UNITED STATES COURT OF APPEALS
FOR THE 11th CIRCUIT

LUCAS WALL,	:	
	:	
Appellant/Plaintiff,	:	
	:	
v.	:	Case No. 22-11532-BB
	:	
CENTERS FOR DISEASE CONTROL & PREVENTION *et al.*	:	
	:	
Appellees/Defendants.	:	

APPELLANT & *AMICI CURIAE*'S UNOPPOSED JOINT MOTION TO COMPEL CLERK TO DOCKET 4 TIMELY FILED FRIEND-OF-THE-COURT BRIEFS

COME NOW appellant and four friends of the court, *pro se*, and jointly move for an order compelling the clerk to docket four *amicus curiae* briefs timely submitted with the consent of both parties pursuant to FRAP 29. *See* highlighted docket entries from July 5 attached as Ex. 1. Notably the four lead *amici curiae* are all listed on the docket[1], but despite submission of electronic and paper copies of their briefs, the clerk's office refuses to file them.

This same issue was a problem at the start of this case in May 2022. Appellant Lucas Wall had to file an emergency motion to compel the clerk to

[1] *Amicus curiae* Kleanthis Andreadakis is also listed on the docket. He is part of the dual citizens group.

file two *amicus curiae* briefs submitted *pro* se in support of his motion to enjoin the International Traveler Testing Requirement, which the Court granted. *See* Order of May 11, 2022.

Despite this Order, the clerk's office refuses to docket the four *pro se amicus curiae* briefs filed July 5 in support of Mr. Wall's arguments and urging reversal of the district court's judgment. This is extremely frustrating because all four groups of *amici curiae* made efforts to alert staff in the clerk's office that these briefs would be submitted. *See* Ex. 3, e-mail from Michael Faris to Eleanor Dixon and Tony Richardson sent July 1:

> "I will be filing on or before July 5 a pro se amicus curiae brief supporting the appellant in the case of Wall v. CDC, No. 22-11532-BB, on behalf of myself and about 20 other disabled airline passengers. We understand from other friends of the court who have already participated in this case that the 11th Circuit does not allow pro se parties to use CM/ECF to file amicus briefs. Therefore we will e-mail the electronic version of our brief to you two for uploading to CM/ECF, unless there is another clerk who will handle that. If so, please provide his/her e-mail address."

Case Administrator Tony Richardson responded to Mr. Faris on July 5 that "We do not accept email filings. You my sign-up for e-filing in order to file your documents via ECF. Otherwise, your documents can be submitted to the Clerk's Office via mail." Ex. 3. However, his efforts to sign up for e-filing were rejected because Mr. Faris is not a party to this case.

The same occurred to the other three groups of *amici curiae*, including Janviere Carlin and Uri Marcus, who attempted to file the two friend-of-the-court briefs in May and were also rejected from registering to do so using the Court's Electronic Case Filing system because they are not parties. As case administrator, Ms. Richardson was well aware of the previous problems encountered by *pro se amici* trying to file briefs in this matter, yet she still refused to accept merits brief filings by e-mail from all *amici* and suggested they sign up for e-filing, which all friends tried but were denied.

Ms. Richardson's conduct is especially troubling because Mr. Wall reminded her to "please note there is a Court Order in effect for this case requiring the Clerk's Office to file amicus curiae briefs received by e-mail. Please see the Order dated May 11, 2022. Amici earlier tried filing via ECF but were unable to do so because they are not parties to the case." *Id*. Yet Ms. Richardson ignored the Court's May 11 Order and refused to accept filings by e-mail. All four groups of *amici* submitted their briefs by e-mail to Ms. Richardson and Ms. Dixon on July 5, the deadline to file friendly briefs in support of the appellant. Exs. 2 & 4-6.

Mr. Marcus responded to Ms. Richardson on July 5 that "We had the same trouble last time, back in May. A Court Order was issued requiring the Clerk's Office to file amicus curiae briefs received by e-mail. See the attached. No

matter what we did, the ECF rejected us filing our amicus curiae briefs because we were not parties to the case." Ex. 7.

Later that day, Ms. Richardson suggested that Mr. Marcus "please contact Andrea Ware, Case Administration Manager." However, efforts to resolve the problem with Ms. Ware were also unsuccessful.

