is my professional judgment that Service members who are not fully vaccinated against COVID-19 pose an unacceptable risk to military operations while in garrison[13] or at deployed locations in the field. Although Combatant Commands can waive medical readiness

[12] *See* Air Force Manual (AFMAN) 36-2136, *Reserve Personnel Participation*, Sept. 6, 2019, para. 1.7.1-1.7.2 ("All reservists have to meet the medical standards in AFI 48-123 and the associated Medical Standards Directory (MSD) to be considered medically qualified to fully participate in the Air Force Reserve. . . . Note: Air Force Reserve commanders may initiate involuntary transfer to the Individual Ready Reserve (IRR) for failing to meet medical standards. . . Reservists with any expired Individual Medical Readiness requirement as defined in AFI 10-250 will not participate in any point-gaining activities other than a military medical/dental evaluation or examination consistent with DoDI 1215.06."); Air National Guard Instruction (ANGI) 36-2001, *Management of Training and Operational Support within the Air National Guard*, Apr. 30, 2019, para. 2.1 ("Members must meet the standards as outlined in DoDI 1215.06 [requiring medical readiness] when taking part in a pay or points gaining activity.") *See also* Department of the Air Force Instruction (DAFI) 36-2110, *Total Force Assignments*, Aug 2, 2021 ("Members with any expired Individual Medical Readiness requirements in accordance with DAFMAN 48-123 are subject to involuntary reassignment to a non-participating status").

[13] "In garrison" refers to Service members at their assigned duty location (e.g., base) and not currently deployed.

requirements[14] to allow a Service member to deploy, those decisions are informed by risk assessments on a case-by-case basis.[15] Medical readiness is similarly important while in garrison, to ensure each Service member is able to perform their duties in support of the mission. In garrison, illness can delay or prevent a Service member from being effectively trained or prepared to perform their duties if tasked to deploy. Vaccination is the most effective way of decreasing the risk that a member will unexpectedly be taken out of the fight or otherwise be prevented from performing their duties.

19. Policies and procedures were established, and implemented, to allow Service members the opportunity to request an exemption from the COVID-19 vaccination mandate based on medical or administrative criteria, including religious objections. All Department of the Air Force Service members who remain unvaccinated are subject to limitations on their service. Being unvaccinated impacts readiness for deployment, travel, and certain assignments or trainings. Service members with an approved religious accommodation are not treated differently than Service members with pending or approved exemptions in other categories.

20. Service members may request an administrative exemption through a religious accommodation based on their sincerely held beliefs. The Department of the Air Force does not have a blanket policy of denying religious accommodation requests. Each religious accommodation is individually considered by the Service member's chain of command to ascertain, among other things, whether the circumstances may lessen the compelling government interest in the health and medical readiness of every Service member or whether the situation

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[14] The waiving of a medical readiness requirement would be required for Service members with an approved exemption to deploy without meeting one or more medical requirements for that deployment.

[15] Some unvaccinated Service members deployed within a few months of the vaccine mandate, before there was a sufficient pool of vaccinated members to institute a vaccination requirement to that deployed location to reduce the operational risks. Although the mission continues, it does so at a heightened risk to success and typically with less effective mitigation measures that reduce the operational effectiveness of the member and/or units.

lends itself to less restrictive alternatives to vaccination that are just as effective in furthering those interests.[16] If a request is initially denied, the Service member may appeal that decision to the Air Force Surgeon General. If the appeal is denied, that Service member must comply with the requirements of the COVID-19 vaccination mandate.

21. As previously noted, the Department of the Air Force also has procedures for processing medical exemptions. Requests for medical exemptions are adjudicated by professional military medical providers based on the medical condition(s) of the individual. Medical exemptions primarily exist to support the compelling government interest in protecting the health of the Force where vaccination is contraindicated for that Service member. Approved medical exemptions are temporary and the Service member is expected to receive the vaccination when the temporary exemption expires.

22. Likewise, the Department of the Air Force allows administrative exemptions to account for individual circumstances, primarily, individuals on terminal leave (that is, on leave immediately prior to separating or retiring and not expected to return to duty), individuals approved to retire or separate within a short period of time, and individuals participating in a vaccine clinical trial. These exemptions reflect how the military's compelling interests intersect. For example, providing an exemption for Service members to participate in vaccine clinical trials would be in the interest of the military because it provides the opportunity for new and better vaccines in the future. With that said, to the best of my knowledge, I am not aware of any Service member in the Department of the Air Force who is currently exempt from the COVID-19 vaccine because they are participating in a vaccine clinical trial. Additionally, it is the

[16] I am aware that some courts have expressed skepticism that the religious accommodation process is individualized. The low number of approvals reflects the difficulty in identifying situations where a Service member's beliefs can be accommodated without undermining Force Health Protection and Readiness; both are a Department of the Air Force-wide and individual interest.

professional judgment of the Department of the Air Force, military and civilian leadership, that its interest in military readiness and mission accomplishment is not served by requiring members to be vaccinated when they are not returning to duty (i.e., terminal leave) or are leaving military service within a short timeframe (i.e., retiring or separating). Since many of those with administrative exemptions are in the process of leaving the Air Force, I expect the number of administrative exemptions to continue declining.

23. Good order and discipline, which includes obeying orders, is a foundational principle in the U.S. military. Absent a pending or approved exemption, Service members are expected to promptly comply with the lawful order to vaccinate. When a Service member willfully refuses to comply with a lawful order it erodes good order and discipline. The military cannot properly function when orders are disregarded because of personal objections. Senior Department of the Air Force officials are reviewing the religious accommodation requests and taking into account any religious concerns in determining whether the member should be ordered to receive the vaccine. If the senior officials determine the member still needs to vaccinate (i.e., religious accommodation request disapproved), ignoring the order is not an acceptable option and would likely result in the Service member being subject to formal disciplinary proceedings, including discharge proceedings.

24. Military operations require complete trust in the integrity of units and individual Service members to swiftly and unwaveringly execute lawful orders. For many military operations, obedience is literally a matter of life or death. Our ability to secure our nation's interests and to

protect our people depends on unhesitating compliance with orders. The only exception is an order that is "patently illegal."[17]

25. The judgment of the Military Services is that the order to receive the COVID-19 vaccine is a lawful order and it is "a key Force Protection and readiness issue."[18] Vaccination is the most effective and readily available tool to protect the Force and to ensure military personnel are fully mission capable and ready to execute operations. The more unvaccinated members in the Force, the greater the threat to readiness and successful mission accomplishment. Therefore, ensuring Service members are vaccinated is a national security issue and the amount of risk acceptable to our national security should be left to the military chain of command, and the Legislative and Executive branches.

COVID-19 Threat to the Department of the Air Force

26. Since the beginning of the pandemic, COVID-19 has unquestionably threatened the health and safety of the Armed Forces – as a whole and individually – and has diminished our abilities to perform our mission and effectively defend the nation. As of March 14, 2022, a total of 91,984 Department of the Air Force Service members had contracted COVID-19 during the pandemic, resulting in 229 hospitalizations, of which 14 died. Of those who died, 12 (86%) were completely unvaccinated.

27. Service members must often work in close physical proximity. The configuration of aircraft often requires Service members to sit and work in cramped operating conditions without the possibility of socially distancing. Likewise, Service members working on the ground are

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[17] Manual for Courts-Martial (MCM), Part IV, ¶ 16.c.(2)(a)(i), 2019 (For a violation of Article 90, Willfully disobeying superior commissioned officer, "an order requiring the performance of a military duty or act may be inferred to be lawful, and it is disobeyed at the peril of the subordinate. This inference does not apply to a patently illegal order, such as one that directs the commission of a crime"). *See also* id. at ¶ 18.c(1)(c) (referencing ¶ 16.c for a violation of Article 92, Failure to obey order or regulation).

[18] Memorandum for the Joint Force from General Mark A. Milley, Chairman of the Joint Chiefs of Staff, CM-0141-21 (Aug. 9, 2021).

often unable to socially distance due to the nature of military operations. Additionally, most forward-deployed locations do not have extensive medical facilities like those we are accustomed to in garrison. An outbreak of COVID-19 in Service members deployed to the field, where everyone is in close contact and living within the same area for months at a time, could easily overwhelm local medical capacity, taking away from the ability to effectively treat front-line battle injuries and other illnesses. Furthermore, such an outbreak could severely diminish operational capabilities, as deployed locations are often minimally manned. If a Service member were to get sick – let alone contract long-COVID, get hospitalized, or die – that would directly impact our ability to perform the mission. For example, an outbreak could limit the number of available pilots and aircrew to directly accomplish operations, or the number of maintainers and weapons loaders to ensyre aircraft are serviced and fully armed in support of operations. COVID-19 is a threat across all career fields and operational needs, an infection removing a Service member from the fight could leave little redundancy or backup to perform that Service member's duties. Under these conditions, an outbreak impacting multiple Service members could potentially risk the mission altogether. While illness is always a hazard in a deployed environment, COVID-19 has already had a real impact on military readiness and operations and we have a duty to mitigate the impact and ongoing risk to the greatest extent possible.

Harm to Readiness if Preliminary Injunction is Issued

28. A preliminary injunction preventing the Department of the Air Force from enforcing the vaccination mandate against a Plaintiff, and from determining the assignment of Service members based on their unvaccinated status, removes control of health and readiness from the Services and places it under the control of the judiciary. Every individual plaintiff judicially-exempted from being fully vaccinated against COVID-19 undermines the Department of the Air

Force's ability to support operations and defend our nation. This danger would be exponentially greater if the Department of the Air Force was enjoined from enforcing the vaccination mandate for large numbers of Service members, and would create an unacceptable risk to operational readiness. The Department of the Air Force is facing an unprecedented number of religious accommodation requests for exemption from the COVID-19 vaccination. Given the sheer volume of religious accommodation requests, an injunction that prevents the Air Force from enforcing the vaccination mandate, or from determining the assignment of Service members based on their unvaccinated status, would seriously threaten our readiness. We would be required to keep in service a large number of personnel who are non-deployable – or worse, be forced to assign and deploy unvaccinated Service members despite an intolerable risk to military operations. The amount of risk the Department of the Air Force should accept to the health and readiness of the Force should be left to the professional judgment of senior military officials based on the individualized circumstances of the requestor (e.g., career field, duties, and work environment).

29. Over the last two years, the Department of the Air Force has deployed unvaccinated individuals because there was no alternative when vaccination was not available. In doing so, our Service members were exposed to a heightened risk of illness and operations at an increased risk of failure. Operational efficiency was also degraded and Service members were delayed in reaching the theater of operations. Deployed Service members were exposed to and contracted COVID-19. As a result, personnel were taken out of the fight to quarantine or isolate and assets were unavailable for in-theater use as some members were medically evacuated to better medical facilities. This is not a sustainable model for continued operational success, vaccination is necessary to minimize the risk from COVID-19. Additionally, COVID-19 vaccination is

necessary to enhance our ability to project power into certain regions. Some allied and friendly countries require Service members to be vaccinated against the COVID-19 disease prior to entering their country.

30. If all religious accommodation requests were approved, or if the Department of the Air Force was prevented from enforcing the mandate on those Service members, the Department would be faced with an unparalleled crisis – unvaccinated fighter and bomber pilots who cannot deploy without risking the overall success of the mission; Reservists who cannot be called to active duty without risking the health of others. Across the Service, we would have some leaders who are exempt from the vaccination requirement themselves but still obligated to enforce a requirement to be medically ready that they themselves do not have to meet. In that circumstance, the authoritative force of the vaccination mandate would be entirely undermined, along with the fundamental principle of obedience to lawful orders and military discipline itself. This would weaken readiness and diminish the true strength of the Force. For these reasons, having large numbers of unvaccinated Service members poses an unacceptable risk to mission accomplishment and to the health of the Force.

31. An injunction that would prohibit discipline and adverse administrative action, would also irreparably harm good order and discipline. Service members have even alleged that non-adverse, routine personnel decisions, such as assignment or training decisions, are punishments and should be enjoined. Deployments, assignments, and training, however, are not rights or privileges. Rather, they are command decisions about how best to allocate personnel for national security and mission success. Any injunction that would prohibit the Air Force from not only enforcing the vaccination mandate but also from determining the assignment of Service members based on their unvaccinated status would wrest control of the Force from military leaders, would

cause immense and lasting harm to military discipline, and would create an unacceptable risk to operational readiness.

Conclusion

32. **In summary, it is my professional military judgment, and that of the Department of the Air Force military and civilian leadership, that our mission requires a healthy, fit, and medically ready fighting force, and that the most effective means of furthering this compelling interest is for Service members to receive the COVID-19 vaccine. An injunction blocking the enforcement of the mandate for a single Plaintiff, group of Plaintiffs, or class of many thousands seeking an exemption, would severely undermine military readiness and cause irreparable harm to military operations. Allowing unvaccinated members to serve without restriction, would significantly increase risk to accomplishing the Air Force mission while causing substantial and lasting harm to military order and discipline.**

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 this 23rd day of March 2022.

KEVIN B. SCHNEIDER, Lt Gen, USAF
Director of Staff

Exhibit 3

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF COLONEL ARTEMIO C. CHAPA

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

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

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

3. It is the professional judgment of the Military Services and military medical providers that vaccines are the least restrictive, most effective and readily available tool the Armed Forces has to keep Airmen and Guardians safe, fully mission capable and prepared to execute the Commander-in-Chiefs orders to protect vital United States' national interests.

General Information about Exemptions

4. Per Air Force Instruction (AFI) 48-110_IP, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases*, dated October 7, 2013 (certified current February 16, 2018),[1] "[t]here are two types of exemptions from immunization – medical and administrative. Granting medical exemptions is a medical function. Granting administrative exemptions is a nonmedical function." In accordance with the applicable Department of Defense and Department of the Air Force policy,[2] the only administrative exemptions available for the COVID-19 vaccine are for religious accommodations, service members on terminal leave (i.e., not returning to duty), actively participating in a vaccine clinical trial started before November 22, 2021, or retiring or separating from service within a short timeframe.[3]

Medical Exemptions

5. Medical exemptions from immunization requirements are accomplished in accordance with AFI 48-110_IP. I am familiar with the medical exemption policy and process as it falls within the scope of my professional duties. Medical exemptions are vaccine-specific and are determined "based on the health of the vaccine candidate and the nature of the immunization under consideration."[4] Accordingly, there is no automatic presumptive exemption from a vaccine.

[1] AFI 48-110_IP is an inter-service publication. The Army identifies it as Army Regulation (AR) 40-562, Navy as Bureau of Medicine and Surgery Instruction (BUMEDINST) 6230.15B, and Coast Guard (CG) as Commandant Instruction (COMDTINST) M6230.4G.
[2] *See* DAF COVID-19 implementation Guide, dated September 3, 2021; Secretary of the Air Force memorandum, *Supplemental Coronavirus Disease 2019 Vaccination Policy*, dated December 7, 2021; and Force Health Protection Guidance (Supplement 23), Revision 3, *Department of Defense Guidance for Coronavirus Disease 2019 Vaccination Attestation, Screening Testing, and Vaccination Verification*, dated December 20, 2021.
[3] Additional administrative exemption tracking codes may be used for situations where a Service member is physically unavailable to take the vaccine (e.g., civilian incarceration or AWOL).
[4] AFI 48-110_IP, paragraph 2-6.(a).

6. A service member may request a medical exemption from the COVID-19 immunization requirement through a military medical provider.[5] The service member must make an appointment with the Military Treatment Facility (MTF) to be evaluated by a military medical provider. The military medical provider will evaluate the service member to determine if a medical exemption is warranted. The military medical provider's decision to grant or deny a medical exemption request is based on the provider's individualized assessment of the service member's medical situation. By way of example, individuals who are granted a medical exemption from the COVID-19 vaccine may include (1) people who previously received passive antibody therapy within the last 90 days, including treatment with monoclonal antibodies or convalescent plasma;[6] (2) Multisystem Inflammatory Syndrome in Adults (MIS-A); (3) acute current COVID-19 infection; (4) pregnancy; (5) myocarditis or pericarditis following first dose or current unresolved myocarditis/pericarditis; (6) prior anaphylaxis to Pfizer COVID vaccine or a component of the vaccine;[7] or (7) immediate allergic reaction of any severity to a previous dose or known (diagnosed) allergy to a component of the COVID-19 vaccine.[8] A military medical provider may seek further consultation if medically indicated.

7. The provider will also counsel the service member including providing specific information about COVID-19, Centers for Disease Control scientific recommendations, the

[5] A military medical provider can be a military service member, civilian, or contractor so long as they are privileged at a "Military Treatment Facility."
[6] As of February 11th, 2022, the CDC has updated the guidance that it is no longer necessary to delay COVID-19 vaccination following receipt of monoclonal antibodies or convalescent plasma. The AF Medical Service is evaluating removing this as a medical exemption criteria.
[7] This is defined as the onset within 4 hours of urticarial, wheezing/dyspnea, vomiting or diarrhea, hypotension, or angioedema.
[8] Air Force Medical Readiness Agency, "COVID-19 Vaccine Exemptions Guidance for AFMS Medical Personnel" (Sept. 3, 2021).

potential risks of infection, benefits of vaccination, and vaccine-specific information about the product constituents, risks, and benefits.

8. If a military medical provider makes a determination that a medical exemption applies to a service member, the provider documents the exemption in the Aeromedical Services Information Management System (ASIMS),[9] which is used to track Individual Medical Readiness,[10] and the Electronic Health Record. At this time, all medical exemptions to the COVID-19 vaccination requirement granted by the Air Force are temporary. The duration of a medical exemption depends on the underlying reason for the medical exemption. It may be as short as 30 days and as long as one year. Scientific information can also be updated to remove a medical exemption criteria, such as the February 11, 2022, CDC notice that it is no longer recommended to delay COVID-19 vaccination following receipt of monoclonal antibodies or convalescent plasma. Additionally, because new or additional COVID-19 immunization products may be approved that do not cause the same medical concerns (e.g. allergic reactions), permanent medical exemptions are not permitted at this time. After the medical exemption expires, the member may be reevaluated to determine if a new exemption is warranted. Additionally, a military medical provider may revoke a medical exemption when it is no longer clinically warranted. The military medical provider will also submit a Memorandum For Record to the service member's commander notifying them if the medical exemption was approved or denied. The number of medical exemptions fluctuates as temporary exemptions are granted and expire, but the overall trend has been a decrease in the number of active medical exemptions and the Air Force expects that trend to continue. Indeed, from January 7, 2022 to the date of this

[9] An alternative database it can be entered is Military Health System Genesis.
[10] The Individual Medical Readiness displays a member's medical readiness, including what immunization requirements have been accomplished, which are coming due, and which are outstanding.

declaration, the number of temporary medical exemptions for the Total Force Service Members dropped from 1,723 to 818. As of May 20 2022, there were just 405 temporary medical exemptions in active duty in Air Force.

9. A service member's commander may review the member's Individual Medical Readiness to ensure the member has met all the medical requirements directed. Once a medical exemption is annotated in ASIMS, the service member's Individual Medical Readiness will display that the member is medically exempt for the COVID-19 vaccination requirement and it will no longer display the member as coming due or overdue for the requirement.

10. If a military medical provider determines that a service member does not meet the criteria for a medical exemption, the provider will document the denial in the member's Electronic Health Record and provide the rationale for disapproval. Like any other medical condition, a service member may seek a second opinion.[11] To qualify for a medical exemption, the second opinion must come from a military medical provider, whether at the same or different Medical Treatment Facility. If the second medical evaluation denies the medical exemption as well, the provider annotates this denial in the Electronic Health Record and it is considered a final medical exemption disposition. If the medical evaluations conflict, the Chief of Medical Staff and military medical provider may consult with the facility's allergist or with the Defense Health Agency Immunization Healthcare Division for resolution and final adjudication by the Chief of the Medical Staff for the Military Treatment Facility.

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

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

Temporary Nature of Medical Exemptions

12. Medical exemptions are granted based on concerns that a COVID-19 vaccine would place the individual service member at a heightened health risk. Healthcare determinations are based upon individual provider encounters with each patient, with the provider assessing the service member's medical history and considering all relevant aspects of that patient's unique medical circumstances and needs. Decisions concerning vaccination, to include the medical necessity to issue a temporary exemption are no exception to this rule and are tailored to the individual patient.

13. As previously noted, Department of the Air Force policy is to grant only temporary medical exemptions from immunization requirements. The duration of these exemptions necessarily vary based on the medical conditions and history of the patient at the time of evaluation, along with the specifics of the vaccine. Circumstances under which a temporary exemption could be granted are wide-ranging. A temporary medical exemption for allergic reaction to the vaccine or components of the vaccine is a good example. While a service member may have a severe allergic reaction to an ingredient, it may not occur with a future COVID-19 vaccine of a different formulation. A temporary exemption allows the Air Force to reassess individuals with allergies or severe adverse reactions to determine whether an updated or new vaccine has been approved with constituents the member can safely take.[12] An exemption may also be temporarily granted for other medical reasons and conditions, such as when receiving the vaccine caused myocarditis or pericarditis following the first dose, or when the vaccine could create a confusing clinical diagnostic assessment during an active COVID-19

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

infection (e.g., is a fever due to a side effect from a COVID-19 vaccine or due to the COVID-19 infection), or for a pregnancy (which is time limited).

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

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

16. A service member with a medical exemption is still subject to restrictions and/or limitations related to the fact that they are unvaccinated (e.g., deployment eligibility, foreign country entry restrictions, frequent COVID-19 testing or extended quarantine requirements, restrictions from all non-mission essential travel, etc.). Therefore, receipt of a medical exemption does not permit the recipient to continue to freely perform any and all duties without consequences. To the extent necessary for the mission and commander decision-making, that member may be reassigned and/or likely categorized as non-deployable just as any other unvaccinated person with or without a pending religious accommodation.

17. Moreover, receiving any type of exemption from the vaccine requirement will likely require an additional medical waiver in order to deploy overseas, be assigned to an operational unit, or engage in other special duties or assignments. For example, if a service member is

scheduled to deploy to a specific geographic area the member may need to obtain separate medical clearance from their Service and from the Combatant Command[13] to enter that commander's geographic area of responsibility. Different Combatant Commands have specific requirements for vaccination based on the endemic biomedical threats that naturally exist in their geographic area as well as any biowarfare threats from adversaries. An unvaccinated member who deploys to a geographic region where there is an endemic infectious disease would put not only his health at risk, but also the health of any other service member. Thus, a determination that a member is not deployable takes into account the risk to other personnel, the risk to mission as well as the unvaccinated member. These deployment determinations do not take into account whether a member is unvaccinated for secular or religious reasons; all unvaccinated service members are treated the same for purposes of determining whether they should travel or deploy.

18. Even if a member has a medical exemption for the COVID-19 vaccine, that exemption does not automatically render a service member deployable. Individuals who receive a medical exemption cannot be deployed until the Combatant Command makes a separate determination based on an individual's medical circumstances and associated risks. Additionally, many of the common reasons that a service member may receive a medical exemption from an immunization requirement, on their own, could separately make the service member not medically qualified and non-deployable. For example, AFI 48-110_IP, ¶ 2.6 lists immune competence, pharmacologic or radiation therapy and/or pregnancy as common reasons for a medical

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

exemption from an immunization.[14] These conditions would almost certainly lead to a finding of unsuitability for deployment and an inability for the service member to serve on an aircraft or go overseas on deployment regardless of vaccination status.

19. As a physician, this process of individual service member review with individual vaccine medical review to adjudicate proper temporary medical exemption clearly consolidates an un-biased alignment with policy,[15] occupational health, member protection, and military interest. Both granting a temporary medical exemption and requiring service members without a medical condition to be vaccinated are evidence of the goal of the military interest in preserving a healthy, responsive force and medical readiness.

20. On May 20, 2022, the numbers of temporary medical exemptions from the COVID-19 vaccine in the ASIMS data was 818 Total Force Service Members (405 U.S. Air Force, 6 U.S. Space Force, 246 Air National Guard and 161 Air Force Reserve Command), with 180 of these for pregnancy.[16] The "Medical Temporary" code documents all exemptions due to medical conditions (e.g., pregnancy, allergic reaction, participation in vaccine trial). The Department of the Air Force cannot readily ascertain howmany Service members, if any at all, have medical exemptions for each particular medical condition.

Administrative Exemption for Vaccine Clinical Trials

[14] AFI 48-110_IP ¶ 2.6 also lists evidence of immunity based on serologic tests, documented infection, or similar circumstances as a possible basis for a medical exemption for an immunization. However, the paragraph makes it clear that these are "[g]eneral examples of medical exemptions" and that the exemptions are based on the health of the patient and "the nature of the immunization under consideration." Section 2.1(g) also makes it clear that serologic tests can be used only "[f]or *some* vaccine-preventable diseases." (emphasis added). Pursuant to DoD policy and CDC recommendations about vaccination, a prior COVID-19 infection, by itself, is not grounds for a medical exemption to the COVlD-19 vaccination requirement.

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

[16] This is a snapshot in time. Medical exemptions from COVID-19 are all temporary in nature. The period of an exemption is dependent on the underlying medical reason, but can be as short as 30 days (or less) for someone who has an acute COVID-19 infection to 365 days for an individual with a severe allergic reaction. Many exemptions are limited to 30, 60, or 90 days. The pregnancy numbers are calculated from numbers of pregnant member without COVID vaccination, not a direct calculation titled as pregnancy medical exemption, and is a snapshot in time.

21. I am familiar with the administrative exemption policy and process for Vaccine Clinical Trials as part of my professional duties. Pursuant to Force Health Protection Guidance (Supplement 23), Revision 3, *Department of Defense Guidance for Coronavirus Disease 2019 Vaccination Attestation, Screening Testing, and Vaccination Verification*, service members who are "actively participating in COVID-19 vaccine clinical trials begun prior to November 22, 2021, are exempt from mandatory vaccination against COVID-19 until the trial is complete in order to avoid invalidating the such clinical trial results." Although not a medical condition, a temporary exemption from the COVID-19 vaccination requirement for a Service member while they are actively participating in a vaccine clinical trial is annotated in ASIMS as "Medical Temporary." If a Service member is not actively participating (e.g., chose not to continue the trial, etc.) or if the clinical trial is not for a vaccine, the service member is not exempt. This exemption would be temporary and the Service member would be required to vaccinate at the end of the trial if they had not received an EUA-authorized or World Health Organization (WHO) EUL vaccine.

22. Service members shall follow their command policies regarding the requirement to obtain command permission to participate in a clinical trial. If approved, the Service member would be required to provide the study information and proof of participation to the MTF for review of a medical temporary exemption. There are different types of vaccine clinical trials, included blinded (where the member is unaware if they received the actual vaccine or a placebo) and not blinded (where member knows if they received the vaccine). If the member received a placebo and was blinded, the MTF would document a "Medical Temporary" exemption in ASIMS. The member would be temporarily exempt until the study was unblinded or until the study ends. If the member received the actual vaccine, and not a placebo, and it was EUA-authorized or on the

World Health Organization (WHO) EUL, the MTF would document the immunization in ASIMS showing the member had been vaccinated.

23. ASIMS is unable to identify in a searchable format how many service members are actively participating in a vaccine clinical trial and have a temporary medical exemption. This "Medical Temporary" code is the same code used to document exemptions due to medical conditions (e.g., pregnancy, allergic reaction) as described above. As such, the Department of the Air Force is not readily able to ascertain how many Service members, if any at all, in the pool of "Medical Temporary" ASIMS data are participating in a vaccine clinical trial. I am not personally aware of anyone that currently has an exemption from the COVID-19 vaccine because they are participating in a vaccine clinical trial.

24. Moreover, even if an individual participates in a vaccine clinical trial, it does not mean they are unvaccinated. For example, during a blinded trial, an individual's vaccination status is unknown, even to that person.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 23rd day of May 2022.

CHAPA.ARTEMIO.CERDA.1169367589

Digitally signed by CHAPA.ARTEMIO.CERDA.1169367589
Date: 2022.05.23 09:04:06 -04'00'

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

Exhibit 4

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF LIEUTENANT COLONEL NEKITHA M. LITTLE

I, Nekitha M. Little, hereby state and declare as follows:

1. I am a Lieutenant Colonel in the United States Air Force currently assigned as the Deputy Division Chief, Military Compensation Policy, Force Management for Military Personnel (A1P). I have been in this position since approximately August 1, 2019. As a part of my duties, I am responsible for developing and interpreting policy related to military pay and compensation guidance, which includes leave policy, to ensure consistency with Congressional statutes and the Office of the Secretary of Defense and Department of the Air Force Instructions, enhance the Air Force mission, and improve the quality of life for Airmen and Guardians.

2. I make this declaration in my official capacity as the Deputy Division Chief, Military Compensation Policy, and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. After the Secretary of Defense mandated the COVID-19 vaccine for all service members, the Department of the Air Force developed and promulgated a departmental-wide

implementation guide, which included guidance on administrative exemptions available. The Air Force has granted administrative exemptions to certain service members on terminal leave because the members do not normally return to duty when terminal leave begins. The Air Force has decided to grant administrative exemptions for members on terminal leave because it has assessed that its interest in military readiness and mission accomplishment is not served by requiring members to be vaccinated when they are no longer anticipated to return to duty.

4. "Terminal leave" is considered a valid administrative exemption to the vaccine mandate. I am familiar with this terminal leave policy as it falls within the scope of my professional duties. In accordance with Air Force Guidance Memorandum to Department of Air Force Instruction 36-3003, *Military Leave Program*, dated April 7, 2021, terminal leave is defined as ". . . chargeable leave taken in conjunction with retirement or separation from active duty. Member's last day of leave coincides with the last day of active duty." Terminal leave is not automatic, and members must request the leave from their unit commanders via the LeaveWeb system, which is the system of record for all leave requests. Once a member is on terminal leave, they are no longer considered on active duty, hence the acceptance of this as an administrative exemption as referenced in 48-110, Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases, 16 February 2018.

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

LITTLE.NEKITHA.M.1103890892 Digitally signed by LITTLE.NEKITHA.M.1103890892 Date: 2022.05.19 17:20:23 -04'00'

NEKITHA M. LITTLE, Lt Col, USAF
Deputy Division Chief
Military Compensation Policy

Attachment:

AFI 36-3003, paragraph 1.2.5.3

Exhibit 5

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF LIEUTENANT COLONEL JUSTIN L. LONG

I, Justin L. Long, hereby state and declare as follows:

1. I am a Lieutenant Colonel in the United States Air Force currently assigned as the Chief, Retirements, Separations, Force Management, and Assignment Policy for Military Personnel (A1P). I have been in this position since approximately 16 June 2021. As a part of my duties, I am responsible for developing and interpreting policy related to military retirements, separations, force management, and assignments, to ensure consistency with Congressional statutes, the Office of the Secretary of Defense and Department of the Air Force instructions.

2. I make this declaration in my official capacity as the Chief, Retirements, Separations, Force Management, and Assignment Policy Branch and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. On August 24, 2021, the Secretary of Defense (SecDef) issued a mandate for all members of the Armed Forces under the Department of Defense's authority on active duty or in the Ready Reserve to immediately begin full vaccination against Coronavirus Disease 2019 (COVID-19). Thereafter, on September 3, 2021, the Secretary of the Air Force (SecAF) provided additional

mandatory vaccination guidance for Department of the Air Force (DAF) commanders that they take all steps necessary to ensure all uniformed service members receive the COVID-19 vaccine. This guidance directed Commanders to "take action systematically and as expeditiously as possible to ensure prompt and full vaccination of Service members." The guidance further directed all Active Duty Airmen and Guardians, unless exempted, be fully vaccinated by 2 November 2021 (SecAF Memo, September 3, 2021, Mandatory Coronavirus Disease 19 Vaccine of Department of the Air Force Military Members). In addition, the Department of the Air Force developed and promulgated a departmental-wide implementation guide, which included guidance on available administrative and medical exemptions.

4. On December 7, 2021, the SecAF provided a memorandum, "Supplemental Coronavirus Disease 2019 Vaccination Policy." The memo established specific policy and provided guidance applicable to regular Air Force and Space Force members, and Air Force Reserve and Air National Guard members. The memo included supplemental guidance concerning those who requested separation or retirement prior to 2 November 2021, those whose requests for medical, religious or administrative exemption from the COVID-19 vaccine are denied, and those who refuse to take the COVID-19 vaccine.

5. This memo states the following regarding pending separation or retirement: "unvaccinated regular Airmen and Guardians who submitted a request to retire or separate prior to 2 November 2021, with a retirement or separation date on or before 1 April 2022, may be granted an administrative exemption from the COVID-19 vaccination requirement until their retirement or separation date."

6. Furthermore, the memo states that "unvaccinated 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." In addition, the memo states "Service members who receive a denial of their medical, religious, or administrative exemption request have five (5) calendar days to do one of the following:

1) Begin a COVID-19 vaccination regime…;

2) Submit an appeal to the Final Appeal Authority or request a second opinion [on a medical exemption]. If a final appeal or exemption is denied, the service member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen; or

3) If able, based upon the absence of or a limited Military Service Obligation, and consistent with opportunities afforded service members prior to November 2, 2021, request to separate or retire on or before April 1, 2022, or no later than the first day of the fifth month following initial or final appeal denial."

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 20th day of May 2022

LONG.JUSTIN.LAMAR.1255594490 Digitally signed by LONG.JUSTIN.LAMAR.1255594490 Date: 2022.05.20 08:58:23 -04'00'

JUSTIN L. LONG, Lt Col, USAF
Chief, Retirement, Separation, Force Management, and Assignment Policy

Exhibit 6

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF COLONEL ELIZABETH M. HERNANDEZ

I, Elizabeth M. Hernandez, hereby state and declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as the Chief of the Military Justice Law and Policy Division in the Military Justice and Discipline Directorate at Joint Base Andrews, Maryland. I have been in this position since July 2021. As a part of my duties, I am responsible for providing counsel on military justice matters to senior leaders, as well as guidance on military justice policy and processes to legal offices at every level of command. The Division also represents the Air Force on the Joint Service Committee on Military Justice: an inter-agency, joint body dedicated to ensuring the Manual for Courts-Martial and Uniform Code of Military Justice constitute a comprehensive body of criminal law and procedure.

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

3. Department of the Air Force[1] commanders approach every instance of a military member's refusal to obey a lawful order to receive the COVID-19 vaccination on a case-by-case basis. This is the same as it would be for allegations of misconduct or issues in work performance. In the case of COVID-19 vaccine refusals, the Secretary of the Air Force withheld authority to take action in order to ensure consistency and uniformity in disposition. Accordingly, before any administrative or disciplinary action can be taken based on a COVID-19 vaccine refusal, the case must be reviewed by a Colonel (O-6) with special court-martial convening authority, or higher.

4. If the member has failed to obey a lawful order, disciplinary action may be appropriate. Each commander must look at all the facts and circumstances and evaluate each case individually to determine the appropriate disposition. Generally, more minor misconduct should be addressed at the lowest possible level, as soon as possible, to ensure a service member's career is not negatively affected unnecessarily. More serious misconduct is typically addressed by more serious disciplinary action.

5. Potential dispositions for failing to obey a lawful order to receive the COVID-19 vaccination include adverse administrative actions, non-judicial punishment, administrative demotions, administrative discharges, and courts-martial. Each action follows its own timeline, specific to the needs of the Department of the Air Force, the member, and the commander.

6. Administrative actions are non-punitive tools, intended to improve, correct, and instruct service members who violate established Department of Air Force standards.[2] These actions include, from least severe to most severe: Records of Individual Counseling, Letters of

[1] The Department of the Air Force is comprised of the U.S. Air Force and U.S. Space Force.
[2] Air Force Instruction (AFI) 36-2907, *Adverse Administrative Actions*, dated May 22, 2020 (certified current January 15, 2021).

Counseling, Letters of Admonishment, and Letters of Reprimand. Each of these actions are administered in a manner to protect the service member's due process rights. These protections include an ability to consult with a free defense counsel, provide a response, and provide other relevant information to the issuing authority. If the administrative paperwork is filed in the service member's Personnel Information File or Unfavorable Information File (UIF), the service member may appeal to the issuing authority or a superior authority for removal. There is no available data on the average processing time for these actions, but normally, the process could be expected to take anywhere from two to three weeks.

7. Non-judicial punishment provides commanders with a means of maintaining good order and discipline. It is intended to promote positive behavior changes in service members without subjecting the service member to a criminal (i.e., court-martial) conviction. This type of action has significant due process protections and an appeal process. As always, the service member has access to free defense counsel services to assist in responding to these actions. For calendar year 2021, the average processing time for cases involving service members on Active Duty was 60 days. The average processing time for cases involving Reserve service members was 173 days.

8. Adverse administrative action (e.g., Letter of Reprimand), Non-Judicial Punishment, or Courts-martial conviction may be placed in a UIF. Depending on the rank of the service member and the type of action, placing the document in the UIF may be mandatory in accordance with AFI 36-2907. The UIF is an official record of unfavorable information about an individual. It documents administrative, judicial, and nonjudicial actions.

9. An administrative demotion is a quality force management tool available to Department of the Air Force commanders to help ensure a quality enlisted force. This process does not apply to commissioned officers. Administrative demotions are intended to place service members at a

rank commensurate with their skill level and ability; they are not intended to be punitive. The process starts when the service member's immediate commander notifies the service member of a recommendation for demotion. The service member has an opportunity to access free defense services and respond to the demotion recommendation before it goes to the demotion authority (a commander senior to the initiating commander) for decision. The service member can appeal the demotion authority's decision to the commander senior to the demotion authority. There is no available data on the average processing time for these actions.

10. Administrative discharges are appropriate when a service member does not show potential for further service. In the case of a refusal to comply with the COVID-19 vaccination mandate, absent an exemption, regular service members will be subject to initiation of administrative discharge proceedings. The characterization of an administrative discharge is dependent upon many factors, to include duty performance, prior misconduct, and basis of the discharge. Although there are different processes for enlisted and officer members, the service characterizations and bases for discharge are generally the same. Section 736 of the Fiscal Year 2022 National Defense Authorization Act limits the characterization of any discharge on which the sole basis is the member failed to obey a lawful order by refusing the COVID-19 vaccine to either Honorable or Under Honorable Conditions (General). The process starts when the service member's immediate commander notifies the service member of a recommendation for administrative discharge. The service member has an opportunity to access free defense services and respond before the discharge recommendation goes to the separation authority, often the senior commander in the unit (O-6/Colonel) for decision. Depending on the characterization of the service separation, the decision may move to a higher level review (General Officer). Additionally, depending on the service member's time in service, they may be entitled to a formal administrative hearing before a decision is made regarding their discharge from the

service. For calendar year 2021, the average discharge processing time for cases involving Active Duty enlisted members not entitled to a board was 38 days. The average discharge processing time for cases involving Reserve enlisted members not entitled to a board is longer than that of Active Duty cases. For both Active Duty and Reserve enlisted members entitled to a board, the average discharge processing time is longer than that of non-board cases. Finally, the average discharge processing time for all forms of officer discharges is longer than that of enlisted discharge cases.

11. In the case of a refusal to comply with the COVID-19 vaccination mandate, absent an exemption, the Secretary of the Air Force has mandated Traditional Reservists and Individual Mobilization Augmentees will be placed in a no pay/no points status and involuntarily reassigned to the Individual Ready Reserve (IRR). Similarly, Active Guard and Reserve (AGR) members who refuse to comply with the COVID-19 vaccination mandate, absent an exemption, will have their AGR tour curtailed and involuntarily reassigned to the IRR. Reassigning a member to the IRR is not a discharge or separation. Currently, there is no policy mandating administrative separation for Traditional Reservists, Individual Mobilization Augmentees, or AGR members.

12. A court-martial is a criminal trial for military members and is reserved for serious criminal offenses. There are three levels of courts-martial – general, special, and summary. If a service member were to face a court-martial for failing to obey a lawful order, the service member would be able to challenge the lawfulness of the order during the proceedings.

13. Possible sentences in a court-martial include confinement, reduction in grade (enlisted only), and punitive discharges. For enlisted members, punitive discharges include bad conduct or dishonorable discharges. For commissioned officers, the punitive discharge available is a

dismissal (the equivalent of a dishonorable discharge). Punitive discharges are adjudged in cases where a service member has committed serious misconduct.

14. As of the date of this declaration, no service member in the Department of the Air Force has had court-martial charges preferred[3] against him or her for failing to obey a lawful order by refusing the COVID-19 vaccine.

15. A service member who receives a punitive discharge and/or at least two years of confinement automatically receives appellate review of the conviction and/or sentence by the Air Force Court of Criminal Appeals. If the service member does not receive a punitive discharge and/or at least two years of confinement, the service member receives appellate review of the conviction and/or sentence by the Office of The Judge Advocate General of the Air Force. For calendar year 2021, the average processing time from offense to trial for a special court-martial was 270 days. For calendar year 2021, the average processing time from offense to trial for a general court-martial was 526 days.

16. Air Force Review Boards Agency (AFRBA) is responsible for the adjudication of military personnel matters through a number of statutory and secretarial boards. There are two subsets of the AFRBA. First, the Secretary of the Air Force Personnel Council (SAFPC) acts for, recommends to, and announces decisions on behalf of the Secretary of the Air Force for a variety of military personnel issues. SAFPC is comprised of five boards, one of which is the Air Force Discharge Review Board (AFDRB), which has discretionary authority to review administrative discharges. A service member who received an administrative discharge or a bad conduct discharge from a special court-martial may appeal the characterization of the discharge

[3] Preferral of charges is the act of formally accusing a military member of a violation of the Uniform Code of Military Justice. This is the first formal step in initiating a court-martial.

to the AFDRB. The AFDRB estimates a records review decision will take six to 12 months to process.

17. A second subset of the AFRBA includes the Air Force Board for Correction of Military Records (AFBCMR), which is a statutory board of civilians considering applications for correction of military records submitted by Air Force members, former Air Force members, or persons with a proper interest in the correction of a person's military record. The AFBCMR is the highest level of administrative review within the Department of the Air Force. Its decisions are final and binding on all Department of Air Force officials and other government agencies. The AFBCMR determines whether the service member has demonstrated the existence of a material error or injustice that can be remedied effectively through correction of the applicant's military record and, if so, what corrections are needed to provide full and effective relief. Prior to applying to the AFBCMR, a service member must exhaust all other available administrative remedies. This means any service member seeking relief from an administrative discharge or a bad conduct discharge from a special court-martial first must have applied to the AFDRB and been denied relief. Service members with punitive discharges from a general court-martial may apply directly to the AFBCMR. Administrative applications take about three months to complete. Cases involving formal AFBCMR consideration take an average of 12 months.

18. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 23rd day of May 2022.

HERNANDEZ.ELIZABETH.MARIE.1279606660
Digitally signed by HERNANDEZ.ELIZABETH.MARIE.1279606660
Date: 2022.05.23 09:10:38 -04'00'

ELIZABETH M. HERNANDEZ, Colonel, USAF
Chief, Military Justice Law and Policy Division

Attachment:
AFI 36-2907, *Adverse Administrative Actions*, dated May 22, 2020 (certified current January 15, 2021).

Exhibit 7

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

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 immunizations from DoD. This includes assisting in policy development, providing implementation guidance and education, and engaging in clinical studies 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, while the Omicron variant and subvariants are considered to be more transmissible than the Delta variant.[1] However, not all mutations are beneficial to the virus – some can result in virus death and therefore do not infect the host. This is part of the normal biology cycle of all viruses.

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

[1] https://www.yalemedicine.org/news/covid-19-variants-of-concern-omicron last accessed May 20, 2022.

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 and then may be transmitted to another person by touching the contaminated surface followed by touching the eye, nose, or mouth. 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, about 1 million individuals with COVID-19 disease have died within the US.[4] Worldwide, over 6 million have died.[5] As of May 18, 2022, CDC reports that over 82 million individuals in the U.S. have been diagnosed with COVID-19 disease, over 4.6 million have been hospitalized, and over 999,000 have died (approximately 3 in 1,000 in the total U.S. population of 330 million).[6] Per the CDC, the elderly and those with underlying medical history of cardiovascular disease, diabetes, chronic

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[2] https://www.cdc.gov/coronavirus/2019-ncov/faq.html, last accessed May 20, 2022.

[3] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html, last accessed May 20, 2022.

[4] https://covid19.who.int/, last accessed May 20, 2022

[5] *Id*

[6] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, last accessed May 20, 2022.

respiratory, liver, or kidney disease, smoking, being overweight or obese, HIV, certain intellectual or developmental disabilities, pregnancy, substance abuse disorders, a weakened immune system, transplant recipients, or cancer are more likely to develop serious illness.[7] 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.[8] 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 (ARDS) and cytokine storm. Recognition of the viral and hyperinflammatory phases informs treatment strategies for those with COVID-19 disease. Therapies that directly target the SARS-CoV-2 virus are anticipated to have the greatest effect early in the course of the disease, whereas immunosuppressive/anti-inflammatory/antithrombotic (anti-clotting) therapies are likely to be more beneficial after COVID-19 has progressed to stages characterized by low oxygen levels such as seen in ARDS.[9]

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[7] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html, last accessed May 20, 2022.

[8] 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.

[9] https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/, last accessed May 20, 2022.

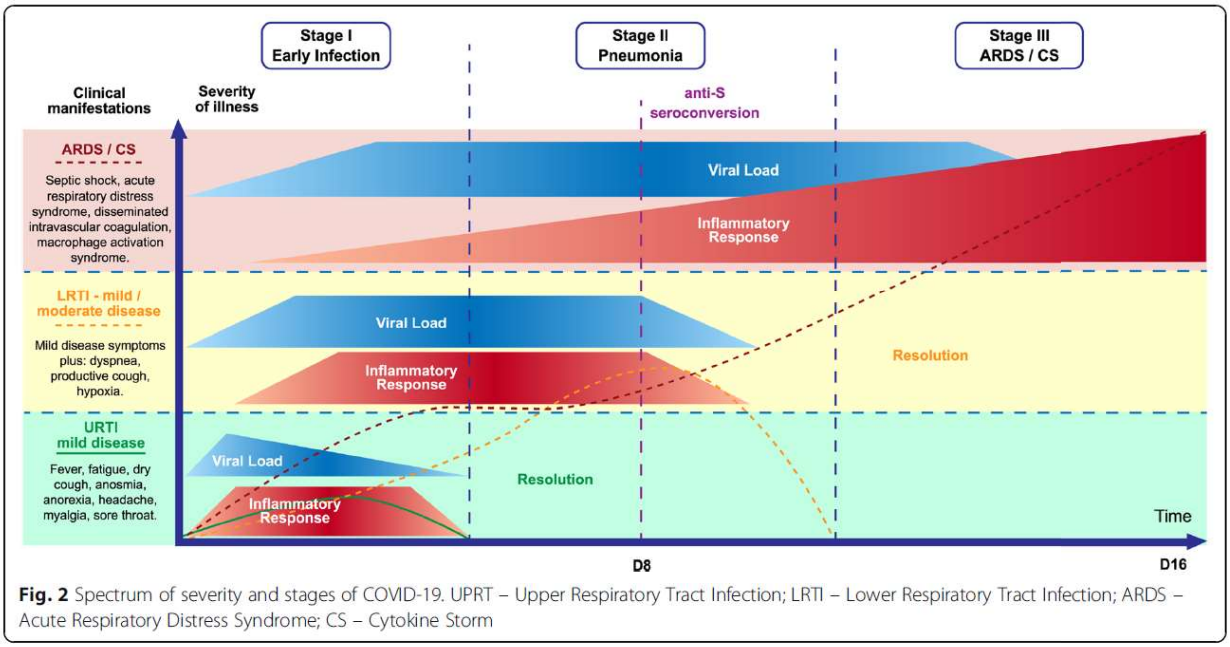

Fig. 2 Spectrum of severity and stages of COVID-19. UPRT – Upper Respiratory Tract Infection; LRTI – Lower Respiratory Tract Infection; ARDS – Acute Respiratory Distress Syndrome; CS – Cytokine Storm

8. The strongest recommendation for pre-exposure to COVID-19 disease remains vaccination, with highest level of evidence demonstrated through robust randomized control trials.[10] In contrast, the efficacy and/or outcomes of COVID-19 disease treatments are variable and depend on a person's underlying medical history, genetics, the COVID-19 variant causing disease, immune response, and interval between symptom onset and treatment initiation. Only one outpatient therapy, remdesivir, has received FDA approval to date. Other therapies are administered under a FDA emergency use authorization.[11] Just as it is acknowledged that there have been adverse events following COVID-19 vaccine receipt, it should also be understood that there are risks to COVID-19 disease treatment, even in those who are healthy enough to be managed in the outpatient setting. A non-exhaustive list of risks associated with COVID-19

[10] https://www.covid19treatmentguidelines.nih.gov/overview/prevention-of-sars-cov-2/, last accessed May 20, 2022.