Due to the refusal of the clerk's office personnel to grant ECF access to the *pro se amici* and to accept their briefs by e-mail, Mr. Wall filed them the night of July 5 to ensure they were timely stamped. However, the clerk's office staff also rejected these filings, entering on the docket July 11: "Notice of receipt: Amicus Brief... NO ACTION WILL BE TAKEN Pursuant to FRAP 25(a)(2)(B)(iii) a person cannot electronically file through another person's account. Please resubmit thru the appropriate account of the ECF filer reflected on the signature block of the filed document." Ex. 1.

This is perplexing and aggravating because yet again the clerk's office is asking the *pro se amici* to file using ECF, yet the staff deny us access to do so. *See* Ex. 8, a screenshot of Mr. Marcus' failed attempt to file his group's *amicus curiae* brief using ECF. Furthermore, all four *amici* groups mailed four paper copies of our briefs to the clerk's office as required. But these have not been scanned and added to the docket, and there is no mention on the

docket that the paper briefs were received. Yet we all have U.S. Postal Service confirmations that they were delivered.

It's important to note that both Mr. Wall and counsel for the government appellees both consented to the filing of all four friend-of-the-court briefs, and the government does not oppose this motion to compel the clerk's office to docket the four briefs filed July 5.

"The United States or its officer or agency or a state may file an *amicus* brief without the consent of the parties or leave of court. Any other *amicus curiae* may file a brief only by leave of court or ***if the brief states that all parties have consented to its filing***…" FRAP 29(a)(2) (emphasis added).

Amici are 313 airline workers, 16 disabled passengers, three industrial hygiene experts, and three dual citizens. Both parties have consented to the filing of these briefs, so there should be no obstruction to allowing the *amici* to submit arguments to help guide the Court's decision on this critical matter of interest to tens of millions of Americans.

The Court needs to compel the clerk to stop obstructing the *pro se amici*'s numerous attempts to file (by e-mail, ECF, and paper). Nowhere in FRAP 29 is there a prohibition on *amicus curiae* briefs being submitted *pro se*, and the clerk's office has not made any effort to communicate to the *amici* why

our briefs are not being timely docketed. These 335 Americans deserve to have our voices heard. We have all spent numerous hours researching the law and composing our briefs in support of Mr. Wall's arguments.

The four briefs are attached to this filing.

We consulted July 29 with Alisa Klein, counsel for the appellees. She informed us the government does not oppose this motion.

WHEREFORE, we jointly request this Court issue an order granting the following relief:

"The Clerk is hereby COMPELLED to immediately file and docket the *amicus curiae* briefs submitted via e-mail, ECF, and paper by 313 Airline Workers, 16 Disabled Passengers, 3 Industrial Hygiene Experts, and 3 Dual Citizens."

Respectfully submitted this 31st day of July 2022.

Lucas Wall

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CERTIFICATE OF INTERESTED PERSONS

We all certify that the CIPs included in our briefs are correct and complete.

CERTIFICATE OF COMPLIANCE

We certify that this motion complies with the requirements of FRAP 27(d) because it has been prepared in 14-point Georgia, a proportionally spaced font, and it conforms with the limit of 5,200 words because this document contains 1,216 words, according to Microsoft Word (excluding sections not counted pursuant to FRAP 32(f)).

Exhibit 1

General Docket
United States Court of Appeals for the Eleventh Circuit

Court of Appeals Docket #: 22-11532 **Docketed:** 05/04/2022
Nature of Suit: 2899 Adminstrative Review Act
Lucas Wall v. Centers for Disease Control and Prevention, et al
Appeal From: Middle District of Florida
Fee Status: Fee Paid

Case Type Information:
1) U.S. Civil
2) U.S. Defendant - Non PLRA
3) -

Originating Court Information:
District: 113A-6 : 6:21-cv-00975-PGB-DCI
Civil Proceeding: Paul G. Byron, U.S. District Judge
Secondary Judge: Daniel C. Irick, U.S. Magistrate Judge
Date Filed: 06/07/2021
Date NOA Filed:
05/03/2022

Prior Cases:
21-12179 **Date Filed:** 06/25/2021 **Date Disposed:** 06/30/2021 **Disposition:** Dismissed
21-90017 **Date Filed:** 06/24/2021 **Date Disposed:** 06/28/2021 **Disposition:** Other