[11] https://aspr.hhs.gov/COVID-19/Therapeutics/Documents/side-by-side-overview.pdf, last accessed May 20, 2022.

disease treatments includes cardiovascular and/or respiratory events, allergic reactions, fetal harm, and drug interactions. Further, some treatments must be administered shortly after diagnosis – within a matter of days – in order to be effective.[12]

9. Although most people with COVID-19 are better within weeks of illness, some experience post-COVID-19 conditions, most commonly referred to as long-COVID. Long-COVID-19 conditions include a wide range of new, returning, or ongoing health problems occurring four or more weeks after infection, lasting for at least 2 months and are not explained by an alternative diagnosis. Those who were asymptomatic during their COVID-19 infection may also develop long-COVID-19. At present, there is no cure for long-COVID; instead, treatment is geared towards symptom management. 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.[13] A United Kingdom study showed minimal improvement in long-COVID-19 symptoms at 12 months after COVID-19 diagnosis as compared to symptoms present at 5 months.[14] Another study comparing outcomes in patients referred to outpatient rehabilitation clinics after COVID-19 reported poorer general, mental, and

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[12] *Id.*

[13] Groff, et al, Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection, *JAMA Network Open*, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/27849 18.

[14] Clinical characteristics with inflammation profiling of long COVID and association with 1-year recovery following hospitalisation in the UK: a prospective observational study *Lancet Respir Med* 2022 https://doi.org/10.1016/S2213-2600(22)0127-8

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 employed.[15] 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.[16] 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.[17] 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

[15] 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.

[16] 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.

[17] 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.

particularly high risk. The authors report that the risks were evident regardless of age, race, sex, and other cardiovascular risk factors, including obesity, hypertension (high blood pressure), diabetes, chronic kidney disease, and hyperlipidemia (high cholesterol). Additionally, these risks were evident in people without any cardiovascular disease before COVID-19 exposure, "providing evidence that these cardiovascular risks might manifest even in people at low risk for cardiovascular disease."[18] A further study of multiple health care systems across the United States found that the incidence of cardiac complications after SARS-CoV-2 infection or mRNA COVID-19 vaccination were low overall but were significantly higher after infection than after vaccination for both males and females in all age groups.[19]

- Among males aged 12–17 years, the incidences of myocarditis and myocarditis or pericarditis were 50.1–64.9 cases per 100,000 after infection, 2.2–3.3 after the first vaccine dose, and 22.0–35.9 after the second dose; incidences of myocarditis, pericarditis, or multisystem inflammatory syndrome (MIS) were 150.5–180.0 after infection. Relative risk (RR) for cardiac outcomes comparing infected persons with first dose recipients were 4.9–69.0, and with second dose recipients, were 1.8–5.6; all RRs were statistically significant.
- Among males aged 18–29 years, the incidences of myocarditis and myocarditis or pericarditis were 55.3–100.6 cases per 100,000 after infection, 0.9–8.1 after the first vaccine dose, and 6.5–15.0 after the second dose; incidences of myocarditis, pericarditis, or MIS were 97.2–140.8 after infection. RRs for cardiac outcomes

[18] *Id.*

[19] Block JP, et al. Cardiac Complications After SARS-CoV-2 Infection and mRNA COVID-19 Vaccination – PCORnet, United States, January 2021-January 2022, Vol 71, No. 14 April 8, 2022 https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7114e1-H.pdf

comparing infected persons with first dose recipients were 7.2–61.8, and with second dose recipients, were 6.7–8.5; all RRs were statistically significant.

- Among males aged ≥30 years, the incidences of myocarditis and myocarditis or pericarditis were 57.2–114.0 cases per 100,000 after infection, 0.9–7.3 after the first vaccine dose, and 0.5–7.3 after the second dose; incidences of myocarditis, pericarditis, or MIS were 109.1–136.8 after infection. RRs or cardiac outcomes among infected persons compared with first dose recipients were 10.7–67.2, and compared with second dose recipients, were 10.8–115.2; all RRs were statistically significant.

TABLE 2. Incidence of cardiac outcomes among males aged ≥5 years after SARS-CoV-2 infection or mRNA COVID-19 vaccination and risk ratios, by age group and risk window — National Patient-Centered Clinical Research Network, United States, January 1, 2021–January 31, 2022

Age group, yrs/ Outcome/ Risk window	Incidence* among males: SARS-CoV-2 infection cohort†	Incidence* among males: mRNA COVID-19 vaccination cohort: First dose§	Second dose§	Unspecified dose¶	Any dose**	Risk ratio (95% CI) SARS-CoV-2 infection versus mRNA COVID-19 vaccination: mRNA COVID-19 vaccination cohort: First dose§	Second dose§	Unspecified dose¶	Any dose**
5–11††									
Myocarditis									
7-day	12.6	0	0	0	0	NC	NC	NC	NC
21-day	17.6	4.0	0	6.5	3.2	4.4 (0.5–35.7)	NC	2.7 (0.3–22.1)	5.4 (1.1–26.1)
Myocarditis or pericarditis									
7-day	12.6	0	0	0	0	NC	NC	NC	NC
21-day	17.6	4.0	0	6.5	3.2	4.4 (0.5–35.7)	NC	2.7 (0.3–22.1)	5.4 (1.1–26.1)
Myocarditis, pericarditis, or MIS§§									
7-day	93.0	—¶¶	—	—	—	NC	NC	NC	NC
21-day	103.0	—	—	—	—	25.7 (3.5–187.0)	NC	16.0 (2.2–116.0)	31.7 (7.7–131.2)
42-day	133.2	—	—	—	—	33.3 (4.6–240.5)	28.2 (3.9–203.9)	10.3 (2.5–42.3)	20.5 (7.4–56.7)
12–17††									
Myocarditis									
7-day	50.1	2.2	22.0	16.7	12.9	23.0 (5.3–99.5)	2.3 (1.2–4.4)	3.0 (1.3–6.7)	3.9 (2.1–7.0)
21-day	59.0	3.3	26.7	20.4	16.0	18.0 (5.4–60.6)	2.2 (1.2–4.0)	2.9 (1.4–6.0)	3.7 (2.1–6.4)
Myocarditis or pericarditis									
7-day	56.0	2.2	26.7	22.3	16.0	25.7 (6.0–110.3)	2.1 (1.1–3.9)	2.5 (1.2–5.2)	3.5 (2.0–6.1)
21-day	64.9	3.3	35.9	29.7	21.6	19.8 (5.9–66.2)	1.8 (1.0–3.1)	2.2 (1.1–4.2)	3.0 (1.8–5.0)
Myocarditis, pericarditis, or MIS§§									
7-day	150.5	—	—	—	—	69.0 (16.8–283.2)	5.6 (3.5–9.2)	6.8 (3.6–12.7)	9.4 (6.2–14.4)
21-day	159.3	—	—	—	—	48.7 (15.2–155.7)	4.4 (2.9–6.9)	5.4 (3.1–9.4)	7.4 (5.0–10.8)
42-day	180.0	—	—	—	—	4.9 (3.2–7.4)	4.6 (3.0–6.9)	5.4 (3.2–9.1)	4.9 (3.5–6.7)
18–29									
Myocarditis									
7-day	55.3	0.9	6.5	7.0	4.6	61.8 (8.5–451.8)	8.5 (3.7–19.1)	7.9 (3.3–19.0)	12.0 (6.4–22.5)
21-day	63.7	3.6	8.4	11.6	7.5	17.8 (6.4–49.8)	7.6 (3.7–15.7)	5.5 (2.7–11.0)	8.4 (5.0–14.2)
Myocarditis or pericarditis									
7-day	85.5	2.7	12.1	22.0	11.5	31.8 (9.9–102.0)	7.0 (3.8–12.9)	3.9 (2.3–6.6)	7.4 (4.8–11.5)
21-day	100.6	8.1	15.0	27.8	16.1	12.5 (6.2–25.2)	6.7 (3.9–11.7)	3.6 (2.3–5.8)	6.3 (4.3–9.1)
Myocarditis, pericarditis, or MIS§§									
7-day	97.2	—	—	—	—	36.2 (11.3–115.5)	8.0 (4.4–14.6)	4.4 (2.6–7.4)	8.5 (5.6–12.9)
21-day	112.3	—	—	—	—	13.9 (7.0–28.0)	7.5 (4.4–13.0)	4.0 (2.5–6.4)	7.0 (4.8–10.1)
42-day	140.8	—	—	—	—	7.2 (4.5–11.4)	8.4 (5.0–13.9)	4.5 (2.9–6.9)	6.4 (4.6–8.8)
≥30									
Myocarditis									
7-day	57.2	0.9	0.5	3.0	1.3	67.2 (31.4–143.8)	115.2 (42.6–311.7)	18.9 (11.2–31.7)	45.7 (30.2–69.2)
21-day	63.0	1.9	1.2	4.2	2.2	32.4 (19.3–54.3)	50.8 (26.7–96.4)	15.1 (9.7–23.7)	28.3 (20.4–39.3)
Myocarditis or pericarditis									
7-day	100.2	3.8	3.1	15.0	6.3	26.6 (18.2–38.7)	32.3 (21.3–48.8)	6.7 (5.2–8.6)	16.0 (12.9–19.8)
21-day	114.0	7.3	7.3	20.1	10.4	15.6 (11.8–20.7)	15.6 (11.7–20.7)	5.7 (4.5–7.1)	10.9 (9.1–13.1)
Myocarditis, pericarditis, or MIS§§									
7-day	109.1	—	—	—	—	28.9 (19.9–42.0)	35.1 (23.3–53.0)	7.3 (5.7–9.4)	17.4 (14.1–21.5)
21-day	123.0	—	—	—	—	16.8 (12.7–22.3)	16.8 (12.7–22.2)	6.1 (4.9–7.7)	11.8 (9.9–14.0)
42-day	136.8	—	—	—	—	10.7 (8.6–13.4)	10.8 (8.6–13.5)	5.4 (4.4–6.7)	8.7 (7.4–10.1)

Abbreviations: MIS = multisystem inflammatory syndrome; NC = not calculated.

* Cases per 100,000 persons.

† Persons in the infection cohort included those who received ≥1 positive SARS-CoV-2 molecular or antigen test result.

§ The first dose cohort included persons who had either the first of 2 doses ≥20 days before a second dose or a specific code for a first dose; the second dose cohort included persons who had either the second of 2 doses ≥20 days after a first dose or a specific code for a second dose.

¶ The unspecified dose cohort included persons who had a single dose that was not specified as a first or second dose; doses specified as booster doses were excluded.

** The any dose cohort is the first, second, and unspecified dose cohorts combined; persons who had 2 doses are represented twice in the cohort but had different index dates for their first and second doses.

†† BNT162b2 (Pfizer-BioNTech) is the only mRNA COVID-19 vaccine approved for persons aged 5–17 years.

§§ Diagnoses of myocarditis, pericarditis, or MIS after a positive SARS-CoV-2 test result compared with diagnoses of myocarditis or pericarditis after vaccination. The 42-day risk ratios were only calculated for this outcome and comparison. The incidence of myocarditis or pericarditis in this risk window was 4.0, 37.1, 19.7, and 12.8 cases per 100,000 for males aged 5–11, 12–17, 18–29, and ≥30 years after a first dose of an mRNA COVID-19 vaccine; 4.7, 39.4, 16.8, and 12.7 cases per 100,000 after a second dose; 12.9, 33.4, 31.3, and 25.3 cases per 100,000 after an unspecified dose; and 6.5, 37.1, 22.0, and 15.8 cases per 100,000 after any dose.

¶¶ Dashes indicate the incidence for vaccination cohorts was not applicable because the comparison for incidence of myocarditis, pericarditis, or MIS after infection was to myocarditis or pericarditis after vaccination.

An additional study of patients enrolled in Veterans Affairs system found an increased risk of diabetes among those who had tested positive for COVID-19 when compared to contemporary and historical control groups. The review of millions of records found that people who had been diagnosed with COVID-19 were 46% more likely to develop Type 2 diabetes for the first time.[20] In order to further investigate medical issues of and treatment for those afflicted with long-COVID, on April 5, 2022, President Biden issued a Presidential Memorandum "directing the Secretary of Health and Human Services (HHS) to coordinate a new effort across the federal government to develop and issue the first-ever interagency national research action plan on Long COVID. The effort will advance progress in prevention, diagnosis, treatment, and provision of services, supports, and interventions for individuals experiencing Long COVID and associated conditions. The Presidential Memorandum also directs HHS to issue a report outlining services and supports across federal agencies to assist people experiencing Long COVID, individuals who are dealing with a COVID-related loss, and people who are experiencing mental health and substance use issues related to the pandemic."[21]

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, the

[20] Xie Y and Al-Aly Z. Risks and burdens of incident diabetes in long COVID: a cohort study *The Lancet, Diabetes and Endocrinology* Volume 10, Issue 5:311-321 https://www.thelancet.com/journals/landia/article/PIIS2213-8587(22)00044-4/fulltext.

[21] https://www.whitehouse.gov/briefing-room/statements-releases/2022/04/05/fact-sheet-the-biden-administration-accelerates-whole-of-government-effort-to-prevent-detect-and-treat-long-covid/, last accessed May 20, 2022

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.[22] 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-COVID-19, potentially impacting their long-term ability to successfully perform their duties. 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.

[22] 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 May 20, 2022.

11. Between February 2020 and April 2022, there were 397,708 new and repeat cases of COVID-19 among active duty service members (**Table**). The largest monthly peak in cases occurred in January 2022, with 125,126 cases identified (**Figure)**. 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 1.9% in May and July 2021, and decreased to 0.4% in December 2021. The percentage of hospitalized cases remained low at 0.3% in January 2022 but increased to 0.8% in February 2022 and then dropped to 0.2% in April 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 April 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.

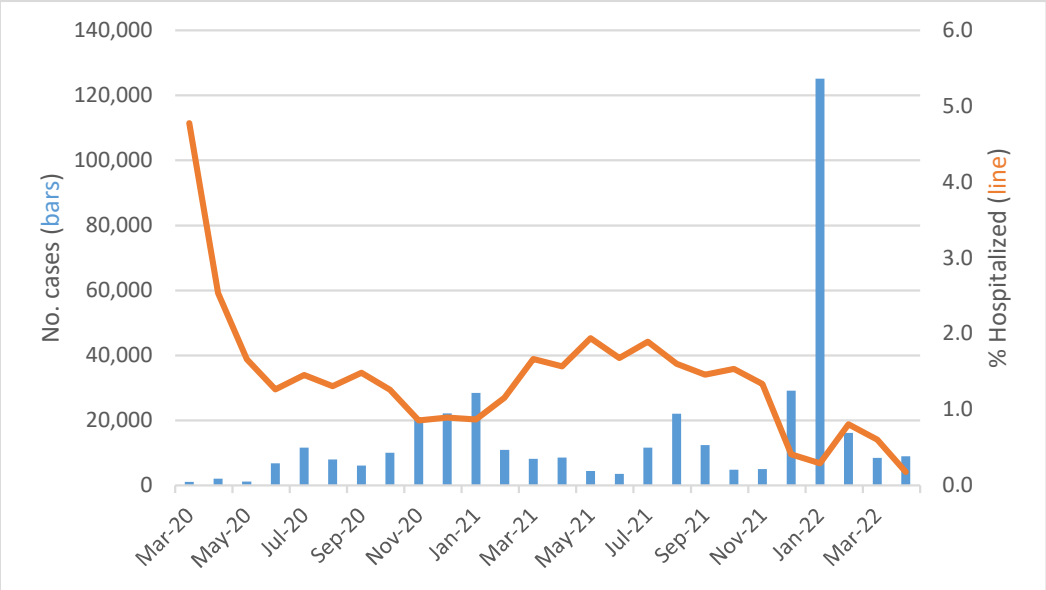
Table. COVID-19 cases, hospitalizations, and deaths among active duty service members, February 2020 - April 2022

	No. cases	No. hospitalizations	% hospitalizations	No. deaths
Feb-20	7	2	28.6	0
Mar-20	1,151	55	4.8	0
Apr-20	2,128	54	2.5	1
May-20	1,203	20	1.7	0
Jun-20	6,791	86	1.3	0
Jul-20	11,609	169	1.5	0
Aug-20	8,013	105	1.3	0
Sep-20	6,119	91	1.5	0
Oct-20	10,073	127	1.3	1
Nov-20	20,438	175	0.9	0

Dec-20	22,149	198	0.9	2
Jan-21	28,453	248	0.9	2
Feb-21	10,989	127	1.2	5
Mar-21	8,153	136	1.7	0
Apr-21	8,592	135	1.6	1
May-21	4,432	86	1.9	0
Jun-21	3,574	60	1.7	0
Jul-21	11,596	220	1.9	1
Aug-21	22,101	355	1.6	5
Sep-21	12,466	182	1.5	6
Oct-21	4,820	74	1.5	6
Nov-21	5,003	67	1.3	1
Dec-21	29,178	120	0.4	0
Jan-22	125,126	364	0.3	0
Feb-22	16,145	130	0.8	0
*Mar-22	8,451	51	0.6	0
*Apr-22	8,948	16	0.2	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 – April 2022



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

12. Internally, 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. Data through May 20, 2022 demonstrated that of the 636,914 COVID-19 cases within the DoD, 6,282 individuals were hospitalized and 688 have died,

including 96 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.

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. Immunizations are 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, reducing the risk of drug-drug interactions or adverse reactions to the treatment.

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. The COVID-19 vaccines developed using mRNA technology have resulted in several inaccurate claims.

- An initial claim is that mRNA vaccine clinical trials have never been studied in humans prior the implementation of mRNA COVID-19 vaccines. However, mRNA vaccines are and have been in various clinical trial phases for diseases such as influenza, Zika, rabies, and cytomegalovirus, with the earliest study starting in 2013 (rabies).[23] The consideration of mRNA technology use continues to expand. In March 2022, the National Institutes of Health launched a clinical vaccine trial using mRNA technology for those with Human Immunodeficiency Virus (HIV).[24] Outside of vaccines for infectious diseases, lipid nanoparticle-mRNA vaccines are also in clinical trials for those with certain cancers, such as melanoma, ovarian cancer, and breast cancer.[25]

- A second claim is that the mRNA in the COVID-19 vaccines can alter our DNA. The COVID-19 vaccine mRNA is encased in a lipid nanoparticle which is taken up by the cell. The mRNA is then translated to a protein for recognition by our immune system in the cytoplasm of the cell. DNA is not found in the cytoplasm – it's in the nucleus of the

[23] https://clinicaltrials.gov/, last accessed April 25, 2022

[24] https://www.nih.gov/news-events/news-releases/nih-launches-clinical-trial-three-mrna-hiv-vaccines, last accessed May 20, 2022.

[25] https://clinicaltrials.gov/ct2/results?cond=cancer&term=mRNA+vaccines&cntry=&state=&city=&dist=&Search=Search, last accessed May 20, 2022

cell. For mRNA to get into the nucleus, it has to cross the nuclear membrane but it does not have a nuclear access signal to do so.[26]

- A third claim is that COVID-19 vaccine mRNA technology is gene therapy, subject to different FDA safety requirements than what was conducted. However, the mRNA COVID-19 vaccines are not gene therapy. The companies Pfizer-BioNTech and Moderna developed their respective vaccines using a piece of genetic code from the SARS-CoV-2 virus to elicit an immune response in recipients. This is not the same thing as gene therapy, which restructures nucleic acids (DNA and RNA) to (potentially) cure disease. In gene therapy, a faulty gene is replaced with a functional gene. This is not to say that gene therapy does not exist. Clinical trials of gene therapy have shown some success in treating certain diseases, such as severe combined immune deficiency (i.e. "bubble boy" disease), hemophilia, and leukemia. Vaccines that use mRNA technology are not gene therapies because they do not alter a person's genes. A recently published study which reported the ability to reverse transcribe the Pfizer COVID-19 mRNA vaccine *in vitro* into a human liver cell line[27] followed a separate study by Zhang which reported that SARS-CoV-2 RNA (from the disease, not the vaccine) can be reverse transcribed and integrated into the genome of human cells.[28] The study design by Zhang and colleagues was challenged and

[26] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/mrna.html, last accessed May 20, 2022

[27] Alden M, et al. Intracellular Reverse Transcription of Pfizer BioNTech COVID-19 mRNA Vaccine BNT162b2 In Vitro in Human Liver Cell Line. *Curr. Issues Mol. Biol*. 2022, 44, 1115-1126. https://doi.org/10.3390/cimb44030073.

[28] Zhang L, et al. Reverse-transcribed SARS-CoV-2 RNA can integrate into the genome of cultured human cells and can be expressed in patient-derived tissues. *Proc. Natl. Acad. Sci*. USA 2021, 118, e2105968118. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8166107/pdf/pnas.202105968.pdf.

to date his findings have not yet been duplicated.[29,30] The study by Alden, who suggests that the Pfizer COVID-19 mRNA vaccine could be reverse transcribed in to the human liver cell line, was quickly challenged as well.[31] First, the study involved a liver cancer cell line, which is not representative of normal cells. Additionally, the amount of vaccine used in the experiment (2 mcg/mL of vaccine to 200,000 cells) is far higher than the amount of vaccine adults receive through the vaccination (30 mcg/dose to the individual, made up of trillions of cells). Next, the study does not show evidence of uptake in the nucleus, where DNA is located. Rather, uptake was only seen in the cytoplasm (which is outside the nucleus). In summary, there is no evidence that mRNA COVID-19 vaccine alter a person's genes.

17. According to the CDC, over 581 million doses of COVID-19 vaccine have been given in the United States from December 14, 2020, through May 16, 2022.[32] Evidence consistently shows that the incidence of COVID-19-associated hospitalizations and deaths are higher in unvaccinated than vaccinated persons, even in Omicron predominance. During the week

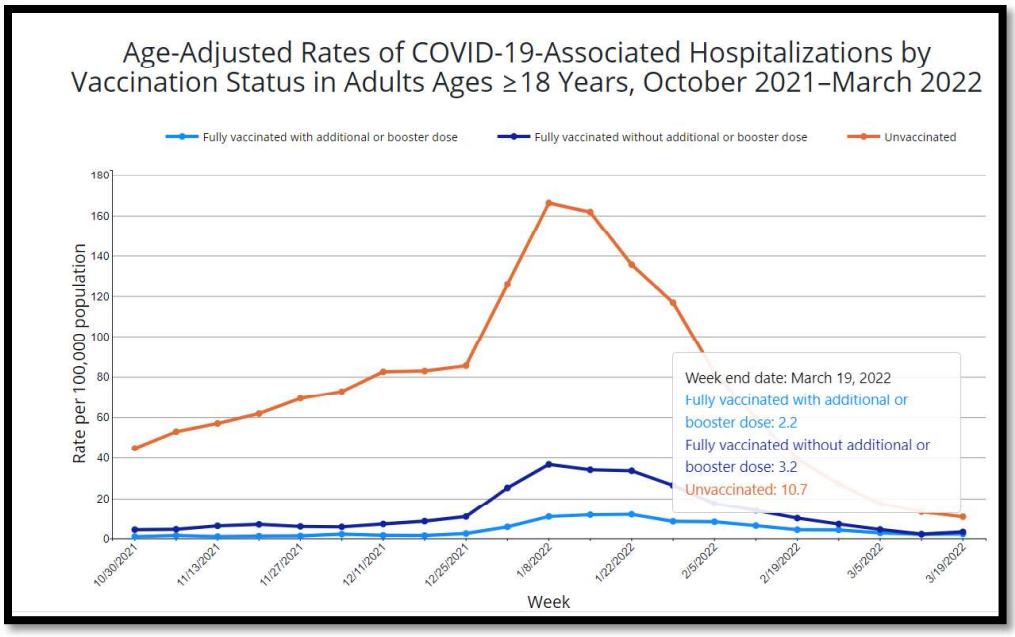
[29] Parry R., et al. No evidence of SARS-CoV-2 reverse transcription and integration as the origin of chimeric transcripts in patient tissues, *Proc. Natl. Acad. Sci* 118 (33) e2109066118, August 3, 2021 https://www.pnas.org/doi/10.1073/pnas.2109066118.

[30] Kazachenka A, and Kassiotis G. SARS-CoV-2 Host Chimeric RNA-Sequencing Reads to Not Necessarily Arise From Visru Integration Into the Host DNA *Front. Microbiol.,* 02 June 2021 | https://doi.org/10.3389/fmicb.2021.676693.