Current Cases:
None

LUCAS WALL	Plaintiff - Appellant	Lucas Wall Direct: 202-351-1735 [NTC Pro Se] 3601 COSMOS WY THE VILLAGES, FL 32163
versus		
CENTERS FOR DISEASE CONTROL AND PREVENTION	Defendant - Appellee	Brian James Springer [COR LD NTC U.S. Government] U.S. Department of Justice 950 CONSTITUTION AVE NW WASHINGTON, DC 20530-0001 Andrew F. Freidah [NTC Retained] U.S. Department of Justice Civil Division Firm: 202-307-0162 1100 L ST NW WASHINGTON, DC 20005 Alisa Beth Klein [COR NTC U.S. Government] U.S. Attorney General's Office 950 PENNSYLVANIA AVE NW WASHINGTON, DC 20530-0001 Stephen Michael Pezzi [NTC Retained] U.S. Department of Justice Civil Division Firm: 202-307-0162 1100 L ST NW WASHINGTON, DC 20005 Marcia Kay Sowles [NTC Retained] U.S. Dept. of Justice Firm: 202-514-4960

	1100 L ST NW ROOM 11028 WASHINGTON, DC 20005
DEPARTMENT OF HEALTH AND HUMAN SERVICES Defendant - Appellee	Brian James Springer [COR LD NTC U.S. Government] (see above) Andrew F. Freidah [NTC Retained] (see above) Alisa Beth Klein [COR NTC U.S. Government] (see above) Stephen Michael Pezzi [NTC Retained] (see above) Marcia Kay Sowles [NTC Retained] (see above)
GREATER ORLANDO AVIATION AUTHORITY Defendant - Appellee ***NOT AN APPELLEE	Sally Rogers Culley [NTC Retained] Rumberger Kirk & Caldwell, PA Firm: 407-872-7300 300 S ORANGE AVE STE 1400 PO BOX 1873 ORLANDO, FL 32801 Patrick M. Delaney Direct: 850-414-3583 [NTC Retained] Office of the Attorney General Firm: 850-414-3300 PL-01 The Capitol TALLAHASSEE, FL 32399-1050 Daniel Jay Gerber Direct: 407-872-7300 [NTC Retained] Rumberger Kirk & Caldwell, PA Firm: 407-872-7300 300 S ORANGE AVE STE 1400 PO BOX 1873 ORLANDO, FL 32801 Suzanne Barto Hill [NTC Retained] Rumberger Kirk & Caldwell, PA Firm: 407-872-7300 300 S ORANGE AVE STE 1400 PO BOX 1873 ORLANDO, FL 32801
CENTRAL FLORIDA REGIONAL TRANSPORTATION AUTHORITY Defendant - Appellee ***NOT AN APPELLEE	Monica Marie McNulty Kovecses Direct: 407-423-4000 [NTC Retained] Akerman, LLP 420 S ORANGE AVE STE 1200 ORLANDO, FL 32801 David S. Wood Direct: 407-423-4000 [NTC Retained] Akerman, LLP 420 S ORANGE AVE STE 1200 ORLANDO, FL 32801

TRANSPORTATION SECURITY ADMINISTRATION	Defendant - Appellee	Andrew F. Freidah [NTC Retained] (see above) Stephen Michael Pezzi [NTC Retained] (see above) Marcia Kay Sowles [NTC Retained] (see above)
DEPARTMENT OF HOMELAND SECURITY	Defendant - Appellee	Andrew F. Freidah [NTC Retained] (see above) Stephen Michael Pezzi [NTC Retained] (see above) Marcia Kay Sowles [NTC Retained] (see above)
DEPARTMENT OF TRANSPORTATION	Defendant - Appellee	Andrew F. Freidah [NTC Retained] (see above) Stephen Michael Pezzi [NTC Retained] (see above) Marcia Kay Sowles [NTC Retained] (see above)

SERVICE		U.S. Attorney Service - Middle District of Florida [NTC Not Applicable] U.S. Attorney's Office Firm: 813-274-6000 400 N TAMPA ST STE 3200 TAMPA, FL 33602
KLEANTHIS NICHOLAS ANDREADAKIS		Kleanthis Nicholas Andreadakis Direct: 804-988-1402 [NTC Not Applicable] 5108 HUNTERS MEADOW PL HENRICO, VA 23231
JANVIERE CARLIN		Janviere Carlin Direct: 757-274-3406 [NTC Not Applicable] 93 LONDONDERRY WY UXBRIDGE, MA 01569
URI MARCUS		Uri Marcus Direct: 909-833-0065 [NTC Not Applicable] Nrf PO BOX 126 OJAI, CA 93024
TYSON GABRIEL		Tyson Gabriel [NTC Not Applicable] Firm: 623-243-7263 4501 N. 22ND ST UNIT 190 PHOENIX, AZ 85016