[31] Merchant HA, Comment on Aldén et al. Intracellular Reverse Transcription of Pfizer BioNTech COVID-19 mRNA Vaccine BNT162b2 In Vitro in Human Liver Cell Line. *Curr. Issues Mol. Biol*. 2022,44, 1115–1126 https://safe.menlosecurity.com/doc/docview/viewer/docN754220A02DC32e462aaa249407362c1dc12a6e06fe2cbeb2a5768306187446bfe7510b679f45

[32] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html, last accessed May 20, 2022.

ending March 19, 2022, the rate of COVID-19 associated hospitalization was 2.2 per 100,000 in those who were fully vaccinated with an additional or booster dose; 3.2 per 100,000 in those who were fully vaccinated without an additional or booster dose; and 10.7 per 100,000 in those who were unvaccinated.[33]

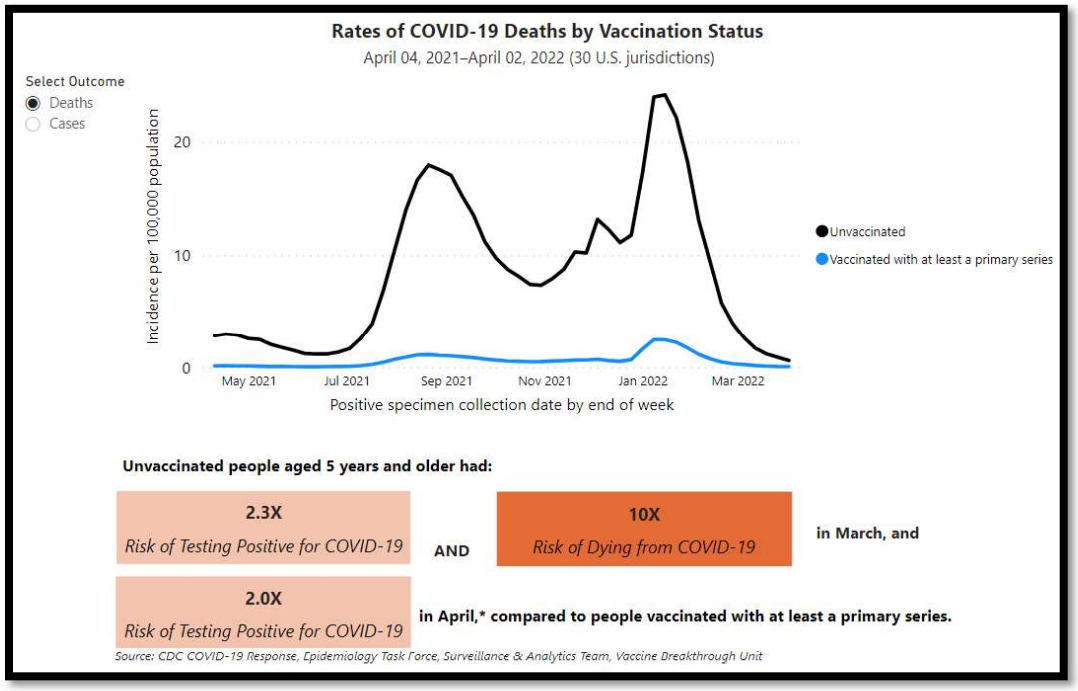


According to CDC data in March 2022, unvaccinated persons 5 years of age and older had a 2.3 times greater risk of testing positive for COVID-19 and a 10 times greater risk of dying from COVID-19 compared to fully vaccinated individuals, and unvaccinated persons 12 years of age and older had a 1.9 times greater risk of testing positive for COVID-19 and 17 times greater risk of dying from COVID-19 compared to fully vaccinated adults with a booster dose.[34] In April 2022, unvaccinated persons aged 5 years and older had a 2.0 times greater risk of testing positive

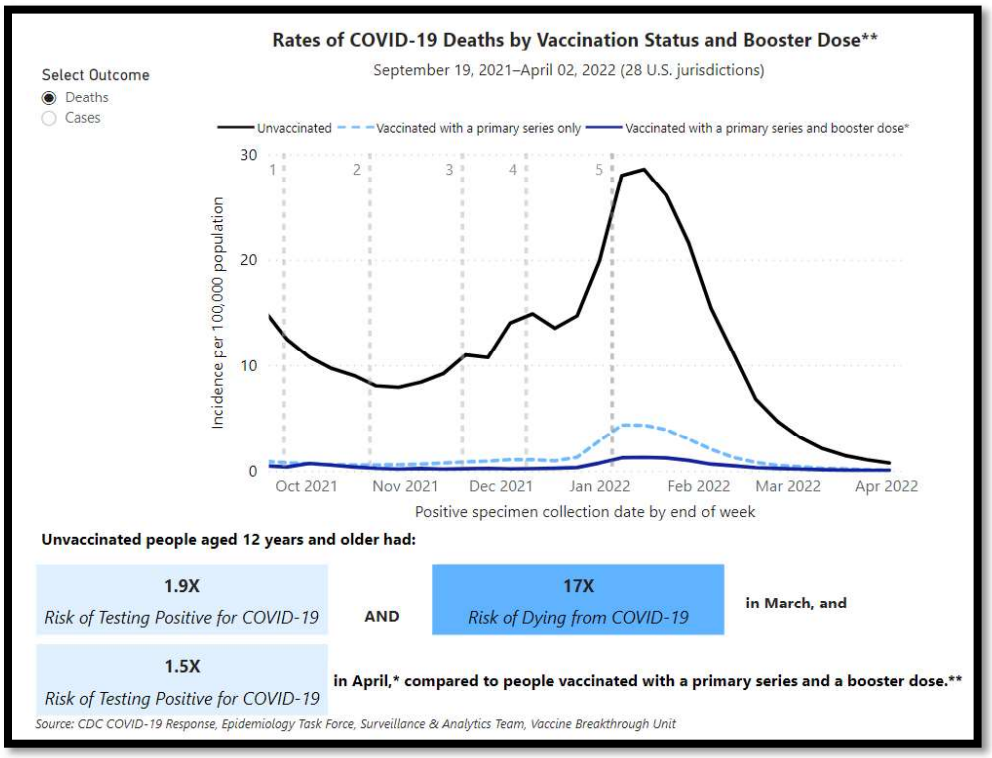
[33] https://covid.cdc.gov/covid-data-tracker/#covidnet-hospitalizations-vaccination, last accessed May 20, 2022.

[34] https://covid.cdc.gov/covid-data-tracker/#rates-by-vaccine-status, last accessed May 20, 2022.

for COVID-19 compared to people vaccinated with at least the primary series and those unvaccinated persons 12 years of age and older had a 1.5 times greater risk of testing positive for COVID-19 compared to fully vaccinated people with a booster dose.[35]



[35] *Id.*



18. As of May 18, 2022, DoD immunization sites have administered over 8.2 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 May 13, 2022, a total of 8,862 unique VAERS reports associated with COVID-19 vaccine (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.

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

20. 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."[36] 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."[37] As described below, the manufacturers of the lab tests 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 results does not meet "evidence of immunity." The presence of antibodies is not the same thing as being immune.

21. 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. Growing epidemiologic evidence indicates that vaccination following infection further increases protection from subsequent infection and hospitalization, including in the setting of increased circulation of more infectious SARS-CoV-2 strains…Viral testing to assess for acute SARS-CoV-2 infection or serologic

[36] https://www.cdc.gov/healthyschools/bam/diseases/vaccine-basics.htm, last accessed May 20, 2022.

[37] https://www.fda.gov/consumers/consumer-updates/coronavirus-disease-2019-testing-basics, last accessed May 20, 2022.

testing to assess for prior infection is not recommended for the purpose of vaccine decision-making."[38]

22. 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 correlates of protection have not been established and antibody testing does not evaluate the cellular immune response."[39]

23. 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.

24. 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.

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[38] 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, last accessed May 20, 2022.

[39] *Id.*

25. "Herd immunity" is an epidemiologic concept that explains how a community may be protected from an infectious disease that is human-to-human transmitted.[40,41] Herd immunity can be achieved through vaccination or through natural infection, if enough individuals 1) survive the disease and 2) mount a life-long immune response. Safe and effective vaccines are unequivocally considered the safer approach to a vaccine-preventable disease as compared to the unpredictable response that an individual may have to exposure to disease, as described above. When a large proportion of a community is immune, vulnerable members of the community are indirectly protected because their chance of infection exposure is very low. Herd immunity does not eliminate risk, but the phenomenon means that population risk is greatly reduced. Herd immunity is only possible when humans are the only source of infection transmission, when immunity can be clearly established to prevent lifelong infection and transmission, and when an adequate proportion of the population can safely develop immunity to protect all others. Measles (rubeola virus infection) is a classic example of the successful application of the concept of herd immunity. It is important to recognize that there is no disease where a successful vaccination program would cease once a certain level of immunity is reached, unless the disease is considered eradicated (i.e. smallpox in humans). The CDC recommends children continue to receive routine immunizations for diseases that we have not seen in this country for many years (i.e., polio) or rarely see (i.e. epiglottitis from *Haemophilus influenza*) so the vaccine preventable disease does not resurge. The Department of Defense vaccine program follows these same principles.

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[40] Desai AN, Majumder MS. What Is Herd Immunity? *Journal of American Medical Association.* 2020;324(20):2113. doi:10.1001/jama.2020.20895.

[41] 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.

26. 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.[42,43]

27. The 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 immune status from an antibody level, a correlate of protection 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.

28. Those who receive the COVID-19 vaccine contribute to the information available from studying the outcomes from 581 million doses administered in the US and over the 11.75 billion doses administered globally.[44] Antibody response to vaccination is more consistent and

[42] https://www.cdc.gov/measles/cases-outbreaks.html, last accessed May 20, 2022.

[43] National Update on Measles Cases and Outbreaks — United States, January 1–October 1, 2019. Vol 68 No 40 https://www.cdc.gov/mmwr/volumes/68/wr/pdfs/mm6840e2-H.pdf

[44] https://ourworldindata.org/covid-vaccinations?country=OWID_WRL, last accessed May 20, 2022.

there is minimal risk compared to the potential long-term complications and treatments needed to treat COVID-19 disease and its consequences. 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.[45] As of May 13, 2022, data of DoD Active Duty breakthough COVID-19 infection cases following vaccination demonstrates that the cumulative hospitalization for unvaccinated individuals is 782/100,000, the cumulative hospitalization for those fully vaccinated without a booster is 253/100,000 and those who received a booster is 247/100,000.

29. In October 2021, prior to the presentation of the Omicron variant, the newest SARS-CoV2 variant of concern, CDC summarized a review of 96 peer-reviewed and preprint publications, providing an overview of current scientific evidence regarding infection-induced immunity.[46] 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.

[45] 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, https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.html.

[46] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html, last accessed May 23, 2022.

- 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.
- Current evidence indicates that the level of protection may not be the same for all viral variants.
- The body of evidence for infection-induced immunity is more limited than that for vaccine-induced immunity in terms of the quality of evidence (e.g., probable bias towards symptomatic or medically-attended infections) and types of studies (e.g., observational cohort studies, mostly retrospective versus a mix of randomized controlled trials, case-control studies, and cohort studies for vaccine-induced immunity). There are insufficient data to extend the findings related to infection-induced immunity at this time to persons with very mild or asymptomatic infection or children.

30. Debate continues about whether natural immunity versus vaccine-induced immunity is more protective against outcomes from breakthrough infections (a reinfection in someone who was previously infected versus an infection in a previously not infected individual who was fully immunized). A, retrospective study from Israel during a period of Delta

dominance 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.[47] However, an observational study,[48] also out of Israel, compared adverse events in 884,828 Pfizer-BioNTech vaccinated matched unvaccinated individuals in addition to comparing 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). Additional comparisons between adverse events following COVID-19 vaccine and complications following COVID-19

[47]Gazit S, Shlezinger R et al. SARS-CoV-2 Naturally Acquired Immunity vs Vaccine-induced Immunity, Reinfections versus Breakthrough Infections: a Retrospective Cohort Study. Clin Infect Dis . 2022 Apr 5;ciac262.doi: 10.1093/cid/ciac262

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

disease can also be observed in the following figure.

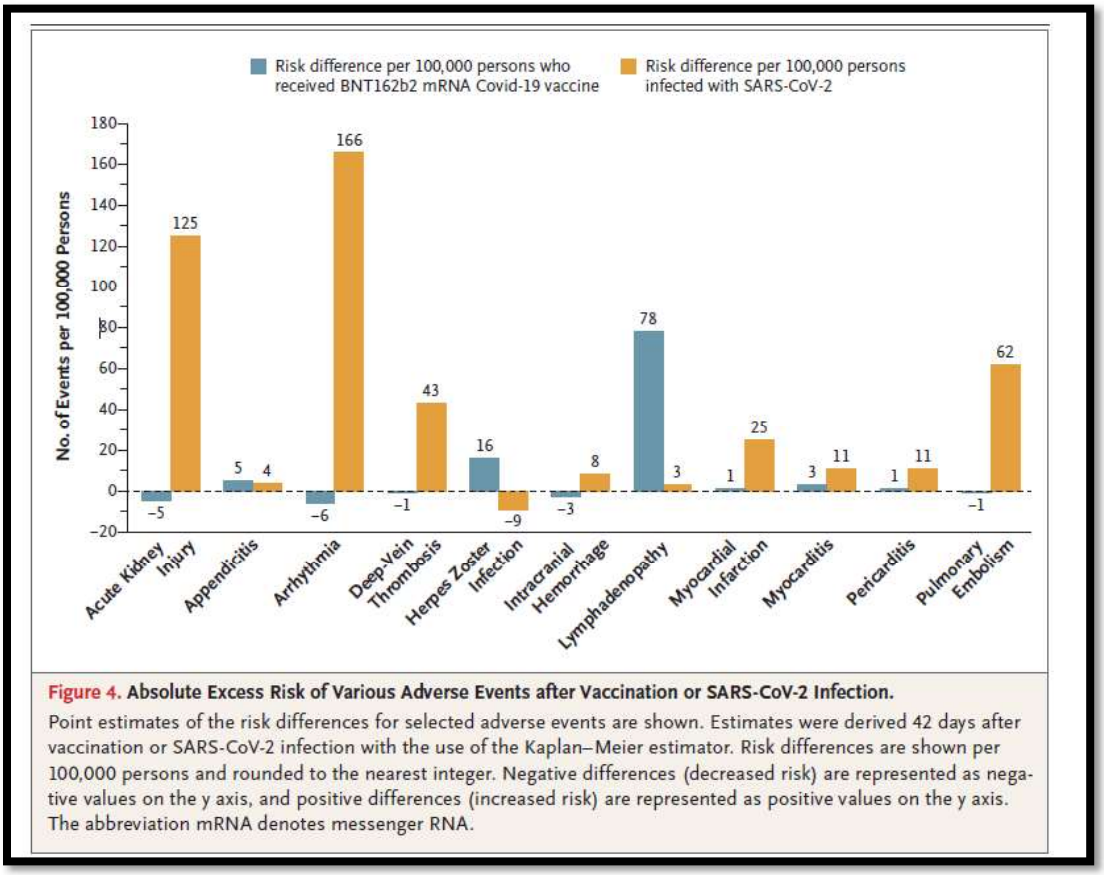

Figure 4. Absolute Excess Risk of Various Adverse Events after Vaccination or SARS-CoV-2 Infection.
Point estimates of the risk differences for selected adverse events are shown. Estimates were derived 42 days after vaccination or SARS-CoV-2 infection with the use of the Kaplan–Meier estimator. Risk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

The Omicron variant

31. On November 26, 2021, the World Health Organization (WHO) designated the Omicron variant (Pango lineage B.1.1.529), first identified in November 2021 in Botswana and South Africa, a "variant of concern" upon recommendations of the Technical Advisory Group on SARS-CoV-2 Virus Evolution, which assesses if specific mutations and combinations of mutations alter the behavior of the virus.[49] The United States designated Omicron as a variant of

[49] https://www.who.int/news/item/26-11-2021-classification-of-omicron-(b.1.1.529)-sars-cov-2-variant-of-concern, last accessed May 23, 2022.

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.[50] 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."[51]

32. Compared to the other COVID-19 variants of concern (Alpha, Beta, Gamma, and Delta), the Omicron variant is the most highly mutated strain, with at least 50 mutations within the genome and at least 32 mutations in the spike protein alone. This can result in increased infectivity and immune escape of the Omicron variant compared with the early wild-type strain and the other four VOCs.[52] The receptor binding domain (RBD) of the spike protein 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

[50] https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html, last accessed May 23, 2022.

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

[52] Tian D The emergence and epidemic characteristics of the highly mutated SARS-CoV-2 Omicron variant J Med Virol. 2022 Jun;94(6):2376-2383. doi: 10.1002/jmv.27643. Epub 2022 Feb 11.

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 Spike 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.

33. Multiple investigators turned their attention to assessing antibody effectiveness against the Omicron variant in COVID-19 disease survivors compared to vaccine recipient. 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.[53] The better the neutralization, the better the protection. Results showed that the Omicron variant was totally or partially resistant to neutralization by all mAbs tested. Sera from those vaccinated, sampled 5 months after being fully vaccinated, had limited inhibition of the Omicron variant. 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[54] also demonstrated that those

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[53] 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).

[54] Rossler A., et al SARS-CoV-2 Omicron Variant Neutralization in Serum from Vaccinated and Convalescent Persons, *N Engl J Med* 2022; 386:698-700https://www.nejm.org/doi/full/10.1056/NEJMc2119236.

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.[55] 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 "Omicron" 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 against the Omicron variant. In Figures 1d and 1e, (2 doses of either Pfizer-BioNTech or Moderna), there is some neutralization against Omicron. Those who received a booster (Figure 1f and 1g) had higher levels of neutralization against Omicron compared to the two-dose primary series. Those who had a history of disease and were then vaccinated with a two-dose primary series or a two-dose primary series and a booster (Figures 1h-1j) had better Omicron neutralization. In summary, the study found that neutralizing activity against Omicron "is most impacted in unvaccinated, convalescent individuals and in naïve individuals who acquired immunity through two mRNA COVID-19

[55] Carreño, J.M., Alshammary, H., Tcheou, J. *et al.* Activity of convalescent and vaccine serum against SARS-CoV-2 Omicron. *Nature* 602**,** 682–688 (2022). https://doi.org/10.1038/s41586-022-04399-5 https://www.nature.com/articles/s41586-022-04399-5.

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%."[56]

[56] *Id.* at 2.

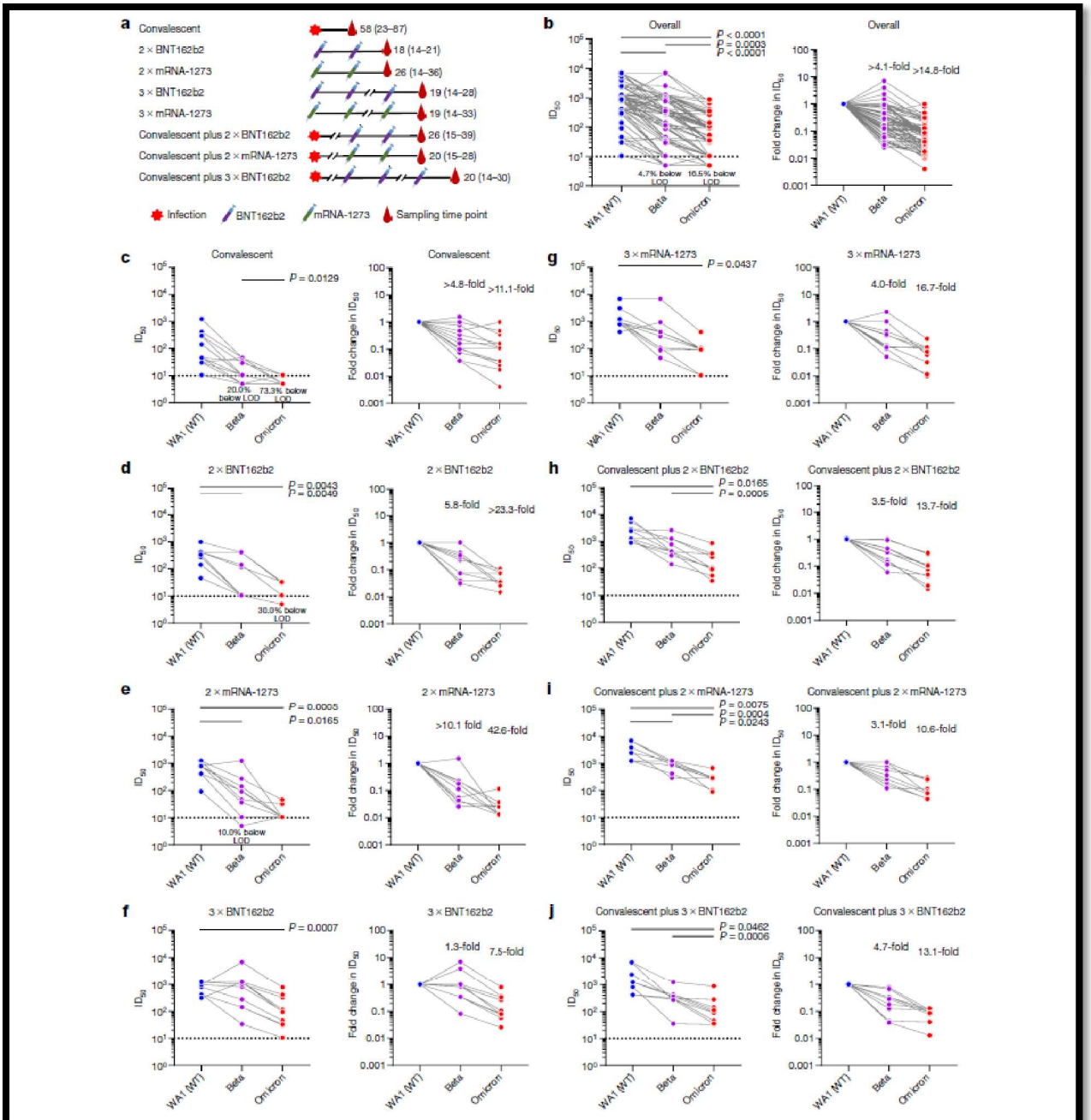
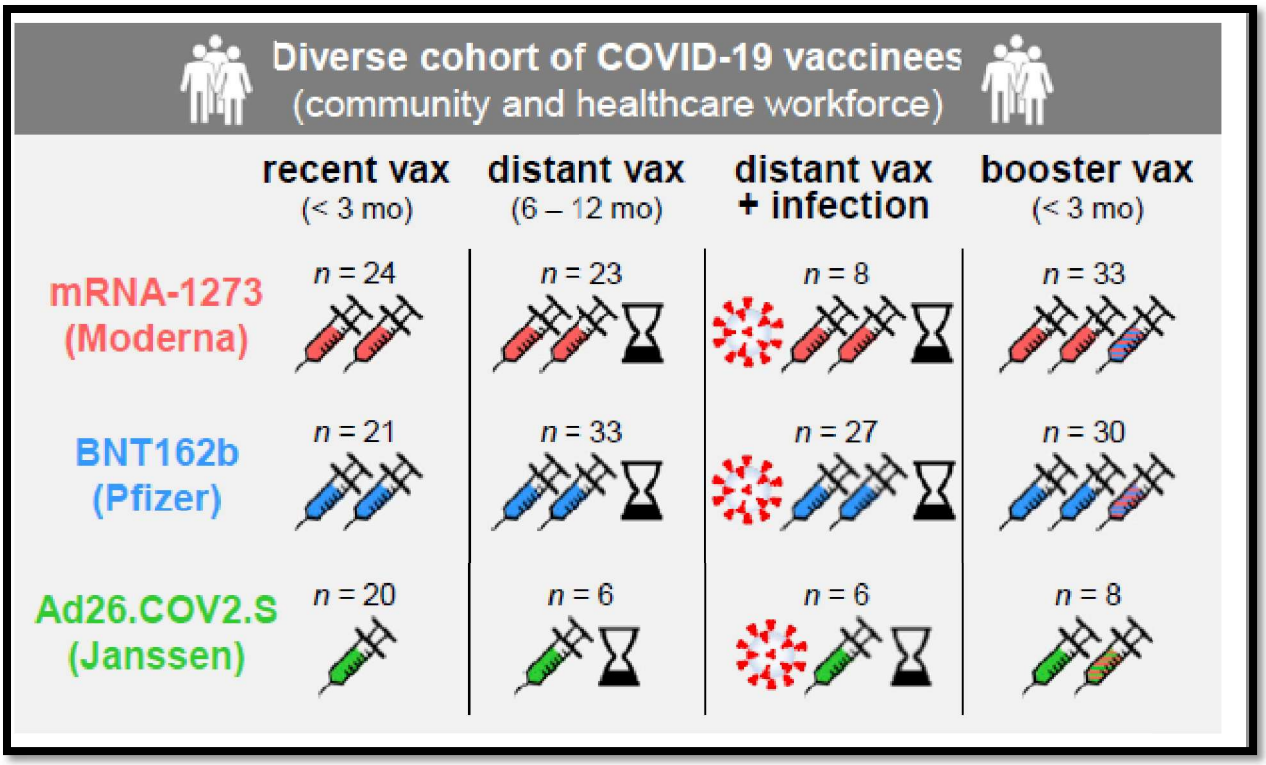


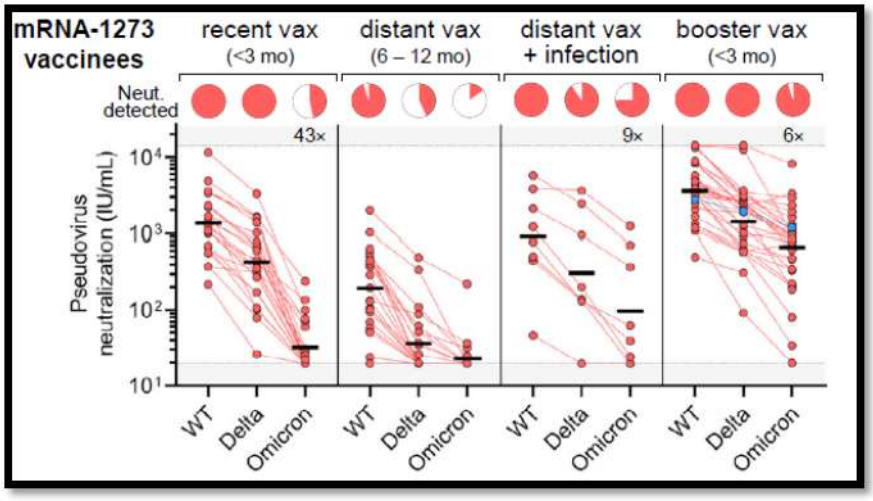
Fig. 1 | Sera from convalescent and vaccinated individuals exhibit strongly reduced neutralizing activity against Omicron compared with wild type SARS-CoV-2. a, Overview of different exposure groups from whom samples were obtained. Further details are provided in Supplementary Tables 1, 2. **b**, Absolute titres (left) and fold reduction (right) for neutralization by all serum samples of wild-type (WA1 (WT)), Beta and Omicron SARS-CoV-2 variants. **c**–**j**, Neutralization of wild-type (WA1 (WT)), Beta and Omicron SARS-CoV-2 variants by sera from convalescent individuals (**c**), after two BNT162b2 vaccinations (**d**), after two mRNA-1273 vaccinations (**e**), after three BNT162b2 vaccinations (**f**), after three mRNA-1273 vaccinations (**g**), from convalescent individuals after two BNT162b2 vaccinations (**h**), from convalescent individuals after two mRNA-1273 vaccinations (**i**) and from convalescent individuals after three BNT162b2 vaccinations (**j**). One-way ANOVA with Tukey's multiple comparisons test was used to compare the neutralization titres; $P < 0.05$ indicated. $n = 85$ (**b**), 15 (**c**), or 10 (**d**–**j**) samples. 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 the geometric mean fold change.