MICHAEL FARIS	Michael Faris [NTC Not Applicable] 160 CHARLOTTE CIR ELIZABETHTOWN, KY 42701

05/04/2022	35 pg, 4.83 MB	CIVIL APPEAL DOCKETED. Notice of appeal filed by Appellant Lucas Wall on 05/03/2022. Fee Status: Fee Paid. No hearings to be transcribed. The appellant's brief is due on or before 06/13/2022. The appendix is due no later than 7 days from the filing of the appellant's brief. Awaiting Appellant's Certificate of Interested Persons due on or before 05/20/2022 as to Appellant Lucas Wall. Awaiting Appellee's Certificate of Interested Persons due on or before 06/03/2022 as to Appellees Centers for Disease Control and Prevention, Central Florida Regional Transportation Authority and Greater Orlando Aviation Authority [Entered: 05/06/2022 12:32 PM]
05/06/2022	1 pg, 197.68 KB	APPEARANCE of Counsel Form filed by Alisa B. Klein for CDC et al. [22-11532] (ECF: Alisa Klein) [Entered: 05/06/2022 05:16 PM]
05/06/2022	1 pg, 119.2 KB	APPEARANCE of Counsel Form filed by Brian J. Springer for Centers for Disease Control and Prevention and Department of Health and Human Services [22-11532] (ECF: Brian Springer) [Entered: 05/06/2022 05:24 PM]
05/06/2022	32 pg, 587.69 KB	*EMERGENCY MOTION for injunction pending appeal filed by Lucas Wall. Motion is Opposed. [9663585-1]* [22-11532] (ECF: Lucas Wall) [Entered: 05/06/2022 11:40 PM]
05/09/2022	346 pg, 13 MB	**RECEIVED/NO ACTION TAKEN-INCORRECT EVENT USED TO FILE A DOCUMENT**Appendix filed [1 VOLUMES] by Appellant Lucas Wall. [22-11532]--[Edited 05/09/2022 by TLR] (ECF: Lucas Wall) [Entered: 05/07/2022 01:35 AM]
05/09/2022	32 pg, 256.5 KB	Certificate of Interested Persons and Corporate Disclosure Statement filed by Party Lucas Wall. On the same day the CIP is served, any filer represented by counsel must also complete the court's web-based stock ticker symbol certificate at the link here http://www.ca11.uscourts.gov/web-based-cip or on the court's website. See 11th Cir. R. 26.1-1(b). [22-11532] (ECF: Lucas Wall) [Entered: 05/07/2022 03:07 AM]
05/09/2022	3 pg, 139.7 KB	**RECEIVED/NO ACTION TAKEN-INCORRECT EVENT USED TO FILE A DOCUMENT**Appellant's Notice to the Court Re: Incorrect Party & Attorney Docketing filed by Party Lucas Wall. [22-11532]--[Edited 05/09/2022 by TLR] (ECF: Lucas Wall) [Entered: 05/07/2022 10:56 PM]
05/09/2022	2 pg, 91.49 KB	Public Communication: The parties are notified that the response(s) to the "EMERGENCY MOTION for injunction pending appeal" filed by Appellant Lucas Wall is due by May 10, 2022. [Entered: 05/09/2022 08:47 AM]