34. An additional study[57] 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 (< 3 months), distant vaccination (6-12 months), history of infection and distant vaccination, and recent booster vaccination (< 3 months), as depicted below.

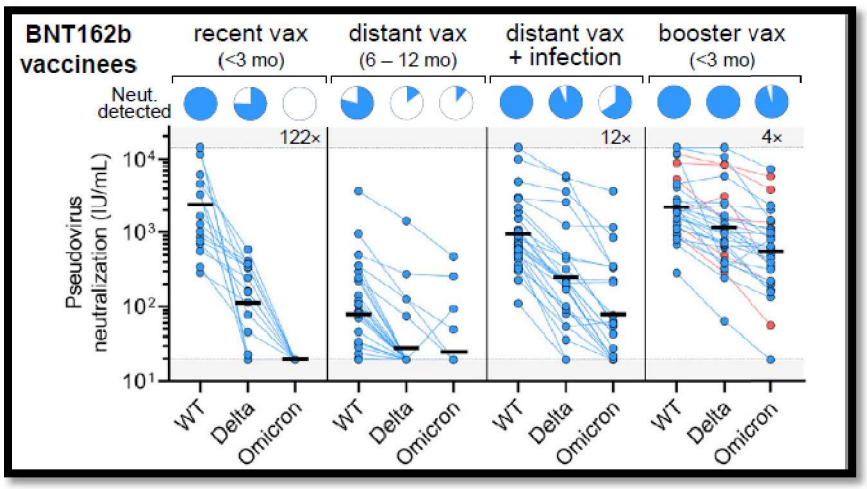


35. Against the Omicron variant, recent (< 3 months) vaccine recipients exhibited a 43-fold lower neutralization than against the wild type (WT) strain. Those with a history of vaccination and infection had a 9-fold decrease in neutralization than WT, whereas those who received a booster dose less than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

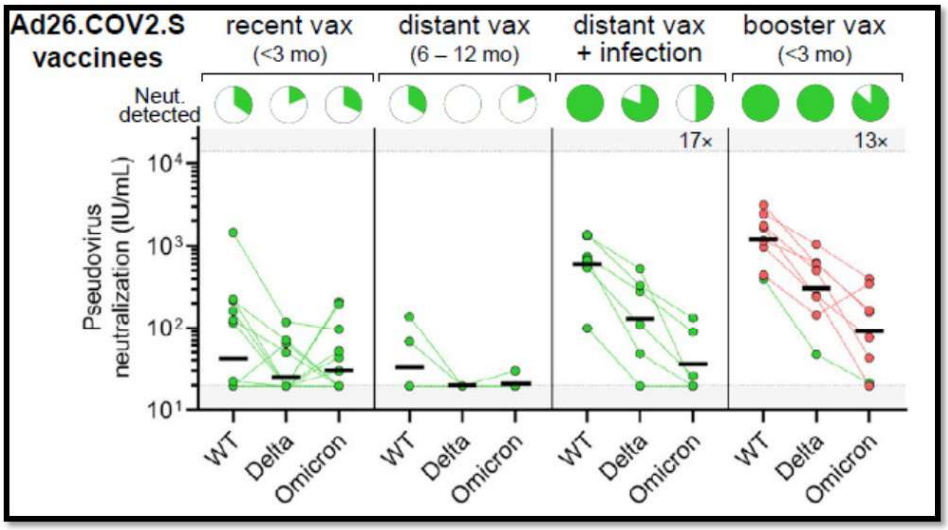
[57] Garcia-Beltran WF, et al mRNA-based COVID-19 vaccine boosters induce neutralizing immunity against SARS-CoV-2 Omicron variant. *Cell* 2022 Feb 3;185(3):457-466.e4. doi: 10.1016/j.cell.2021.12.033.



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



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



38. 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.[58] 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

[58] 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 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[59]. 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 has ranged between 29-48% over the last 5 seasons.[60]

39. 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.[61] 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-

[59] 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. Morb Mortal. Wkly Rep 2022;71:1-9. DOI: https://www.cdc.gov/mmwr/volumes/71/wr/mm7107e2.htm.

[60] https://www.cdc.gov/flu/vaccines-work/past-seasons-estimates.html, last accessed May 23, 2022.

[61] 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. 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." Moreover, a recent analysis of data from a multistate hospital network on severe COVID-19 outcomes during the Alpha, Delta, and Omicron waves found that "receipt of 2 or 3 doses of a COVID-19 mRNA vaccine conferred 90% protection against COVID-19 associated invasive mechanical ventilation (IMV) or in-hospital death among adults… Among immunocompetent adults with no chronic medical conditions, vaccine efficacy for 2 or 3 doses was 98%... Protection against IMV or death was consistent throughout the Delta and Omicron periods and was higher in adults who received a third vaccine dose, including 94% during the Omicron period." [62]

40. 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 and continues to be protective against severe disease, hospitalization, and death. The longer the interval from vaccination or natural infection, the increased risk for breakthrough disease. Vaccination and a history of disease was shown to be less protective than vaccination and booster dose against both the Delta and Omicron variants. 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 provides the most robust protection against initial infection, severe illness, hospitalization, long-term sequelae, and death."[63]

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[62] Mark W. Tenforde, MD, et al. Effectiveness of mRNA Vaccination in Preventing COVID-19-Associated Inveasive Mechanical Ventialation and Death – United States, March 2021–January 2022. MMWR Morb Mortal. Wkly Rep 2022; 71:459-465. Available at: https://www.cdc.gov/mmwr/volumes/71/wr/pdfs/mm7112e1-H.pdf.

[63] 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-

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.[64] CDC updates as of May 16, 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** and has occurred in approximately 4 cases per one million doses administered. TTS is a rare but serious adverse event that causes blood clots in large blood vessels and low platelets (blood cells that help form clots). A review of reports indicates a causal relationship between the J&J/Janssen COVID-19 vaccine and TTS.

C. **Guillain-Barre (GBS) in people who have received the J&J/Janssen COVID-19 vaccine is rare.** GBS is a rare disorder where the body's immune system damages nerve cells, causing muscle weakness and sometimes paralysis. Most people fully recover from GBS, but some have permanent nerve damage. GBS has largely been reported in men ages 50 years and older. Based on a recent analysis of data from the Vaccine Safety Datalink, the rate of GBS within the first 21 days following J&J/Janssen COVID-19 vaccination was found to be 21 times higher than after Pfizer-

November 2021. MMWR Morb Mortal. Wkly Rep 2022;71:125-131. January 28, 2022 http://dx.doi.org/10.15585/mmwr.mm7104e1.

[64] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html, last accessed April 25, 2022.

BioNTech or Moderna (mRNA COVID-19 vaccines). After the first 42 days, the rate of GBS was 11 times higher following J&J/Janssen COVID-19 vaccination. The analysis found no increased risk of GBS after Pfizer-BioNTech or Moderna (mRNA COVID-19 vaccines).

D. **Myocarditis and pericarditis after COVID-19 vaccination are rare.** Myocarditis is inflammation of the heart muscle, and pericarditis is inflammation of the outer lining of the heart. Most patients with myocarditis or pericarditis after COVID-19 vaccination responded well to medicine and rest and felt better quickly. Most cases have been reported after receiving Pfizer-BioNTech or Moderna (mRNA COVID-19 vaccines), particularly in male adolescents and young adults. A review of vaccine safety data in VAERS from December 2020–August 2021 found a small but increased risk of myocarditis after mRNA COVID-19 vaccines. Over 350 million mRNA vaccines were given during the study period and CDC scientists found that rates of myocarditis were highest following the second dose of an mRNA vaccine among males in the following age groups:

- 12–15 years (70.7 cases per one million doses of Pfizer-BioNTech)
- 16–17 years (105.9 cases per one million doses of Pfizer-BioNTech)
- 18–24 years (52.4 cases and 56.3 cases per million doses of Pfizer-BioNTech and Moderna, respectively)

As of May 12, 2022, there have been 968 reports in VAERS among people younger than age 18 years under review for potential cases of myocarditis and pericarditis. Of those, 250 remain under review. Through confirmation of symptoms and diagnostics by provider

interview or review of medical records, 668 reports have been verified. See the following for a breakdown of reports by age group.

- 5-11 years: 22 verified reports of myocarditis after 18,439,324 doses administered
- 12-15 years: 348 verified reports of myocarditis after 23,288,179 doses administered
- 16-17 years: 298 verified reports of myocarditis after 12,687,076 doses administered

Multiple studies and reviews of data from vaccine safety monitoring systems continue to show that vaccines are safe. As the COVID-19 vaccines are authorized for younger children, CDC and FDA will continue to monitor for and evaluate reports of myocarditis and pericarditis after COVID-19 vaccination and will share more information as it becomes available.

E. **Reports of death after COVID-19 vaccination are rare**. 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.** More than 581 million doses of COVID-19 vaccines were administered in the United States from December 14, 2020, through May 16, 2022. During this time, VAERS received 14,680 preliminary reports of death (0.0025%) among people who received a COVID-19 vaccine. CDC and FDA clinicians review reports of death to VAERS including death certificates, autopsy, and medical records. Continued monitoring has identified nine deaths causally associated with J&J/JanssenCOVID-19 vaccination. CDC and FDA continue to review reports of

death following COVID-19 vaccination and update information as it becomes available.

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.[65] In March 2022, Rosenblum, et al., published safety data captured by VAERS reports and v-safe, a new active surveillance system, during the first 6 months of the US COVID-19 vaccination program. During that time, a total of 340,522 VAERS reports were processed following administration of more than 298 million doses of mRNA COVID-19 vaccine. Of these VAERS reports, 313,499 (92.1%) were not serious and managed outside of the hospital setting, 22,527 (6.6%) were serious (defined as inpatient hospitalization, prolongation of hospitalization, permanent disability, life-threatening illness, congenital anomaly or birth defect) and 4,496 (1.3%) were deaths. Over half of the 4,914,583 v–safe participants self-reported local (i.e injection site pain) and systemic (i.e fever) symptoms, most commonly after dose two. COVID-19 vaccine

[65] https://www.who.int/news/item/27-10-2021-gacvs-statement-myocarditis-pericarditis-covid-19-mrna-vaccines-updated, last accessed May 20, 2022.

safety monitoring has been the "most comprehensive in US history". Most reported adverse events captured by VAERS or v-safe were mild and short in duration. The authors report that the mRNA COVID-19 vaccine post-authorization safety profile that was generally consistent with pre-authorization trials and early post-authorization surveillance reports. They conclude by stating "vaccines are the most effective tool to prevent serious COVID-19 disease outcomes and the benefits of immunisation in preventing serious morbidity and mortality strongly favour vaccination."[66]

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[67] lists approximately 90 products, of which all of them had one of the following three statements about immunity interpretation:

A. "You should not interpret the results of this test as an indication or degree of immunity or protection from reinfection."[68]

[66] Rosenblum HG., et al Safety of mRNA vaccines administered during the initial 6 months of the US COVID-19 vaccination programme: an observational study of reports to the Vaccine Adverse Event Reporting System and v-safe *Lancet Infect Dis*. 2022 Mar 7;S1473-3099(22)00054-8 https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(22)00054-8/fulltext.

[67] https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/eua-authorized-serology-test-performance, last accessed May 20, 2022.

[68] https://www.fda.gov/media/146369/download, last accessed May 20, 2022.

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."[69]

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."[70]

The Continued Need for COVID-19 Vaccination

44. Decreasing COVID-19 infections, hospitalizations, and/or deaths, combined with the lifting of mask mandates, loosening of travel restrictions, and the desire to return to a "normal" environment may indicate to some that there is no longer a need to mandate vaccination or to enforce it. To the contrary, continued vaccination remains essential to protecting against serious illness, hospitalization, and death; is key to limiting the opportunities for the virus to mutate (thus causing new variants); and is necessary in reducing public risks that could require future safety measures such as travel restrictions and reinstituting public health measures. The COVID-19 landscape just in the past few weeks has tempered some of the excitement of an imminent pandemic exit. As a country, we are only 66.5% fully vaccinated – a suboptimal environment for

[69] https://www.fda.gov/media/138627/download, last accessed May 20, 2022.

[70] https://www.fda.gov/media/137542/download, last accessed May 20, 2022.

seeking "herd immunity" if such an environment is even possible.[71] Other countries have far less of their population vaccinated.[72] A recent study, not yet peer-reviewed, showed that unvaccinated, not previously infected individuals who became infected with the Omicron variant are unlikely to develop protective immune responses against other variants. In other words, antibodies produced by the Omicron variant didn't offer a level of cross-protection from infection from other variants. Conversely, people with Omicron "breakthrough" infections after three doses of the mRNA vaccines designed to neutralize earlier versions of the virus had high levels of neutralizing antibodies against the two Omicron variants.[73]

45. On April 12, 2022, the Secretary of Health and Human Services renewed the determination that a public health emergency still exists.[74] As depicted in the following US community level chart, data between May 12-18 2002depicts an increasing number of counties with high COVID-19 community levels while low and medium community levels are decreasing (a worsening trend).[75]

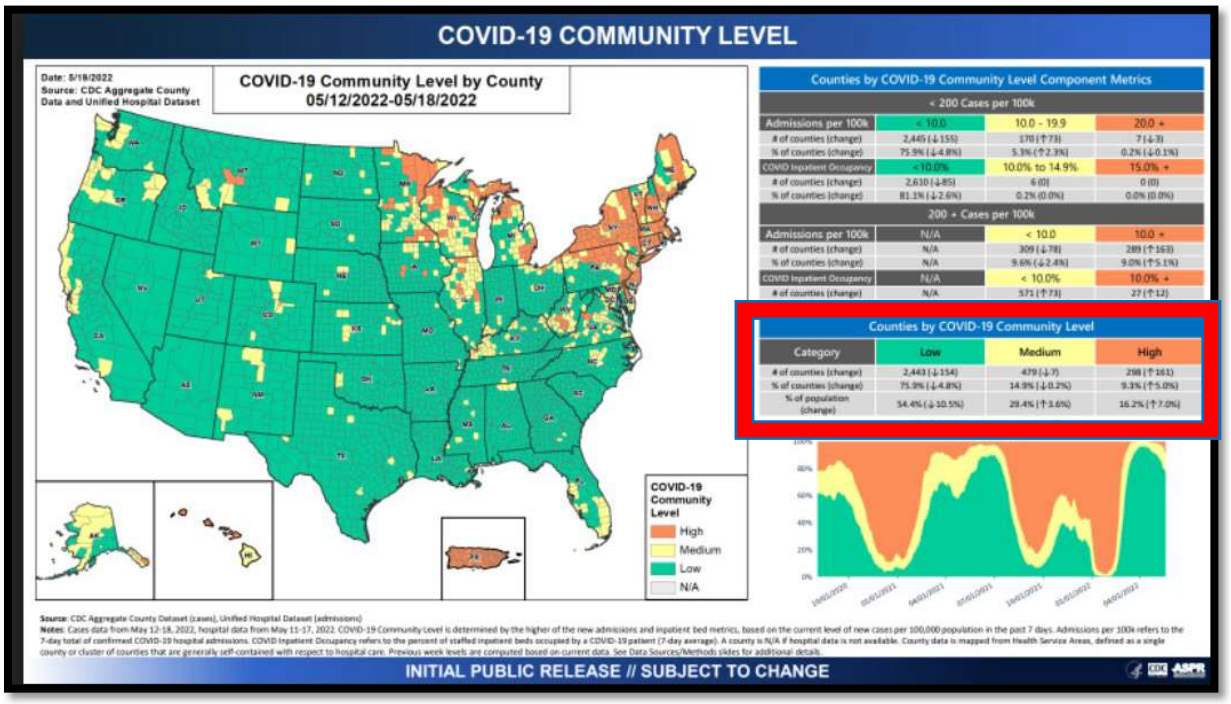
[71] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, last accessed May 23, 2022.

[72] https://ourworldindata.org/covid-vaccinations, last accessed May 23, 2022.

[73] Staisny K, et al Human primary Omicron BA.1 and BA.2 infections result in sub-lineage-specific neutralization, (preprint) posted April 13, 2022; https://doi.org/10.21203/rs.3.rs-1536794/v1.

[74] https://aspr.hhs.gov/legal/PHE/Pages/COVID19-12Apr2022.aspx, last accessed May 23, 2022.

[75] https://healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9, last accessed May 20, 2022.



46. Per CDC, the current 7-day daily average for May 11–17, 2022, was 3,250. This is a 24.2% increase from the prior 7-day average (2,617) from May 4–10, 2022.[76]

47. Although updated formulations of COVID-19 vaccines concerning more recent variants are undergoing clinical studies at present with encouraging preliminary results, most likely they will not be available, presuming efficacy and safety has been demonstrated to the FDA and CDC, until Fall 2022, as people start moving back indoors due to cooler weather. Exiting the COVID-19 pandemic requires global commitment and medical preparedness, particularly in those whose responsibilities, like the military, take them around the world. The Ukraine conflict, where millions of displaced families are congregated in close quarters and under high stress are a prime source for not only COVID-19 infection and other diseases, are a nidus for new COVID-19 variant

[76] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, last accessed May 23, 2022.

development and transmission – threats to which our service members, and the partner-nation-forces they work with, will be exposed. The concern of the virus and the possibility of increased infection and illness is on full display at this moment in China, which has re-implemented strict COVID-19 testing following a spike cases in the region.[77] Other countries are starting to see an uptick in cases as well.[78] The pandemic is not over. Accordingly, the DoD must utilize what is currently available to maintain the health of its population – and that includes vaccination which remains its most effective preventative and protective measure.

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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 May 24, 2022, in Falls Church, Virginia

RANS.TONYA.SUE.1081263031
Digitally signed by RANS.TONYA.SUE.1081263031
Date: 2022.05.24 11:44:37 -04'00'

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

[77] https://www.bbc.com/news/world-asia-china-61137649, last accessed May 26, 2022.

[78] https://coronavirus.jhu.edu/data/new-cases, last accessed May 23, 2022.

Exhibit 8

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF COLONEL ASHLEY HEYEN

I, Ashley Heyen, hereby state and declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as the Director of Assignments at the Department of the Air Force Air Reserve Personnel Center (ARPC). I have been in this position since September 2020. As a part of my duties, I am responsible for liaising with the Air Force and Air Force Reserve Personnel Center on military readiness programs. As a force support officer, I serve as the focal point for developing and interpreting both policy and guidance for Air Force Reserve (AFR) military readiness programs.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as the Director of Assignments at the Air Reserve Personnel Center and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. The Air Force Reserve IRR program serves as a resource pool of reservists who, if they meet readiness standards, may be eligible to return to the Selected Reserve in a participating status (traditional reservists are members of the Selected Reserve). Reassignment to the IRR

commences at the unit level, by a member's commander. The reassignment action is then processed by Headquarters Air Reserve Personnel Center and may take a few months. Officers with a military service obligation will remain in the IRR at least until their military service obligation expires and will also remain eligible for promotion. Members who have been reassigned to the IRR are not eligible for Tricare Reserve Select medical insurance benefits, but may be eligible for Tricare dental benefits, a DD Form 2 (green ID card) to access minimal base amenities, and a Montgomery GI Bill or Post 9-11 GI Bill if they have previously qualified for these benefits. Reserve Component members routinely transfer to and from the IRR in order to manage commitments in their personal lives (e.g., following the birth of a baby). The ability to step away from a service obligation to address personal matters is one of the main benefits of being able to transition to and from the IRR. Depending on the timing of the move and how long the member stays in the IRR, a reassignment to the IRR may not adversely affect a member's career.

4. An involuntary reassignment to the IRR allows the Air Force Reserve to transfer a member with remaining military service obligation to the IRR rather than discharging the member out of the Air Force. Members reassigned to the IRR are still able to return to a participating position (provided they meet all of the requirements for their position) with minimal effort and expediency versus having to be re-accessed as a new entry.

5. Air Reserve Personnel Center defines "separation" and "discharge" as follows: a "discharge" is a member being released from their obligation to continue service in the armed forces, and does not have any obligations to return to service. A "separation" is when the member is released from active duty, but still must complete their military reserve obligations.

Reassignment to the IRR is not a separation or discharge. A member in the IRR is still a member of the Air Force.

6. Barring misconduct, individuals that are assigned to the IRR that complete their military service obligation period are honorably discharged.

7. Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 20th day of May 2022.

HEYEN.ASHLEY.LEWIS.1095327636
Digitally signed by HEYEN.ASHLEY.LEWIS.1095327636
Date: 2022.05.20 10:08:21 -06'00'

ASHLEY L. HEYEN, Colonel, USAF
Director of Assignments

Exhibit 9

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF COLONEL PHILIP A. HOLMES
[with regard to "Air Force Engineer"]

I, Philip A. Holmes, hereby state and declare as follows:

1. I am a Colonel in the United States Air Force currently assigned as the Commander of the Air Force Installation and Mission Support Center, Detachment 8, located at Joint Base Langley-Eustis in Virginia. I have been in this position since July 18, 2019. As a part of my duties, I am responsible for leading Air Force Installation and Mission Support Center, Detachment 8, to accomplish its assigned mission and to safeguard the morale, physical well-being, and general welfare of all persons under my command.

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

3. I know the identity of Air Force Engineer. He is an active duty Major in Air Force Installation and Mission Support Center, Detachment 8, and I can provide Air Force Engineer's

name if required, consistent with the protective order in place in this case. I am Air Force Engineer's unit commander.

4. I am Air Force Engineer's immediate commander, although another subordinate in my unit is his immediate supervisor. Air Force Engineer is an active-duty Air Force member and is assigned as Chief of the Operations Support Branch. In this role, Air Force Engineer provides programming, budget, and execution support to Engineers within Air Combat Command. These roles include, but are not limited to, attending meetings virtually and in person, reviewing planning documents, and coordinating construction execution activities – such as the construction of new facilities and buildings – with bases across the country either virtually or in person.

5. Air Force Engineer is in a deployable position. The locations to which Air Force Engineer may deploy range from austere (or bare-base) to established locations with pre-existing building and infrastructure. In fact, in February 2022, Air Force Engineer was selected to deploy. However, since Air Force Engineer was and remains unvaccinated, he was unable to fulfill the deployment tasking due to the international travel requirements associated with the deployment. Based on the Combatant Commands'[1] determination,[2] vaccination was a

[1] The Department of Defense has 11 combatant commands, which are at the highest echelon of military command. Each combatant command has a geographic or functional mission that provides command and control of military forces, regardless of branch of service, in peace and war. The role of the individual services (e.g., Army, Air Force, Navy, etc.) is to organize, train, and equip service members. As directed based on mission needs, the services assign their forces for use by the combatant commands, who then exercise operational control and employ those forces to accomplish missions assigned to the combatant commander. As noted, some combatant commands are geographic, such as Central Command (CENTCOM), whose area of responsibility includes the Middle East. Others are functional, such as Special Operations Command (SOCOM), which utilizes the special operations units within the services to carry out special operations world-wide.

[2] Pursuant to Air Force Instruction (AFI) 48-110_IP, § 3-2(e)(3) "Combatant commanders, in coordination with the appropriate surgeons general or CG–11, establish specific immunization requirements based on a disease threat assessment. *These requirements may differ from standard Service immunization policies for personnel entering their area of responsibility to participate in exercises or other operational missions*. Immunize personnel on official deployment or travel orders in accordance

requirement for this deployment, and since Air Force Engineer was not vaccinated we had to submit a reclama for his selection. A reclama is when a unit notifies higher headquarters that they are unable to fulfill a requirement. In other words, the Air Force was required to locate a replacement and another Air Force member was required to deploy in his stead. This places additions burdens on other service members who may have to deploy more often in order to meet mission requirements Air Force Engineer cannot meet. In turn, this can impact the morale and welfare of service members. Lastly, depending on the timeline for a deployment, a reclama can result in delays in identifying, preparing, and deploying a replacement, which can negatively impact the Combatant Command's mission.

6. While at home station at Joint Base Langley-Eustis, Virginia, Air Force Engineer works in his Detachment's work center in an office environment. The entire detachment includes approximately 25 personnel. He acts in a supervisory role over four personnel, all of whom work in person on site.[3] Air Force Engineer shares a floor-to-ceiling office with another unit member. On a day-to-day basis, approximately 15 service members and civil service personnel are present in the Detachment work center. These additional personnel in his section sit in cubicles with varying degrees of separation from 6 - 10 feet of each other. The cubicles are arranged in a room with no floor to ceiling walls separating the personnel.

7. A majority of the personnel in the unit are civil service personnel with high individual or family risk factors for complications from COVID-19 based on CDC guidance (for example, pregnant, greater than 65 years old, immunocompromised, obese, asthma, etc.). For example,

with the specific guidance established by the combatant commander before departure." (emphasis added). This regulation is a joint regulation that applies to all branches of the Department of Defense.

[3] Out of the four personnel in his section, two recently retired or moved. Those positions will be refilled.

both of the personnel that Air Force Engineer currently supervises have high individual or family risk factors.

8. On August 24, 2021, the Secretary of Defense mandated that the military services begin full vaccination against the COVID-19 virus. On September 3, 2021 the Secretary of the Air Force directed that uniformed Airman and Guardians[4] be vaccinated against the virus, and that active-duty members must be fully vaccinated by November 2, 2021. On September 10, 2021, the Air Force Installation and Mission Support Center (AFIMSC) Commander ordered all AFIMSC active-duty military personnel to become fully-vaccinated against COVID-19 no later than November 2, 2021. On September 20, 2021, Air Force Engineer submitted a religious accommodation request to be exempt from the requirement to receive the COVID-19 vaccination, in accordance with Department of the Air Force Instruction (DAFI) 52-201, *Religious Freedom in the Department of the Air Force*. Air Force Engineer was provided a temporary exemption from the vaccination requirement while their religious accommodation request was processed. On September 21, 2021, in accordance with Air Force policy, I counseled Air Force Engineer that noncompliance with the vaccination requirement may have an adverse impact on his deployment readiness, assignments, and international travel, and may result in other administrative consequences. On September 21, 2021, Air Force Engineer met with an Air Force Chaplain and was counseled by a military physician concerning his religious exemption request in accordance with Air Force policy. The request was reviewed and routed through the chain of command for endorsements and recommendations pursuant to the procedures established by DAFI 52-201.

[4] Space Force personnel are called "Guardians."

9. On December 16, 2021, the Commander of Air Force Materiel Command (AFMC) denied Air Force Engineer's request for a religious accommodation from the COVID-19 vaccination requirement. The Approval Authority found there was a compelling government interest in requiring Air Force Engineer be vaccinated because, "As Chief, Operations Support Branch for AFIMSC Det 8," Air Force Engineer "manage[s] civil engineer personnel, programs and projects, and [is] subject to short-notice deployment; being unvaccinated restricts [his] role and increases the impact on the rest of [his] team." The Approval Authority also found that Air Force Engineer not being vaccinated would "undermin[e] [his] unit's ability to fully respond to mission or contingency requirements."[5] The Approval Authority also noted the health risks to Air Force Engineer in not being vaccinated. In addition, he found that less restrictive means were insufficient to meet the compelling government interest in Air Force Engineer's vaccination because the totality of mitigation measures—including 100% telework, social distancing and masking at all times—afforded less health protection than vaccination, and delayed readiness due to the time needed to become fully vaccinated and other mobility restrictions would "limit [Air Force Engineer's] role and degrade the operational effectiveness of [Air Force Engineer's] unit."

10. On December 24, 2021, Air Force Engineer appealed the AFMC Commander's denial to the Air Force Surgeon General. On January 21, 2022, the Surgeon General denied the appeal. The Surgeon General explained that Air Force Engineer's present duty assignment requires intermittent to frequent contact with others and is not achievable via telework or with adequate distancing. While some of Air Force Engineer's duties could be accomplished remotely, "institutionalizing remote completion of those duties permanently would be detrimental to readiness, good order and discipline, and unit cohesion." Air Force Engineer's "unit has high-

[5] This assessment proved prescient, as Air Force Engineer was unable to support a deployment tasking due to his unvaccinated status and another unit had to be tasked to meet mission needs. *See supra* ¶ 5.

risk personnel that have an elevated potential for severe illness or death, if they were infected." Further, the Air Force "must be able to leverage [its] forces on short notice as evidenced by recent worldwide events" and Air Force Engineer's "health status as a non-immunized individual in this dynamic environment, and aggregate with other non-immunized individuals in steady state operations would place health and safety, unit cohesion, and readiness at risk." Finally, the Surgeon General found that no less restrictive means are available in Air Force Engineer's circumstances that are equally as effective as receiving the COVID-19 vaccination in furthering the Air Force's compelling government interests.

11. The Air Force Surgeon General's conclusions are supported by the Religious Accommodation Request package submitted for his review. The package included individualized information. For example, although his duties "include items that can be accomplished through telework, many of his duties must be in-person."[6] Air Force Engineer's "unit or AFSC . . . have a high ops tempo or deployment tempo."[7] "AFIMSC Det 8 does have personnel assigned that are of medical high-risk (e.g. pregnant, greater than 65 years old, immune compromised, obese, etc.)."[8] Air Force Engineer supervises members who are not "currently on full-time telework" (i.e., he would need to be present to supervise them).[9] "In regards to readiness, CONUS and OCONUS travel restrictions remain fluid, and these alternative

[6] Religious Accommodation Appeal package, pg. 29. At the height of the restrictions, where everyone in the Air Force was operating at a degraded capacity and training courses were limited or cancelled, etc., Air Force Engineer was able to accomplish the majority of his duties via telework. Now that the military is returning to its normal operational capacity, Air Force Engineer is unable to fully complete his duties because he is not able to deploy, attend training, etc.
[7] Religious Accommodation Appeal package, pg. 37.
[8] Religious Accommodation Appeal package, pg. 37. Members who were over the age of 65 have since retired, but there remains other personnel in the unit that are at high-risk as well as personnel over 60 years of age.
[9] Religious Accommodation Appeal package, pg. 37.

mitigation measures would not permit [Air Force Engineer] to maintain a state of readiness commensurate with his assigned duties."[10]

12. On January 31, 2022, Air Force Engineer was provided with the appeal denial memorandum and was notified that he had five calendar days to: (1) receive the COVID-19 vaccine or (2) submit a voluntary separation or retirement request (if eligible). He was further notified that "failure to comply with this lawful order may result in administrative and/or punitive action for Failing to Obey an Order under Article 92, Uniform Code of Military Justice." As of February 7, 2022, Air Force Engineer did not provide sufficient documentation of receiving the COVID-19 vaccine and failed to comply with the order. On April 18, 2022, I issued Air Force Engineer a Letter of Counseling for failure to obey a lawful order.

13. Air Force Engineer is required to be worldwide deployable at all times. From the time an individual receives their first dose of the FDA-approved COVID-19 vaccine, it takes approximately one month to become fully vaccinated. The COVID-19 vaccine has been determined to be necessary to be fully medically ready for deployment. Testing for COVID-19 immediately prior to deployment is also not an effective alternative.

14. Active-duty service members also have the responsibility to stay deployment-ready in the event that they get individually tasked with a deployment. In light of current world events, potential deployment on short notice is an ever-present possibility. Further, there are a number of deployed locations – controlled by Combatant Commanders – and countries that require that individuals be fully vaccinated to be granted entry. Air Force Engineer's unvaccinated status would presumptively prevent him from entering these deployed locations and/or countries should a deployment to one of those locations arise. If Air Force Engineer needs to deploy to these

[10] Religious Accommodation Appeal package, pg. 38.

areas but cannot enter those countries, then he cannot effectively accomplish his deployed duties and the mission would be adversely affected.

15. The symptoms of the COVID-19 virus (e.g., fever, chills, shortness of breath, fatigue, muscle aches, headaches, etc.), the risk that Airmen could get "long COVID," and the possibility that Airmen could get seriously ill, become hospitalized, or die from COVID-19 create an unacceptable risk to personnel and substantially increase the risk of mission failure, both in garrison (i.e., a non-deployed setting) and in a deployed environment. Deployment locations can be austere, remote locations overseas where the threat of sickness is even more serious. Many locations to which Air Force Engineer may be deployed do not have any medical facilities, and those locations that do have medical facilities are unlikely to be at a standard to which we are accustomed in the United States. Thus, treatments for COVID-19 likely would not be readily available. If a service member were to develop severe symptoms in such an austere environment, it would require the service member to be medically evacuated. Depending on the severity of the symptoms and necessary treatment, this could require an entire aircraft to be diverted from its intended mission to be used as an aeromedical evacuation platform. Additionally, if continuous medical supervision is required during the medical evacuation, it would further reduce the medically trained personnel available to provide medical care to other service members at the deployed location. If Air Force Engineer himself developed severe symptoms requiring medical evacuation, then in addition to posing a risk of infection to others, his unit would be deprived of senior leadership while operating in such a remote and austere environment.

16. At Air Force Engineer's home station, Joint Base Langley-Eustis, there are currently service members who are unvaccinated. Some have a temporary medical exemption while others

are awaiting the adjudication of their religious accommodation request or have an administrative exemption because they are about to separate from the military. Additionally, there are non-military civilians who are not currently required to be vaccinated. The Air Force attempts to mitigate the risk through higher headquarters-prescribed common mitigation measures such as social distancing, masking, and remote work, where possible. These measures, in their current form, were implemented in an attempt to mitigate the risk of COVID-19 to personnel working at home station who cannot be vaccinated, but they are not as effective as being fully vaccinated in protecting the health of service members.

17. Moreover, all uniformed members of the Air Force are required to be ready and able to deploy within 72 hours to any location worldwide.[11] In fact, depending on circumstances, a member may be deployed to perform duties completely outside of their normally prescribed Air Force job for which they are trained (this is the "clerks and cooks grab a rifle" concept). The obvious reality is – with the entire world as a potential destination – a deployment could easily be to an environment where some if not all of the above described higher headquarters-directed home station mitigation measures are simply not feasible.

18. A COVID-19 outbreak in an austere deployed environment has a real potential to cripple the mission. In austere locations, it is common for Airmen to live, eat, and sleep in close quarters for months at a time. This may include working, sleeping, and eating in tents, fabric- or canvas-covered shelters, or other temporary structures. Such structures would not allow for social distancing. Any disease outbreak, particularly among unvaccinated individuals, could

[11] There are some exceptions. Certain specific assignments are considered non-deployable for the period a member is in that position. Additionally, there may be situations where a member is categorized as non-deployable (usually medical conditions of some kind). But the member is expected to return to a deployable status, and may be subject to discharge if they remain non-deployable for more than 12 consecutive months, as described below.

easily overwhelm that location's medical capacity, which reduces capacity to treat front-line battle injuries and other illnesses. Further, deployed personnel and staffing are also, by design, manned minimally with only the service members necessary to accomplish the mission. There is little redundancy in the manning and each casualty due to illness has a significant impact on successful mission accomplishment. An outbreak impacting multiple service members could cause mission failure.

19. The Air Force makes assignment decisions based on the best interest of the Air Force. Reassigning Air Force Engineer into a non-deployable status is not a feasible alternative to receiving the COVID-19 vaccination. Ordinarily, the Air Force only places a service member in a non-deployable position when the member faces a critical medical issue that requires the member to be within a certain distance of certain medical facilities. These are also temporary medical issues where the member is expected to return to a deployable status after the medical issue is resolved. Service members who are non-deployable for more than 12 consecutive months will be reviewed for a retention determination (i.e., whether they should remain in the service or be discharged).

20. Having a member non-deployable would place a larger burden on the other members within the unit and would harm overall unit readiness. The Department of Defense considers it an unacceptable risk to the force for Air Force Engineer, or any uniformed member, to deploy without being fully vaccinated against COVID-19. Currently, should a short-notice deployment tasking be received, due to his unvaccinated status, Air Force Engineer could not deploy in support of that mission. Therefore, he simply could not perform the duties required by his military assignment, which would degrade the military effectiveness of his unit.

21. As long as Air Force Engineer remains unvaccinated, his deployability – a vital part of his unit's, as well as any Airman's, mission – is severely limited. Additionally, he is precluded from traveling for temporary duty assignments and may be unable to attend trainings unless it is deemed "mission critical." In an effort to prevent the spread of COVID-19 and to ensure the health and safety of the force, the Department of Defense has limited official travel for unvaccinated service members to only circumstances that are "mission critical" – which is an exceptionally high bar that requires Secretary or Under Secretary of the Air Force approval. For example, since there is almost always other service members available who need a training and could attend in Air Force Engineer's stead, it would be a rare occasion where Air Force Engineer's attendance at the training would be "mission critical." Additionally, because training typically takes place in classroom settings in close proximity to others, many training opportunities require the service member to be vaccinated to attend. The trainings would include courses required to maintain qualifications to be mission-ready. Accordingly, Air Force Engineer may fall behind on qualification-necessary trainings should he remain unvaccinated.

22. To the best of my knowledge, Air Force Engineer has previously met all vaccination requirements for this position as a member of the United States Air Force.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 24th day of May 2022.

HOLMES.PHILIP.A.1169431694 Digitally signed by HOLMES.PHILIP.A.1169431694 Date: 2022.05.24 08:38:38 -04'00'

PHILIP A. HOLMES, Colonel, USAF
Commander

Exhibit 10

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF BRIGADIER GENERAL TERRY L. BULLARD
[with regard to "Air Force Special Agent"]

I, Terry L. Bullard, hereby state and declare as follows:

1. I am an Active Duty officer in the United States Air Force currently assigned as the Commander of the Air Force Office of Special Investigations (AFOSI), stationed at Marine Corps Ground Installation Quantico, Virginia. I hold the grade of Brigadier General in the United States Air Force. I have been in this position since May 16, 2019. As a part of my duties, I am responsible for leading AFOSI to accomplish its assigned mission and to safeguard the morale, physical well-being, and general welfare of all persons under my command.

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

3. I know the identity of Air Force Special Agent. He is a Technical Sergeant member of the United States Air Force Reserve in the role of Individual Mobilization Augmentee (IMA)

assigned to AFOSI 8th Field Investigations Region (8 FIR) IMA Hub, Peterson Space Force Base, Colorado. I can provide Air Force Special Agent's name if required, consistent with the protective order in place in this case. I am Air Force Special Agent's Field Operating Agency commander and 8 FIR's superior commander.

4. AFOSI is the federal law enforcement and counterintelligence agency for the United States Air Force and United States Space Force (collectively the "Department of the Air Force"). As a reservist, Air Force Special Agent is not employed full-time by the Department of the Air Force. He maintains civilian employment unassociated with his military status. When he performs reserve duties, Air Force Special Agent is an investigator. As noted in the religious accommodation request package,[1] he is responsible for the felony-level criminal investigations and national security investigations within his assigned region. The nature of criminal and national security investigations preclude Air Force Special Agent from being able to exclusively accomplish his duties remotely or via telework.

5. Investigations require a hands-on approach, including in-person interviews with potential victims, subjects, and witnesses. In many of these situations, interviews via telephone or video conference are not an acceptable alternative and can undermine the investigation. Additionally, Air Force Special Agent's investigations require him to be able to respond to crime scenes and work in close coordination (and at times close contact) with local, state, and federal law enforcement agencies. As a law enforcement officer, he is also responsible for executing judicial processes, such as search warrants, and testifying in judicial proceedings. He may also be called

[1] *See, e.g.*, "Response to RFIs [Requests for Information] – Religious Accommodation Appeal of [Air Force Special Agent]," dated January 23, 2022. This information was provided to the HAF RRT based on specific questions they had about Air Force Special Agent to make sure the Appeal Authority, the Air Force Surgeon General, was able to make an informed decision. As the AFOSI commander, I am well acquainted with the requirements and duties of a Special Agent, which I took into account when I denied his religious accommodation request.

upon at a moment's notice to physically apprehend a subject, which necessarily involves physical contact with service members or the public. Performing these duties while unvaccinated against COVID-19 increases the risk of infection to himself and to others.

6. The nature of Air Force Special Agent's duties also require him to travel, often with little to no notice, as part of investigations, supporting other operational activities, or to testify at judicial proceedings. Current Department of the Defense policy precludes the travel of all unvaccinated personnel for official duties unless it is deemed "mission critical" by the Secretary of the Air Force or Under Secretary of the Air Force. This travel prohibition applies to all unvaccinated personnel – even members that have received a religious, medical, or administrative exemption.

7. Investigations and AFOSI operations are fluid, making it often impossible to adjust daily assignments or duties as a mitigation measure. Similarly, and as explained in the religious accommodation package, it is not possible to determine how many people Air Force Special Agent may need to interact with in close quarters on any given day or where an investigation may lead. Simply put, so long as he remains unvaccinated, the Department of the Air Force is unable to fully utilize Air Force Special Agent in the performance of his duties. Vaccination is the most effective way of protecting the health and readiness of Air Force Special Agent and other service members.

8. Additionally, as a military member, Air Force Special Agent may be obligated to deploy based upon the needs of the United States Air Force; currently his unvaccinated status impedes his ability to remain available for worldwide deployment. The COVID-19 vaccine is necessary to be fully medically ready for deployment. From the time an individual receives his or her first dose of a FDA-approved COVID-19 vaccine, it takes a minimum of five weeks to become fully

vaccinated. Additionally, the symptoms of the COVID-19 virus (e.g., fever, chills, shortness of breath, fatigue, muscle aches, headaches, etc.), the risk that Airmen could contract "long COVID," and the possibility that Airmen could become seriously ill, become hospitalized, and die from COVID-19, create an unacceptable risk to personnel and substantially increase the risk of mission failure, both in garrison (i.e. a non-deployed setting) and in a deployed environment. The threat of sickness in a deployed environment is even more serious. Most forward-deployed locations do not have extensive medical facilities as we are accustomed to in the United States. Supplies, beds, and staff are many times at a premium. Furthermore, having a COVID-19 outbreak while deployed, where personnel are in close contact and living within the same area for months at a time, could easily overwhelm that location's medical capacity, taking away from the ability to treat front-line battle injuries and other illnesses. Deployed staffing is frequently, often by design, minimally manned. If one service member were to become ill, contract long-COVID, be hospitalized, or die, that section may not have excess personnel capacity to perform similar duties, leaving little redundancy and backup to support the mission. An outbreak impacting multiple service members could potentially risk support to the mission altogether.

9. On August 24, 2021, the Secretary of Defense mandated that the military services begin full vaccination against the SARS-CoV-2 virus. On September 3, 2021, the Secretary of the Air Force directed commanders to ensure that all uniformed Airmen and Guardians be vaccinated against the virus, and specifically that reserve members be fully vaccinated by December 2, 2021. On September 13, 2021, I issued an order to all AFOSI Active Duty and Reserve personnel to comply with the requirement established by the Secretaries of Defense and the Air Force. On November 1, 2021, Air Force Special Agent submitted a written request for religious exemption from the COVID-19 vaccine requirement in accordance with Department of the Air

Force Instruction (DAFI) 52-201, *Religious Freedom in the Department of the Air Force*. He was provided a temporary exemption from the vaccination requirement while his religious accommodation request was processed.

10. On November 2, 2021, in accordance with Air Force policy, Air Force Special Agent was counseled by his chain of command that noncompliance with the vaccination requirement may have an adverse impact on his deployability, assignment, and/or domestic and international travel. On November 10, 2021, Air Force Special Agent met with an Air Force chaplain concerning his religious exemption request, in accordance with Air Force policy. On November 15, 2021, Air Force Special Agent met with an Air Force medical provider, in accordance with Air Force policy. The medical professional provided specific information about the COVID-19 vaccine, as well its contents, efficacy, benefits and risks. The request was subsequently reviewed and routed to an AFOSI Religious Review Team (RRT) pursuant to procedures established by DAFI 52-201.

11. On November 22, 2021, the RRT convened pursuant to guidance contained in DAFI 52-210. The RRT members unanimously determined that, while Air Force Special Agent had sincerely held religious beliefs, there did not exist lesser restrictive means than vaccination to meet the compelling government interests, or to ensure member's ability to fully execute his assigned duties as an AFOSI Special Agent. Air Force Special Agent's immediate commander concurred with this conclusion.

12. On January 18, 2022, after reviewing the recommendations of the RRT, as well as all supporting documentation and my knowledge of the duties of a Special Agent, I disapproved Air Force Special Agent's request. I was authorized to make this determination based upon my status as the Commander of a United States Air Force Field Operating Agency. In making my

decision I assessed a number of factors, including: Air Force Special Agent's sincere religious belief against receiving the COVID-19 vaccination; the nature and requirements of his assigned duties; the compelling government interest in ensuring a safe, healthy, and responsive military force; and any lesser restrictive alternatives. It was and remains my assessment that the Air Force has a compelling interest in ensuring Air Force Special Agent is vaccinated to ensure mission accomplishment and protect the health and readiness of military personnel. Furthermore, I did not and do not believe lesser forms of restriction such as testing, mask wear and telework would be as effective or sufficient in Air Force Special Agent's situation. While some requirements of Air Force Special Agent's position may be met virtually, the inherent nature of the duties of a Special Agent require the ability to engage with others in-person, to respond to crime scenes or conduct physical searches, and to testify in judicial proceedings.

13. On January 23, 2022, Air Force Special Agent appealed my disapproval of his request to the Air Force Surgeon General, as stipulated in DAFI 52-201. The Air Force Surgeon General denied the appeal on February 10, 2022; Air Force Special Agent was provided the denial memorandum on February 17, 2022. In the appeal denial memorandum, Air Force Special Agent was notified that he had five (5) calendar days to receive the mandated COVID-19 vaccine. He was further notified that "Failure to do so may lead to disciplinary and/or administrative action for Failure to Obey an Order." On February 18, 2022, Air Force Special Agent sent an email to his leadership indicating he made an appointment for March 1, 2022, at the Safeway in Concord, California, to receive the first dose of the COVID-19 vaccine. He also provided a screenshot of the appointment confirmation. Although this fell outside of the five (5) day suspense set by the Secretary of the Air Force, no action was undertaken as the individual was taking proactive measures to follow the order he had been given. The individual

subsequently failed to keep this appointment due to reported conflicts with his civilian employment.

14. Air Force Special Agent did not reschedule this appointment and remains unvaccinated. As a result of his failure to comply with a lawful order to be vaccinated, he was found to be in violation of Article 92 of the Uniform Code of Military Justice, and was presented a Letter of Reprimand (LOR) on March 18, 2022. On May 6, 2022, Air Force Special Agent provided a written response to the proposed LOR. On 10 May 2022, after reviewing Air Force Special Agent's response, his commander determined to uphold the LOR.