05/09/2022		Notice of deficient document filed by Lucas Wall. Incorrect Event used (Appendix) to file a document in support of a motion. Appellant must refile the document using the correct motions event no later than May 9, 2022. [Entered: 05/09/2022 01:48 PM]
05/09/2022		Removed from case: Attorney Adam R. Smart for Not Party Service in 22-11532. [Entered: 05/09/2022 03:20 PM]
05/09/2022		Notice of deficient Motion filed by Lucas Wall. Incorrect Event (Notice to the Court Re: Incorrect Party & Attorney Docketing) used to file a document Appellant must refile the document using the Motion filed event within 3 days. [Entered: 05/09/2022 03:39 PM]
05/09/2022	346 pg, 13.43 MB	*Supplemental Motion for injunction pending appeal [9663585-2] filed by Appellant Lucas Wall.* [22-11532] (ECF: Lucas Wall) [Entered: 05/09/2022 09:36 PM]
05/09/2022	3 pg, 140.9 KB	*RECEIVED/NO ACTION TAKEN-Missing CIP**MOTION Correct Party & Attorney Docketing filed by Lucas Wall. Motion is Unopposed. [9664616-1]* [22-11532]--[Edited 05/25/2022 by TLR] (ECF: Lucas Wall) [Entered: 05/09/2022 09:59 PM]
05/10/2022	4 pg, 305.68 KB	Civil Appeal Statement filed by Party Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 05/10/2022 03:25 AM]
05/10/2022		Notice of deficient "MOTION Correct Party & Attorney Docketing" filed by Lucas Walll. Document does not contain a Certificate of Interested Persons. See 11th Cir. Rules 26.1-1 through 26.1-5. Appellant must refile the motion (with a CIP attached) within 3 days of this notice. [Entered: 05/10/2022 10:39 AM]
05/10/2022	4 pg, 447.26 KB	Notice of receipt: MOTION Correct Party & Attorney Docketing filed by Lucas Wall as to Appellant Lucas Wall. NO ACTION WILL BE TAKEN Motion must include a CIP per 11th Cir. Rules 26.1-1 through 26.1-5. [Entered: 05/10/2022 10:42 AM]
05/10/2022	29 pg, 186.59 KB	RESPONSE to Motion for injunction pending appeal filed by Appellant Lucas Wall [9663585-2] filed by Attorney Brian James Springer for Appellees Centers for Disease Control and Prevention and Department of Health and Human Services. [22-11532] (ECF: Brian Springer) [Entered: 05/10/2022 05:19 PM]
05/11/2022	3 pg, 210.52 KB	*MOTION to Correct Party & Attorney Docketing filed by Lucas Wall. Motion is Unopposed. [9665776-1]* [22-11532] (ECF: Lucas Wall) [Entered: 05/11/2022 12:57 AM]
05/11/2022	128 pg, 4.06 MB	*EMERGENCY MOTION to compel filed by Lucas Wall. Opposition to Motion is Unknown. [9665777-1]* [22-11532] (ECF: Lucas Wall) [Entered: 05/11/2022 02:48 AM]