15. Administrative discharge proceedings have not been initiated against Air Force Special Agent, nor have actions been initiated to transfer the member to the Individual Ready Reserve (IRR). Pursuant to an agreement in this case to allow for sufficient time to brief the court, we have agreed not to take steps to initiate transfer of Air Force Special Agent to the Individual Ready Reserve (IRR) until this court acts on the plaintiff's request for injunctive relief, or July 1, 2022, whichever comes first. Accordingly, these actions have not been reviewed by a Discharge Review Board and/or the Air Force Board for Correction of Military Records (AFBCMR).

16. I am aware that Air Force Special Agent claimed, in paragraph 10 of his declaration, that the AFOSI Director of Staff told him that it "was highly likely" that the individual's appeal to the Air Force Surgeon General would be denied, and he felt the statement "left no doubt" that said appeal would, in fact, be denied. To my knowledge, the Director of Staff provided the individual with factual data (accurate at the time it was provided) that there had not been any appeals approved yet by the Air Force Surgeon General.[2] The Director of Staff assured me that

[2] Since that time, the Air Force Surgeon General has approved religious accommodation requests on appeal.

he offered this individual no assessment of his potential success in filing an appeal, and made no statements as to the likelihood of denial or approval.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 20th day of May 2022.

BULLARD.TERRY.L.1054063276
Digitally signed by BULLARD.TERRY.L.1054063276
Date: 2022.05.20 15:00:13 -04'00'

TERRY L. BULLARD
Brigadier General, USAF
Commander, AFOSI

Exhibit 11

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF BRIGADIER GENERAL WILLIAM R. KOUNTZ JR.

I, William R. Kountz, Jr., hereby state and declare as follows:

1. I am a General in the United States Air Force currently assigned at Headquarters, Air Force Reserve Command (AFRC) located at Robins Air Force Base, Georgia. I serve as the Director of Logistics, Engineering and Force Protection. I have been in this position since January, 2019. As director, I lead a staff of 234 personnel across five divisions and oversee a budget of $1.5 billion. I am responsible for the policy, budget, strategy and oversight of AFRC's maintenance, munitions, supply, transportation, civil engineering and force protections functions. I am responsible for organizing, training and equipping the command's in-garrison and expeditionary Agile Combat Support of more than 38,700 personnel assigned to 34 wings across the U.S.

2. I am generally aware of the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties. I know the identity of Air Force NCO. Air Force NCO is a Master Sergeant in my Directorate. I can provide his

name if required, consistent with the protective order in place in this case. I am aware of the status of Air Force NCO's religious accommodation appeals and any subsequent actions taken.

3. Air Force NCO is an Active Guard Reservist (AGR) assigned to the Programs and Resources Branch of the Security Forces Division at HQ AFRC (AFRC/A4SX.)[1] Air Force NCO's AGR orders are presently current through February 23, 2023, meaning he is in an active duty status through such date. Air Force NCO is a member of Security Forces, by trade. The typical duties of a Security Forces Master Sergeant assigned to a Security Forces Squadron involve tactical leadership in support of Air Base Defense for an installation. Security Forces at a base are the primary law enforcement and patrol forces available. They are in charge of installation security, gate operations, and responding to emergency situations. Typical duties of a Security Forces Master Sergeant assigned above the wing involve ensuring operational squadrons and Security Forces personnel are organized, trained, and equipped to fulfill their mission. This includes developing and implementing policy, advocacy, and guidance. Air Force NCO largely performs work inside of a cubicle, but shares one SIPRnet terminal with three other personnel. This SIPR terminal is in a room with a closeable door. This cubicle is part of an open floor plan with multiple cubicles in one room with little separation between rooms. There are approximately six personnel within Air Force NCO's vicinity. Air Force NCO is responsible for providing guidance and direction to the headquarters and subordinate units, and provides command program management and action for all command Security Forces resource and requirements issues. He develops plans and courses of action to obtain and execute funding in order to procure the required equipment and support for both peacetime and wartime missions.

[1] AGR personnel are reservists or members of the Air National Guard (ANG) who are on extended active duty orders. Once the orders expire, absent the issuance of new orders or another change of circumstances, the member would return to their part-time reserve or ANG status. While on AGR orders the member is active duty.

Furthermore, he completes the duties necessary to assist in the management of reserve support of contingencies, deployments and active duty requirements.

4. Additionally, Air Force NCO is the primary program manager of the Reserve Phoenix Raven Program. The Phoenix Raven program provides security to Air Force aircraft transiting in high terrorist and criminal threat areas. The personnel are specially trained and equipped to help detect, deter, and counter threats posed to the aircraft and aircrew. They also advise aircrew on force protection measures. As the Reserve Phoenix Raven Program manager, Air Force NCO is responsible for ensuring the success of that program, which includes ensuring that the individual reserve units providing Ravens meet training and standards. Air Force NCO is not a Phoenix Raven and is not expected to perform Raven duties. Accordingly, his duties require in-person inspections at 37 separation locations. Those inspections involve in-person contact with other service members in close quarters On September 21, 2021, Brigadier General Burger issued an order for Air Force NCO to receive the COVID-19 vaccine. The order directed him to receive his first dose of COVID-19 vaccine and provide proof of the same by October 28, 2021. The order also required him to receive his second dose of a COVID-19 vaccine and provide proof of the same by November 18, 2021. These dates are based on the Secretary of Defense's vaccine directive issued on August 24, 2021, and the deadline set by the Secretary of the Air Force in his memorandum issued on September 3, 2021. The Air Force deadline for the members of the Reserve to be fully vaccinated was December 2, 2021.

5. The order provided also specified that Air Force NCO could alternatively submit a religious accommodation request or proof of a medical exemption by the deadline specified for the first dose of the vaccine. On September 23, 2021, Air Force NCO submitted a religious

accommodation request, which was processed in accordance with applicable Air Force and Department of Defense regulations.

6. On October 7, 2021, Col Jeffrey M. Prindle counseled Air Force NCO that noncompliance with immunization requirements may adversely affect readiness for deployment, assignment, international travel, or result in administrative consequences. Air Force NCO acknowledged receipt of the order and expressed his understanding of this obligation. At that time, Air Force NCO also met with a medical provider concerning his concerns about receiving the vaccine as part of the exemption request process.

7. On October 27, 2021 Air Force NCO's request for a religious accommodation was disapproved by the Air Force Reserve Command (AFRC) Commander. On November 1, 2021, Air Force NCO appealed that denial to the Air Force Surgeon General. On December 27, 2021 his appeal was denied by the Air Force Surgeon General. In doing so, the Surgeon General noted his duties involve contact with others and "may require travel for Unit Effectiveness Inspections, conferences, and other engagements which increases your exposure to other personnel."

8. Before making this determination, the Religious Resolution Team requested specific details from me about Air Force NCO's situation to ensure that the Air Force Surgeon General was able to make an informed decision on the appeal request. In my response, I noted that "as the senior SFS contingency operations and readiness subject matter expert (SME)," Air Force NCO's duties would include conducting inspections. Additionally, Air Force NCO is the Functional Area Manager for the Reserve Phoenix Raven Program. "Sending another representative" "will not provide the same level of oversight and interaction" and it may be "inappropriate to send someone" else in some circumstances because Air Force NCO is the

"subject matter expert" responsible for "ensuring adequate compliance, oversight, and policy." These inspections cannot be transferred to someone else without reducing the effectiveness of the program.

9. After the denial of his religious accommodation appeal, Air Force NCO submitted a request for retirement on January 30, 2022. The Air Force is still processing the request. Air Force NCO requested an effective retirement date of June 1, 2022. Given Air Force NCO's pending retirement request, his Active Guard Reserve (AGR) tour was not curtailed pending his retirement and he did not receive adverse action in accordance with the Secretary of the Air Force's policy dated December 7, 2021. However, Air Force NCO is currently undergoing a pending Medical Evaluation Board (MEB) to determine whether he is entitled to further evaluation for possible disability benefits through the Disability Evaluation System (DES) due to a potentially medically-disqualifying condition that is unrelated to his unvaccinated status. Air Force NCO's medical processing may impact the retirement processing and retirement date.

10. By not being vaccinated against COVID-19, Air Force NCO cannot perform the full range of his required military duties. If Air Force NCO were to test positive for COVID-19, he would infect others in the unit, which could result in one or more individuals being placed into quarantine or otherwise prevent them from performing the mission. All of the positions that would be affected are staff positions that have a remote work option, however they are one individual deep in many cases. There are coverage options that exist within each branch and other personnel could cover the duties required for a short period of time. Air Force NCO was put on AGR orders to fill a Department of the Air Force requirement. *See supra* note 1. But the Department of the Air Force has no ongoing need for a service member who cannot effectively perform his duties or risks his own health or the health and safety of others to remain on AGR

orders. Thus, in accordance with applicable Air Force policy, if Air Force NCO had continued to refuse to vaccinate without submitting a request to retire, his AGR orders would likely be curtailed – that is, shortened.[2]

11. Finally, the COVID-19 vaccine is not only a medical readiness requirement for performing one's duties at home station; along with other medical readiness vaccines and deployment specific vaccines, the COVID-19 vaccine is also necessary to be fully medically ready for military duty. While Air Force NCO is not scheduled to deploy, world events could change his deployment requirements rapidly and without advance notice. Air Force NCO's current assignment is a deployable position. As a Reservist—whether in his traditional part-time status or as an AGR–Air Force NCO must be worldwide deployable at all times. Airmen may need to deploy on a few days' notice. This is in line with the purpose of the Air Force Reserve to provide qualified and trained persons available for active duty service when needed, including in times of emergency, war, and threats to national security. This is on full display with the Russian invasion of Ukraine.

12. From the time an individual receives his or her first dose of the FDA-approved COVID-19 vaccine, it takes about one month to become fully vaccinated. But Airmen may get called to duty on a few days' notice, leaving them without time to become fully vaccinated before beginning duty. Additionally, the symptoms of the COVID-19 virus (e.g., fever, chills, shortness of breath, fatigue, muscle aches, headaches, etc.), the risk that Airmen could get "long COVID," and the possibility that Airmen could get seriously ill, become hospitalized, and die from COVID-19 create an unacceptable risk to personnel and substantially increase the risk of mission failure, both in garrison (i.e., a non-deployed setting) and in a deployed environment. The threat

[2] *See* "Updated Supplemental Coronavirus Disease 2019 Vaccination Policy," dated April 26, 2022.

of sickness in a deployed environment is even more serious. Most forward-deployed locations do not have extensive medical facilities like we are accustomed to here in the United States. Supplies, beds, and staff are many times at a premium. Furthermore, having a COVID-19 outbreak while deployed, where everyone is in close contact and living within the same area for months at a time, could easily overwhelm that location's medical capacity and take away from treating front-line battle injuries and other illnesses

13. Deployed personnel and staffing are also, by design, minimally manned. If one service member were to get sick, contract long-COVID, get hospitalized, or die, that section may only have one extra person performing similar duties, leaving little redundancy and backup to support the mission. An outbreak impacting multiple service members could potentially risk support to the mission altogether. A COVID-19 infection creates an unacceptable risk to personnel and substantially increases the risk of mission failure or degradation, both in garrison (i.e., a non-deployed setting) and in a deployed environment.

14. Based on available information provided by AFRC's Surgeon General, mask wear and testing are not as effective as vaccination in preventing the spread of COVID-19 or minimizing the health risks associated with the disease. They also decrease in effectiveness when a member becomes infected. As a result of this advice from the AFRC Surgeon General, Air Force NCO would appear to be at a greater risk of contracting and spreading COVID-19 than he would be if he was vaccinated. If he remained unvaccinated, the unit would not be able to rely on Air Force NCO because if he tested positive, the unit would have to adjust manpower and mission plans at the last minute. At best, this degrades the mission by placing an undue burden on others to carry Air Force NCO's workload in addition to their own. At worst, it risks mission stoppage.

15. Moreover, according to the AFRC Surgeon General, a person recently exposed to COVID-19 may not test positive for several days, increasing the chances Air Force NCO could be infected without knowing and could spread COVID-19 to other service members and Air Force personnel. Based on my understanding of current medical information, vaccination decreases the likelihood of complications or hospitalization and can shorten the period of time the individual is sick, returning the unit to full mission capability quicker.

16. For the reasons stated above, it is my professional military opinion and the opinion of the Approval and Appeal Authority that there is a compelling government interest in having Air Force NCO receive the COVID-19 vaccination in order to ensure mission accomplishment, good order and discipline, unit cohesion, health, and safety and there are no less restrictive means to prevent his infection with the virus and/or his transmission of it to others.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 24th day of May 2022.

KOUNTZ.WILLIAM.R.JR.1078213031 Digitally signed by KOUNTZ.WILLIAM.R.JR.1078213031 Date: 2022.05.24 17:31:04 -04'00'

WILLIAM R. KOUNTZ JR., Brig Gen, USAF
Director, A4

Exhibit 12

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

AIR FORCE OFFICER, *et al.*,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	No. 5:22-CV-00009
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	
	)	

DECLARATION OF LIEUTENANT COLONEL ETHEL M. WATSON

I, Ethel M. Watson, hereby state and declare as follows:

1. I am a Lieutenant Colonel in the United States Air Force currently assigned as the Chief, Force Support Policy at the Department of the Air Force Directorate of Personnel Policy for the Director of Personnel, Air Force Reserve (REP). I have been in this position since December 2020. As a part of my duties, I am responsible for liaising with the Air Force and Air Force Reserve Personnel Centers on military readiness programs. As an REP officer, I serve as the focal point for developing and interpreting both policy and guidance for Air Force Reserve (AFR) military readiness programs.

2. I have reviewed the allegations set forth in the pleadings filed in this matter. I make this declaration in my official capacity as the Chief, Force Support Policy and based upon my personal knowledge and upon information that has been provided to me in the course of my official duties.

3. On August 24, 2021, the Secretary of Defense issued a mandate for all members of the Armed Forces on active duty or in the Ready Reserve to immediately begin full vaccination against Coronavirus Disease 2019 (COVID-19). Thereafter, the Secretary of the Air Force

provided additional mandatory vaccination guidance for Department of the Air Force (DAF) commanders that they take all steps necessary to ensure all uniformed service members receive the COVID-19 vaccine, which included issuing unit-wide and individual orders to their Ready Reserve members to become fully vaccinated no later than December 2, 2021 (Secretary of the Air Force Mem., Sept. 3, 2021, Mandatory Coronavirus Disease 19 Vaccine of Department of the Air Force Military Members).

4. Since the Secretary of the Air Force's initial mandatory vaccination order, the Chief of Air Force Reserve, who also serves as the Commander, Air Force Reserve Command, began developing guidance to enable compliance for Reserve members serving in both full-time and part-time reserve categories. In instances where Reserve specific guidance was necessary, implementation guidance has been issued separately and is available to all Reserve members at https://www.afrc.af.mil/COVID-19/.

5. Additionally, on April 26, 2022, in the *Updated Supplemental Coronavirus Disease 2019 Vaccination Policy* memorandum, the Secretary of the Air Force approved publication of replacement attachments to the December 7, 2021 memorandum entitled ~~issued a memorandum,~~ "*Supplemental Coronavirus Disease 2019 Vaccination Policy*." The 2021 memorandum itself remains in effect, and only the attachments have been updated. The 2021 memorandum established specific policy and provided guidance applicable to regular Air Force and Space Force members, Air Force Reserve (AFR) and Air National Guard (ANG) members. The 2021 memorandum and updated 2022 supplemental guidance concern (1) service members who requested separation or retirement prior to November 2, 2021, (2) service members whose request for medical, religious or administrative exemption from the COVID-19 vaccination requirement is denied, and (3) service members who refuse to take the COVID-19 vaccine.

6. The updated supplemental guidance addresses separation and retirement for members of the Air Force Reserve. Effective December 2, 2021, all Air Force Reserve members were required to fall into one of the following categories to comply with the vaccination mandate:

a. Completed a vaccination regimen.

b. Have requested or received a medical exemption.

c. Have requested or received a religious accommodation request.

d. Have requested or received an administrative exemption.

7. Unvaccinated members who request a medical exemption or a religious accommodation request will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review. For those members who have declined to be vaccinated, or have not otherwise complied with the guidance above, they are potentially in violation of the Uniform Code of Military Justice (UCMJ) by refusing to obey a lawful order.

8. Traditional Reservists (TRs) who fail to be vaccinated, have not submitted an exemption request, or have not been granted an exemption will be placed in a no pay/no points status and involuntarily reassigned to the Individual Ready Reserve (IRR). The IRR is part of the Ready Reserve of the Armed Forces Reserve Component and is composed of former active-duty, national guard, and reserve military personnel, who, though not actively participating in the military, are still affiliated with the Reserve Component. Placing a member in a no pay/no points status means that the member will not be drilling with the member's unit and thus will not be earning pay for that work or credit toward retirement.

9. Members whose medical exemption or religious accommodation request is denied have five (5) calendar days from receipt of their denial to do one of the following:

a. Begin a COVID-19 vaccination regimen, or

b. If the member submitted a medical exemption request, request a second medical opinion, or

c. If the member submitted a religious accommodation request, submit an appeal to the final appeal authority (the Air Force Surgeon General).

d. If eligible to retire:

i) Individual Mobilization Augmentees and TRs may request to retire and will be placed in a no pay/no points status not later than 60 calendar days post RAR/appeal notification;

ii) Active Guard & Reserve members may be able to retire if they begin terminal leave status no later than 60 calendar days from RAR/appeal notification.

10. If a final appeal is denied, the member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen.

11. If the member's appeal is denied, and the member continues to refuse to take the COVID-19 vaccine, they may be subject to adverse administrative action, such as the placement of a Letter of Reprimand in their personnel file or their actions may be punishable under the UCMJ. They will also be involuntarily reassigned to the IRR.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 24th day of May 2022.

WATSON.ETHEL.M.1013814330 Digitally signed by WATSON.ETHEL.M.1013814330 Date: 2022.05.24 17:04:56 -04'00'

ETHEL M. WATSON, Lt Col, USAF
Chief, Force Support Policy

Attachments:
1. Secretary of the Air Force Memorandum, *Supplemental Coronavirus Disease 2019 Vaccination Policy*, dated 7 December 2021
2. Assistant Secretary of the Air Force, Manpower and Reserve Affairs (SAF/MR) Memorandum, *Updated Supplemental Coronavirus Disease 2019 Vaccination Policy*, dated 26 April 2021.

SECRETARY OF THE AIR FORCE
WASHINGTON

07 DEC 2021

MEMORANDUM FOR ALMAJCOM-FLDCOM-FOA-DRU/CC
DISTRIBUTION C

SUBJECT: Supplemental Coronavirus Disease 2019 Vaccination Policy

This memorandum establishes specific policy and provides guidance applicable to regular Air Force and Space Force members, Air Force Reserve and Air National Guard members. This memo includes supplemental guidance concerning those who requested separation or retirement prior to 2 November 2021, those whose requests for medical, religious or administrative exemption from the COVID-19 vaccine are denied, and those who refuse to take the COVID-19 vaccine. Compliance with this memorandum is mandatory.

As the Secretary of the Air Force, it is my responsibility to promote the health, safety and military readiness of all Air Force and Space Force personnel, regardless of duty status, to include Air National Guard performing any duty or training under both Title 10 and Title 32 of the United States Code. COVID-19 poses a direct risk to the health, safety, and readiness of the force. Vaccination against COVID-19 is an essential military readiness requirement for all components of the Air Force and Space Force to ensure we maintain a healthy force that is mission ready.

Commanders will 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. Refusal to comply with the vaccination mandate without an exemption will result in the member being subject to initiation of administrative discharge proceedings. Service characterization will be governed by the applicable Department of the Air Force Instructions.

Pending Separation or Retirement - unvaccinated regular Airmen and Guardians who submitted a request to retire or separate prior to 2 November 2021, with a retirement or separation date on or before 1 April 2022, may be granted an administrative exemption from the COVID-19 vaccination requirement until their retirement or separation date.

Medical, Religious or Administrative Exemption - unvaccinated 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. Service members who receive a denial of their medical, religious, or administrative exemption request have five (5) calendar days from that denial to do one of the following: 1) Begin a COVID-19 vaccination regimen. If the service member indicates his or her intent is to begin the vaccination regimen, commanders may use their discretion to adjust the timeline based on local COVID-19 vaccination supplies; 2) Submit an appeal to the Final Appeal Authority or

request a second opinion (medical). If a final appeal or exemption is denied, the service member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen; 3) If able, based upon the absence of or a limited Military Service Obligation (MSO), and consistent with opportunities afforded service members prior to 2 November 2021, request to separate or retire on or before 1 April 2022, or no later than the first day of the fifth month following initial or final appeal denial.

Regular service members who continue to refuse to obey a lawful order to receive the COVID-19 vaccine after their exemption request or final appeal has been denied or retirement/separation has not been approved will be subject to initiation of administrative discharge. Discharge characterization will be governed by the applicable Department of the Air Force Instructions. Service members separated due to refusal of the COVID-19 vaccine will not be eligible for involuntary separation pay and will be subject to recoupment of any unearned special or incentive pays.

Commanders will ensure all unvaccinated service members comply with COVID-19 screening and testing requirements and applicable safety standards. Leaders should continue to counsel all unvaccinated individuals on the health benefits of receiving the COVID-19 vaccine.

Unique guidance associated with the Air Force Reserve is provided at Attachment 1. Unique guidance associated with the Air National Guard is provided at Attachment 2.

This Memorandum becomes void one-year after date of issuance.

Frank Kendall
Secretary of the Air Force

Attachments
1. Supplementary Guidance for Members of the Air Force Reserve
2. Supplementary Guidance for Members of the Air National Guard

Attachment 1

Supplementary Guidance for Members of the Air Force Reserve

1. This supplementary addendum establishes specific policy and provides guidance applicable to Air Force Reserve (AFR) members, pursuant to Secretary of Defense and Secretary of the Air Force guidance as well as AFRC/CD's *AFRC Vaccine Guidance* memo, dated 24 September 2021. Compliance with this guidance is mandatory.

2. Effective 2 December 2021, all AFR members were required to fall into one of the following categories to comply with the vaccination mandate:

    a. Completed a vaccination regimen.
    b. Have requested or received a medical exemption.
    c. Have requested or received a Religious Accommodation Request (RAR).
    d. Have requested or received an administrative exemption.

3. Unvaccinated members who request a medical exemption or RAR will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review. For those members who have declined to be vaccinated, or have not otherwise complied with the guidance above, they are potentially in violation of the Uniform Code of Military Justice (UCMJ) by refusing to obey a lawful order. Commanders should use their discretion as appropriate when initiating disciplinary action.

4. Traditional Reserve (TR) and Individual Mobilization Augmentee (IMA) members who fail to be vaccinated and have not submitted an exemption or accommodation will be placed in a no pay/no points status and involuntarily reassigned to the Individual Ready Reserve (IRR). Active Guard and Reserve (AGR) members who fail to be vaccinated and have not submitted an exemption or accommodation will have their AGR tour curtailed and involuntarily reassigned to the IRR.

5. Members whose medical exemption or RAR is denied have five (5) calendar days from receipt of their denial to do one of the following:

    a. Begin a COVID-19 vaccination regimen.
    b. Request a second opinion (medical) or submit an appeal to the final RAR appeal authority (AF/SG). If a final appeal is denied, the member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen.
    c. If eligible to retire:
        i. IMAs and TRs may request to retire with a retirement date on or before 1 June 2022 and will be placed in a no pay/no points status not later than 60 calendar days post RAR/appeal notification.

ii. AGR members may be able to retire if they begin terminal leave status NLT 60 calendar days from RAR/appeal notification.

6. Immediately following notification of final adjudication, AFR members must comply with the vaccination requirement. Any refusal to receive the COVID-19 vaccine, absent an approved exemption, may be punishable under the UCMJ. Continued refusal will result in involuntary reassignment to the IRR.

7. Members will be subject to recoupment for any unearned special, incentive pays or certain training.

8. Where required, AFR Airmen will complete all out-processing requirements, to include the Transition Assistance Program or Permanent Change of Station actions.

Attachment 2

Supplementary Guidance for Members of the Air National Guard

1. This supplementary addendum establishes specific policy and provides guidance applicable to Air National Guard (ANG) members pursuant to Secretary of Defense and Secretary of the Air Force guidance. Compliance with this guidance is mandatory.

2. IAW 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.

3. By 31 December 2021, ANG members, regardless of status, will be classified in the following categories:

    a. Completed or have started a vaccination regimen.
    b. Have requested or received a medical exemption.
    c. Have requested or received a Religious Accommodation Request (RAR).
    d. Have requested or received an administrative exemption.
    e. Declined to be vaccinated.

4. Unvaccinated members who request a medical exemption or RAR will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review.

5. Excluding members with pending or approved medical, religious, or administrative exemption requests, ANG members that have not initiated a vaccination regimen by 31 December 2021 may not participate in drills, training, or other duty conducted under Title 10 or Title 32 U.S.C., and those with a remaining Military Service Obligation will be involuntarily assigned to the Individual Ready Reserve (IRR) in accordance with 10 U.S.C. §651 and DoDI 1235.13.

6. Members whose medical exemption or RAR is denied have five (5) calendar days from receipt of their denial to do one of the following:

    a. Begin a COVID-19 vaccination regimen.
    b. Request a second opinion (medical) or submit an appeal to the final RAR appeal authority (AF/SG). If a final appeal is denied, the member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen.
    c. If eligible to retire:
        i. Title 32 Drill Status Guardsmen, to include Dual Status Technicians, may request to retire with a retirement date on or before 1 April 2022.
        ii. Active Guard and Reserve (AGR) members may be able to retire if they begin terminal leave status NLT 60 calendar days from the RAR/appeal notification.

7. Immediately following notification of final adjudication, ANG members must comply with the vaccination requirement. Those with a remaining Military Service Obligation who continue to refuse vaccination, will be involuntarily assigned to the IRR.

8. Members will be subject to recoupment for any unearned special, incentive pays or certain training.

9. Where required, ANG members will complete all out-processing requirements, to include the Transition Assistance Program or Permanent Change of Station actions.

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC

OFFICE OF THE ASSISTANT SECRETARY

APR 2 6 2022

MEMORANDUM FOR ALMAJCOM-FLDCOM-FOA-DRU/CC
DISTRIBUTION C

FROM: SAF/MR

SUBJECT: Updated Supplemental Coronavirus Disease 2019 Vaccination Policy

References: (a) Secretary of the Air Force, *Supplemental Coronavirus Disease 2019 Vaccination Policy*, December 7, 2020

The Secretary of the Air Force has approved the publication of replacement attachments to the 7 December 2020 memo entitled *Supplemental Coronavirus Disease 2019 Vaccination Policy,* Reference (a). Attachments 1 and 2 to Reference (a) have been superseded and replaced by the enclosed attachments to this updated policy, effective 14 April 2022. Compliance with this updated guidance is mandatory and should be widely distributed.

Please direct all questions and concerns to the HAF DDS COVID Task Force Team Chief at AF.DDS.COVID.Team.Chief@us.af.mil.

JOHN A. FEDRIGO
Acting

Attachments
1. Supplementary Guidance for Members of the Air Force Reserve
2. Supplementary Guidance for Members of the Air National Guard

Attachment 1

Supplementary Guidance for Members of the Air Force Reserve

1. This supplementary addendum establishes specific policy and provides guidance applicable to Air Force Reserve (AFR) members, pursuant to Secretary of Defense and Secretary of the Air Force guidance as well as AFRC/CD's *AFRC Vaccine Guidance* memo, dated 24 September 2021. Compliance with this guidance is mandatory.

2. Effective 2 December 2021, all AFR members were required to fall into one of the following categories to comply with the vaccination mandate:

    a. Completed a vaccination regimen.
    b. Have requested or received a medical exemption.
    c. Have requested or received a Religious Accommodation Request (RAR).
    d. Have requested or received an administrative exemption.

3. Unvaccinated members who request a medical exemption or RAR will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review. For those members who have declined to be vaccinated, or have not otherwise complied with the guidance above, they are potentially in violation of the Uniform Code of Military Justice (UCMJ) by refusing to obey a lawful order. Commanders should use their discretion as appropriate when initiating disciplinary action.

4. Traditional Reserve (TR) and Individual Mobilization Augmentee (IMA) members who fail to be vaccinated and have not submitted an exemption or accommodation will be placed in a no pay/no points status and involuntarily reassigned to the Individual Ready Reserve (IRR). Active Guard and Reserve (AGR) members who fail to be vaccinated and have not submitted an exemption or accommodation will have their AGR tour curtailed and involuntarily reassigned to the IRR.

5. Members whose medical exemption or RAR is denied have five (5) calendar days from receipt of their denial to do one of the following:

    a. Begin a COVID-19 vaccination regimen.
    b. Request a second opinion (medical) or submit an appeal to the final RAR appeal authority (AF/SG). If a final appeal is denied, the member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen.
    c. If eligible to retire:

i. IMAs and TRs may request to retire[1] and will be placed in a no pay/no points status not later than 60 calendar days post RAR/appeal notification.
ii. AGR members may be able to retire if they begin terminal leave status NLT 60 calendar days from RAR/appeal notification.

6. Immediately following notification of final adjudication, AFR members must comply with the vaccination requirement. Any refusal to receive the COVID-19 vaccine, absent an approved exemption, may be punishable under the UCMJ. Continued refusal will result in involuntary reassignment to the IRR.

7. Members will be subject to recoupment for any unearned special, incentive pays or certain training.

8. Where required, AFR Airmen will complete all out-processing requirements, to include the Transition Assistance Program or Permanent Change of Station actions.

[1] Revised on 14 April 2022. Removed date in Section 5.c.i. All previous versions obsolete.

Attachment 2

Supplementary Guidance for Members of the Air National Guard

1. This supplementary addendum establishes specific policy and provides guidance applicable to Air National Guard (ANG) members pursuant to Secretary of Defense and Secretary of the Air Force guidance. Compliance with this guidance is mandatory.

2. IAW 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.

3. By 31 December 2021, ANG members, regardless of status, will be classified in the following categories:

    a. Completed or have started a vaccination regimen.
    b. Have requested or received a medical exemption.
    c. Have requested or received a Religious Accommodation Request (RAR).
    d. Have requested or received an administrative exemption.
    e. Declined to be vaccinated.

4. Unvaccinated members who request a medical exemption or RAR will be temporarily exempt from the COVID-19 vaccination requirement while their exemption request is under review.

5. Excluding members with pending or approved medical, religious, or administrative exemption requests, ANG members who have not initiated a vaccination regimen by 31 December 2021 may not participate in drills, training, or other duty conducted under Title 10 or Title 32 U.S.C. Refusal to comply with the vaccination mandate by 31 December 2021 without an exemption or pending exemption will result in either the ANG member: being subject to initiation of administrative separation proceedings, to include withdrawal of Federal recognition and discharge from the ANG and Reserve of the Air Force; or being involuntarily assigned to the Individual Ready Reserve (IRR) in accordance with 10 U.S.C. §651 and DoDI 1235.13.[2]

6. Members whose medical exemption or RAR is denied have five (5) calendar days from receipt of their denial to do one of the following:

    a. Begin a COVID-19 vaccination regimen.

[2] Revised on 14 April 2022. Updated Section 5. All previous versions obsolete.

b. Request a second opinion (medical) or submit an appeal to the final RAR appeal authority (AF/SG). If a final appeal is denied, the member will have five (5) calendar days from notice of denial to begin the COVID-19 vaccination regimen.
c. If eligible to retire:
    i. Title 32 Drill Status Guardsmen, to include Dual Status Technicians, may request to retire.[3]
    ii. Active Guard and Reserve (AGR) members may be able to retire if they begin terminal leave status NLT 60 calendar days from the RAR/appeal notification.

7. Immediately following notification of final adjudication, ANG members must comply with the vaccination requirement or be subject to the conditions listed in Paragraph 5 above.

8. Members will be subject to recoupment for any unearned special, incentive pays or certain training.

9. Where required, ANG members will complete all out-processing requirements, to include the Transition Assistance Program or Permanent Change of Station actions.

[3] Revised on 14 April 2022. Removed date in Section 6.c.i. All previous versions obsolete.

Exhibit 13

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
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JONATHAN DUNN, Plaintiff, v. LLOYD J. AUSTIN, III, ET AL., Defendants.	Docket No. 22-CV-288 Sacramento, California February 22, 2022 1:32 p.m. Re: Preliminary injunction

TRANSCRIPT OF PROCEEDINGS
BEFORE THE HONORABLE JOHN A. MENDEZ
UNITED STATES DISTRICT JUDGE

APPEARANCES (via Zoom):

For the Plaintiff: LAW OFFICE OF THOMAS MOLLOY, JR., by
MR. THOMAS MURPHY MOLLOY
1125 Wedgewood Drive
Woodway, TX 76702

For the Defendant: U.S. DEPARTMENT OF JUSTICE by
ASSISTANT U.S. ATTORNEY
MS. COURTNEY DANIELLE ENLOW
Assistant U.S. Attorney
1100 L Street, NW
Washington, DC 20530

JENNIFER COULTHARD, RMR, CRR
Official Court Reporter
501 I Street, Suite 4-200
Sacramento, CA 95814
jenrmrcrr2@gmail.com
(530)537-9312

Proceedings reported via mechanical steno - transcript produced via computer-aided transcription

that you want me to add?

MR. MOLLOY: Yes, Your Honor. I would just like to clarify if Lt. Col. Dunn misses that October 2022 promotion board, it is possible that in a future board he could be promoted, but all of that time of missing squadron command and missing military opportunities, that's gone forever. He is behind forever from that now.

THE COURT: Okay. Thank you for that.

Ms. Enlow, anything further?

MS. ENLOW: No, Your Honor. Thank you.

THE COURT: Okay. Give me a few minutes and then we'll come back out and discuss the Court's decision on this motion. Thank you so much for responding to my questions.

(Recess at 2:44 p.m. to 2:57 p.m.)

THE COURT: Okay. Back on the record. If you freeze up again, it's on our end, so we'll let you know. Wave your hands or something and let me know if you cannot hear me.

Okay. As I indicated, I am prepared to issue a ruling on this motion today. I know that, as I said, the parties would appreciate a ruling. I know the plaintiff would appreciate a ruling, given all that's going on, on a daily basis. Again, I wish I could issue a -- and have the time and the lack of 1,000 cases to issue a more comprehensive written ruling, but the transcript is going to have to serve as the Court's ruling.

As with all motions for preliminary injunction, you start with the legal principle that preliminary injunctions are extraordinary remedies and that courts should only issue injunctive relief if, in fact, the four elements of injunctive relief, likelihood of success on the merits, irreparable harm, balance of equities and the injunction is in the public interest have been demonstrated.

This issue, the issues raised by this lawsuit, place burdens on the government to prove to the Court, in particular as we discussed in this case that the policy in this case, the requirement of vaccinating or taking a COVID-19 vaccination is in furtherance of a compelling governmental interest and, in fact, that the government is employing the least restrictive means of furthering that compelling governmental interest.

In terms of -- and focusing just -- there are two claims here upon which the plaintiff is basing his motion, his claim under the Religious Freedom Restoration Act and then his claim -- his free exercise claim under the First Amendment. And the Court will take up both of those claims as to whether there's a basis for injunctive relief.

In terms of whether this policy is in furtherance of a compelling governmental interest, is there a likelihood of success on the merits that the Court would find that the policy is not in furtherance of a compelling governmental interest? The evidence and the arguments at this point do convince the

Court that this policy is, in fact, in furtherance of a compelling governmental interest.

As courts have said over and over again, and this Court takes to heart, the Court must give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest.

The government -- I'm sorry. The military has argued in this case that the mandatory vaccination policy against COVID-19 is necessary to protect the force and defend the American people, that it's necessary to ensure military readiness and it's necessary to ensure the health and safety of airmen and prevent the spread of infectious disease.

This comes down to me, to this Court, in terms of what Ms. Enlow raised, as to what is an acceptable level of risk. What level of risk is appropriate is the way that Ms. Enlow phrased it and argued it.

And, again, in this Court's view, the acceptable level of risk is a military decision that deserves great deference. And given that deference in these circumstances, it's clear to me that just on that issue of whether there is a compelling governmental interest that's been demonstrated here, that that issue comes out in favor of the military.

The plaintiff is not medically ready to deploy 100 percent, as we discussed. There are still -- even though things change from day-to-day and month to month, I can only

take this case as we sit here today. He's not medically ready to deploy to certain areas of the world where he might be required to deploy.

And it does come down, as I said, to what level of risk is appropriate. If the military can eliminate almost all risk through this policy, then there is a compelling governmental interest. And if it's going to impact, as the government has argued or possibly impact -- I don't think it's speculation that it is a possibility that this could impact both military readiness and the need to adequately deploy in a fashion that the military wants deployment to occur, that the policy is necessary.

The tougher issue is, is this the least restrictive means of furthering this compelling governmental interest?

The government argues that the practice of vaccination and ordering the COVID-19 vaccination for all members of the Air Force is, in fact, the least restrictive means in fully accomplishing what the Court has found to be a compelling governmental interest.

There were, as we discussed, at least four reasons raised by the plaintiff as to why requiring the plaintiff to be vaccinated, why it is not, in fact, the least restrictive means of furthering the government's compelling governmental interest.

The government fails to satisfy this test when there

are, in fact, other alternatives of achieving its goal without imposing a substantial burden on the plaintiff's exercise of religion.

Here, again, the Court finds that at this stage of the proceedings, obviously the case has only been in front of the Court for a week and there is a lot more evidence that would be presented over time, but as we sit here today, the Court does find that the government has met its standard of showing why the proposed alternatives are not viable options.

First, although it was briefed, it really wasn't pursued, the idea that teleworking might be a least restrictive alternative. I think both sides agree that that's not an issue that the Court needs to take up or is really being pursued. You obviously cannot telework when you're deployed.

The second is the closer issue, the tougher issue in these cases. And I wanted to also mention, as the briefs do mention, we're operating in these cases right now in an area of, in effect, first impression.

While the parties have done an excellent job of giving the Court decisions issued by district court judges from around the country facing similar issues, almost identical issues to this Court, there's no Ninth Circuit precedent, there's no Supreme Court precedent in which this statute has been applied in a military context.

Obviously these cases will be appealed and we'll start

getting some guidance, but we're operating, as I've done in many cases over the past few years, in an area where there's no case on point, there's no precedent on point. And, again, you need to look simply at instructive cases in other areas, but none of these cases are binding on this Court.

So the issue is whether the natural immunity argument raised by the plaintiff is a sufficient alternative, is a least restrictive alternative that the Air Force should follow here. And the argument that was raised is that right now there is no scientific consensus and it's not well established in the face of that uncertainty. It's not well established in terms of the data concerning natural immunity and, in the face of that uncertainty, that the Court should not and cannot accept that and find that that is, in fact, the least restrictive means of furthering the compelling government interest here.

It was several Supreme Court judges that said that judges aren't scientists. This issue involves a lot of science. I appreciate the affidavits, but affidavits aren't subject to cross-examination, they aren't subject to full-blown hearings. And while they're helpful --

I lost Mr. Molloy. Okay.

-- they don't replace full-blown hearings or a full-blown explanation of issues like this.

And absent that, I am, like many judges, reluctant to make a scientific determination. And I do agree with the

government that on this issue there is a lack of consensus, and it's not well established that a natural immunity is effective, more effective or as effective as the vaccine.

And given that uncertainty, the Air Force here has determined that the best way to minimize risk is to require vaccination. Again, there are host countries that require vaccination and given the need for the military to be able to deploy the plaintiff on short notice to any location, the natural immunity alternative isn't feasible.

The plaintiff raises another argument that routine testing would be another least restrictive means of furthering a compelling government interest. The Court finds, however, that it's not always feasible to get the testing done, especially when you have to deploy quickly, and to get testing done within the time period required.

In the event that plaintiff did, in fact, test positive, the military would be forced to scramble to find a replacement. The military shouldn't be forced to scramble in these types of situations.

Again, the Court raises the fact raised by the defendants that there are a number of host nations that require vaccination for members to enter their countries. And, again, that wasn't specifically addressed by the plaintiff in the opposition -- in the reply brief.

As another district court also explained, the speed of

transmission usually outpaces test results, making test result availability not an effective alternative measure.

And then finally, masking and social distancing is another means that was raised by the plaintiff. It's not, again, the Court finds, feasible under these circumstances and given the plaintiff's specific responsibilities and duties in his role as the -- formally as the leader of -- I think it was up to at least 40 men.

We lost Mr. Molloy again.

Mr. Molloy, can you hear me? No.

Ms. Enlow, can you hear me?

MS. ENLOW: Yes, Your Honor.

THE COURT: Okay. So it's just Mr. Molloy right now. You're in Washington, D.C., right?

MS. ENLOW: Yes, I am.

THE COURT: Okay. I think Mr. Molloy is in Texas. He's back.

Can you hear me, Mr. Molloy?

MR. MOLLOY: Yes, Your Honor, I can. Yes, Your Honor. I'm sorry.

THE COURT: Okay. All right. And so I -- my finding with respect to the preliminary injunction motion is that, in fact, the government has demonstrated that requiring the vaccination -- requiring the plaintiff to be vaccinated, the COVID-19 vaccine, is, under these circumstances, these specific

circumstances, the least restrictive means of furthering the compelling governmental interest.

And again, as I have mentioned previously, I recognize, and there's a lot of discussion in the cases that I read, that military members are not excluded from the protection of statutes or constitutional rights. That is discussed over and over again.

But these same cases also make it clear that the Court should be more deferential to the defendant's judgment on what is required to obtain maximum readiness of the military.

There's a case out of the District of Columbia, *Singh v. McHugh*, which is cited by the defendants in that case. The Court noted the need to respect military judgment while still applying RFRA's strict standard.

For those reasons, the Court does find that the government is likely to show that the vaccination is the least restrictive means of achieving a compelling interest and that the plaintiff is unlikely to succeed on the merits of the RFRA claim.

I also would find that the plaintiff has not demonstrated a likelihood of success on his free exercise claim.

The Supreme Court has held that the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on

the grounds that the law prescribes conduct that his religion prescribes.

A law that is neutral and of general applicability need not be justified by a compelling governmental interest even if the law has the incidental effect of burdening a particular religious practice. A law failing to satisfy these requirements must be justified by a compelling governmental interest and must be narrowly tailored to advance this interest.

There's a recent Ninth Circuit case and not a case involving military but involving a school district, *Doe v. San Diego Unified School District,* a 2021 Ninth Circuit case. In that case, the Ninth Circuit found that a student challenging her school district's vaccine mandate, which did not allow for a religious exception, was not likely to succeed on a free-exercise claim, as she had not raised a serious question about whether the mandate was neutral or generally applicable.

As to neutrality, the Ninth Circuit noted that the terms of the mandate did not make any reference to religion, nor had the student shown a likelihood that the mandate was implemented with the aim of suppressing religious belief rather than protecting the health and safety of students, staff and the community.

Turning to general applicability, the Court noted --

the Ninth Circuit noted that the only exempted students were those who qualified for a medical exemption, which furthered the government's interest in protecting student health and safety, and so it did not undermine the district's interest as a religious exception would and, accordingly, the mandate was subject to rational basis.

Similar to what is involved here, the terms of the Air Force mandate do not make any reference to religion, and plaintiff has not claimed and does not claim that the mandate was implemented with the aim of suppressing religious belief.

The fact that the Air Force has granted medical and administrative exemptions does not render the mandate not generally applicable. And as the Ninth Circuit recognized in the *Doe v. San Diego Unified School District* case, granting the medical exemption furthers their interest in ensuring military readiness and the health of their members as requiring a service member who is, for example, allergic to a component of the vaccine would harm their health.

Accordingly, these exemptions do not undermine the government's interests the way a religious exemption would and, thus, the government is likely to show that the mandate is generally applicable and does not violate the free exercise clause.

In the event that a court -- appellate court might believe, under the free exercise claim, that it's subject to

strict scrutiny for the same reasons that the Court has found that there's not a likelihood of success on the Religious Freedom Restoration Act, I also believe that the free exercise challenge would fail as well for the same reasons as the Court provided with respect to the Religious Freedom Restoration Act.

In terms of the likelihood of irreparable harm to the plaintiff and the other factors, given that the Court has found that there is not a likelihood of success on the merits of the two claims, the Court does not have to reach those issues, but I -- in terms of if it assists both the litigants and the appellate court, I think the irreparable harm issue is a close issue. I think it requires some further evidence.

There obviously is a number of cases, precedent, that indicates that there simply -- a court should find simply that there's a presumption of irreparable harm when a constitutional or statutory right has been infringed, but in a case where plaintiff has failed to demonstrate a sufficient likelihood of success on the merits, then a presumption wouldn't apply.

The plaintiff has argued that he is -- he's already suffered and he's likely to suffer irreversible harm to his career and reputation if he is removed from command.

I'm not sure the evidence is clear on that at this stage, as evidenced by the Court's questions on what could happen if he is ultimately successful in his lawsuit.

Military administrative and disciplinary actions,

including separation, are not, at least at this point in the Court's review of the evidence, not irreparable injuries.

It appears that the plaintiff could later be reinstated and provided backpay if he did prevail on his claim. So at this point I would find that the plaintiff, because he hasn't shown a likelihood of success, has also not met his burden on demonstrating a likelihood of irreparable harm.

And then the last factor is balance of equities in the injunction and public interest, third and fourth requirements of a preliminary injunction. Those two requirements merge when the government is involved. And in this case, again, court's are to give great deference to the professional judgment of military authorities concerning the relative importance of a particular military interest.

In *Winter*, the primary Supreme Court case that set forth the requirements for issuance of a preliminary injunction, the Supreme Court, in fact, reversed the granting of a preliminary injunction on the Navy on just the balance of equities in the injunction and the public interest factors alone.

The Court in *Winters* noted the importance of plaintiff's ecological, scientific and recreational interest in marine mammals but found those interests were plainly outweighed by the Navy's need to conduct realistic training exercises to ensure that it is able to neutralize the threat

posed by enemy submarines. Again, similarly here, the public's interest in military readiness and the efficient administration of the federal government does outweigh plaintiff's claims of job-related and pecuniary loss.

Serious questions have been raised. This is not, obviously, given what's gone on around the country in other cases, a case that district courts don't need further guidance on; but, as I mentioned, at this stage a preliminary injunction, especially enjoining the military, given all that's going on in the world at this time, it would be an extraordinary remedy in this Court's mind. And it can only be granted upon a clear showing that the plaintiff is entitled to the relief that he seeks here.

Courts should be and this court in particular is reluctant to enjoin the military when military readiness is at stake. I thought the discussion in the Texas case -- no. It was Georgia, I'm sorry -- by the judge in Georgia was particularly instructive even though I disagreed with where he came out on the issue, but there's a lot of discussion in this case and other cases I've seen in which the Court talks about how important it is for judges and district courts to seriously weigh what type of anticipated interference there is with the military function; would an injunction seriously impede the military in their performance of vital duties.

The cases strongly suggest that these type of cases

militate strongly against judicial review. We are entitled to review and the plaintiff is certainly entitled to his day in court, given the serious nature of his claim and the fact that it involves both statutory and constitutional issues.

But the judge in the Georgia case, again, which went in favor of the Air Force officer, it was an Air Force officer versus Lloyd Austin, says that "Courts must consider the extent to which the exercise of military expertise or discretion is involved, and courts should defer to the superior knowledge and experience of professionals in matters such as promotions or orders directly related to specific military function." And he writes over and over again, "Judges don't make good generals." I couldn't agree with that statement more.

These are difficult issues that you're asking a district court to make. And given the role of the military in protecting the American people and people around the world, I am reluctant to issue injunctive relief under these circumstances absent a clear -- a clearer or a clear showing that such injunctive relief should be granted.

That's really where I come out and where I disagree with the other cases that have been submitted, particularly by the plaintiff, where injunctive relief has been granted by the district court judge.

Hopefully I've made my decision clear, the basis for my decision. The motion for preliminary injunction is denied.

And I know that this will be pursued. Hopefully the transcript will be clear enough.

And again, I truly appreciate the lawyering in this case. I know it will continue as it moves up through the appellate courts. And given what's going on all around the country, it may end up in the Supreme Court. But thank you for contributing to the discussion and the legal issues, and we'll see where we end up. Thank you both.

Sorry, again, for the Zoom interruptions. We're going to go back to live hearings starting March 1st, so I appreciate your patience as well. Okay. Have a good afternoon.

MR. MOLLOY: Thank you, Your Honor.

MS. ENLOW: Thank you, Your Honor.

THE COURT: Thank you.

(Concluded at 3:29 p.m.)

C E R T I F I C A T E

I certify that the foregoing is a true and correct transcript of the record of proceedings in the above-entitled matter.

Jennifer Coulthard

JENNIFER L. COULTHARD, RMR, CRR
Official Court Reporter

February 28, 2022
DATE

Exhibit 14

Filed Under Seal

Exhibit 15

Filed Under Seal

Exhibit 16

Filed Under Seal

Exhibit 17

Filed Under Seal