05/11/2022	2 pg, 135.43 KB	Notice that My Emergency Motion to Compel Is Unopposed filed by Party Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 05/11/2022 07:47 AM]
05/11/2022	68 pg, 2.07 MB	Reply to response filed by Appellant Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 05/11/2022 10:30 AM]
05/11/2022	2 pg, 71.43 KB	ORDER: "Appellant's Emergency Motion to Compel Clerk to Docket Amicus Curiae Briefs Submitted by 312 Pilots, Flight Attendants, & Dual Citizens" is GRANTED in that the Clerk's Office is directed to place the amicus briefs attached to the motion on the docket in this appeal. ENTERED FOR THE COURT-BY DIRECTION[9665777-2] [Entered: 05/11/2022 04:23 PM]
05/11/2022	92 pg, 1.34 MB	BRIEF OF AMICI CURIAE 309 PILOTS & FLIGHT ATTENDANTS [Entered: 05/11/2022 04:55 PM]
05/11/2022	26 pg, 220.41 KB	BRIEF OF AMICI CURIAE 3 DUAL CITIZENS [Entered: 05/11/2022 04:57 PM]
05/12/2022	1 pg, 50.08 KB	ORDER: "Appellant's Emergency Motion for Preliminary Injunction Pending Appeal Against Appellees CDC & HHS" is DENIED. The Clerk is directed to treat any motion for reconsideration of this order as a non-emergency matter. [9663585-2] CRW, AJ and RJL [Entered: 05/12/2022 10:43 AM]
06/03/2022	19 pg, 127.91 KB	Certificate of Interested Persons and Corporate Disclosure Statement filed by Attorney Brian James Springer for Appellees Centers for Disease Control and Prevention and Department of Health and Human Services. On the same day the CIP is served, any filer represented by counsel must also complete the court's web-based stock ticker symbol certificate at the link here http://www.ca11.uscourts.gov/web-based-cip or on the court's website. See 11th Cir. R. 26.1-1(b). [22-11532] (ECF: Brian Springer) [Entered: 06/03/2022 09:35 AM]
06/10/2022	3 pg, 206.47 KB	***RECEIVED/NO ACTION TAKEN-Missing CIP**MOTION for extension of time to file appellant's brief to 06/27/2022, for extension of time to file appendix to 07/05/2022 filed by Lucas Wall. Motion is Unopposed. [9690187-1]* [22-11532]--[Edited 06/10/2022 by TLR] (ECF: Lucas Wall) [Entered: 06/10/2022 06:42 AM]
06/10/2022		Notice of deficient Motion for extension filed by Lucas Wall. Document does not contain a Certificate of Interested Persons. See 11th Cir. Rules 26.1-1 through 26.1-5. Appellant must refile the motion with a CIP included within 3 days. [Entered: 06/10/2022 10:03 AM]
06/10/2022	4 pg, 369.03 KB	Notice of receipt: Motion for extension of time to file appellant's brief as to Appellant Lucas Wall. NO ACTION WILL BE TAKEN Document does not contain a Certificate of Interested Persons. See 11th Cir. Rules 26.1-1 through 26.1-5. [Entered: 06/10/2022 10:08 AM]
06/10/2022	3 pg, 217.93 KB	*MOTION for extension of time to file appellant's brief to 06/27/2022, for extension of time to file appendix to 07/05/2022 filed by Lucas Wall. Motion is Unopposed. [9690741-1]* [22-11532] (ECF: Lucas Wall) [Entered: 06/10/2022 12:57 PM]
06/10/2022	2 pg, 133.54 KB	NOTICE TO THE COURT THAT AN UNOPPOSED MOTION FILED 1 MONTH AGO HAS NOT BEEN DECIDED filed by Party Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 06/10/2022 01:12 PM]
06/10/2022		ORDER: Motion for extension to file appellant brief filed by Appellant Lucas Wall is GRANTED by clerk. [9690741-2] Appellants brief is due on 06/27/2022. **Any request for a second or subsequent extension of time shall be subject to 11th Cir. R. 31-2(d).** ; ORDER: Motion for extension to file appendix filed by Appellant Lucas Wall is GRANTED by clerk. [9690741-3] Appendix due on 07/05/2022. **Any request for a second or subsequent extension of time shall be subject to 11th Cir. R. 31-2(d).** [Entered: 06/10/2022 01:29 PM]
06/10/2022	1 pg, 83.79 KB	Public Communication: Letter to Pro Se Appellant-Case Administrator response to Appellant's "Notice to the Court..." filed 6/10/22. Please be advised that the 5/11/22, Motion to Correct Party filed by Appellant is currently pending. [Entered: 06/10/2022 01:36 PM]
06/22/2022	6 pg, 226.37 KB	*TIME SENSITIVE MOTION for excess words/pages filed by Lucas Wall. Opposing Counsel takes no Position. [9698949-1]* [22-11532] (ECF: Lucas Wall) [Entered: 06/22/2022 06:40 PM]
06/27/2022	116 pg, 934.7 KB	**EXCEEDS WORD COUNT-LEAVE TO FILE DENIED PER 7/11/22 ORDER**Appellant's brief filed by Lucas Wall. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 06/27/2022 08:58 PM]
06/27/2022	1 pg, 405.7 KB	Notice to the Court Re: Paper Copies of Opening Brief filed by Party Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 06/27/2022 09:16 PM]
06/27/2022	1120 pg, 31.83 MB	Appendix filed [3 VOLUMES] by Appellant Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 06/27/2022 09:48 PM]
06/29/2022	2 pg, 88.01 KB	Notice of deficient Appellant appendix filed by Party Lucas Wall. Deficiencies: complaint, answer to complaint & order/judgment being appealed. [Entered: 06/29/2022 11:56 AM]

06/29/2022	1 pg, 94.94 KB	Notice of deficient Appellant brief filed by Party Lucas Wall.Deficiencies: certificate of interested persons. [Entered: 06/29/2022 02:19 PM]
06/30/2022	1 pg, 51.37 KB	ORDER: Before the Court is "Appellant's Second Unopposed Motion to Correct Party & Attorney Docketing." To the extent Appellant seeks to dismiss the Greater Orlando Aviation Authority and Central Florida Regional Transportation Authority as appellees, the motion is CARRIED WITH THE CASE. The motion is otherwise DENIED. [9665776-2] CRW, JP and RJL [Entered: 06/30/2022 11:02 AM]
07/01/2022	2 pg, 413.24 KB	Letter to the Clerk Re: Corrected Brief filed by Party Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 07/01/2022 05:21 AM]
07/01/2022	147 pg, 934.07 KB	**EXCEEDS WORD COUNT-LEAVE TO FILE DENIED PER 7/11/22 ORDER**Corrected Appellant's Brief filed by Appellant Lucas Wall. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 07/01/2022 06:05 AM]
07/01/2022	1119 pg, 31.72 MB	Corrected Appendix filed [3 VOLUMES] by Appellant Lucas Wall. [22-11532] (ECF: Lucas Wall) [Entered: 07/01/2022 08:18 AM]
07/05/2022	45 pg, 801.56 KB	**RECEIVED/NO ACTION TAKEN-SEE FRAP 25(a)(2)(B)(iii)**Amicus Brief as of right or by consent of the parties filed by Uri Marcus for 3 Dual Citizens. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 07/05/2022 10:47 PM]
07/05/2022	63 pg, 2.53 MB	**RECEIVED/NO ACTION TAKEN-SEE FRAP 25(a)(2)(B)(iii)**Amicus Brief as of right or by consent of the parties filed by Tyson Gabriel for 3 Industrial Hygiene Experts. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 07/05/2022 10:49 PM]
07/05/2022	193 pg, 3.21 MB	**RECEIVED/NO ACTION TAKEN-SEE FRAP 25(a)(2)(B)(iii)**Amicus Brief as of right or by consent of the parties filed by Janviere Carlin for 313 Airline Workers. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 07/05/2022 10:53 PM]
07/05/2022	63 pg, 1.1 MB	**RECEIVED/NO ACTION TAKEN-SEE FRAP 25(a)(2)(B)(iii)**Amicus Brief as of right or by consent of the parties filed by Michael Faris for 16 Disabled Passengers. [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Lucas Wall) [Entered: 07/05/2022 11:19 PM]
07/05/2022	46 pg, 3.32 MB	Notice of receipt: Amicus Brief...filed by Uri Marcus for 3 Dual Citizens as to Not Party Uri Marcus. NO ACTION WILL BE TAKEN Pursuant to FRAP 25(a)(2)(B)(iii) a person cannot electronically file through another person's account. Please resubmit thru the appropriate account of the ECF filer reflected on the signature block of the filed document. [Entered: 07/11/2022 10:56 AM]
07/05/2022	64 pg, 7.08 MB	Notice of receipt: Amicus Brief as of right or by consent of the parties filed by Tyson Gabriel for 3 Industrial Hygiene Experts. as to Not Party Tyson Gabriel. NO ACTION WILL BE TAKEN Pursuant to FRAP 25(a)(2)(B)(iii) a person cannot electronically file through another person's account. Please resubmit thru the appropriate account of the ECF filer reflected on the signature block of the filed document. [Entered: 07/11/2022 11:31 AM]
07/05/2022	194 pg, 20.49 MB	Notice of receipt: Amicus Brief filed by Janviere Carlin for 313 Airline Workers. as to Not Party Janviere Carlin. NO ACTION WILL BE TAKEN NO ACTION WILL BE TAKEN Pursuant to FRAP 25(a)(2)(B)(iii) a person cannot electronically file through another person's account. Please resubmit thru the appropriate account of the ECF filer reflected on the signature block of the filed document.. [Entered: 07/11/2022 03:20 PM]
07/05/2022	64 pg, 5.56 MB	Notice of receipt: Amicus Brief filed by Michael Faris for 16 Disabled Passengers as to Not Party Michael Faris. NO ACTION WILL BE TAKEN Pursuant to FRAP 25(a)(2)(B)(iii) a person cannot electronically file through another person's account. Please resubmit thru the appropriate account of the ECF filer reflected on the signature block of the filed document. [Entered: 07/11/2022 03:33 PM]
07/07/2022		Received 4 paper copies of EBrief, filed by Appellant Lucas Wall. [Entered: 07/07/2022 03:12 PM]
07/07/2022		Received paper copies of EAppendix filed by Appellant Lucas Wall. 3 VOLUMES - 2 COPIES [Entered: 07/07/2022 03:12 PM]
07/08/2022	25 pg, 148.93 KB	***RECEIVED/NO ACTION TAKEN-See 7/11/22, Order**MOTION for extension of time to file appellee's brief to 08/26/2022 filed by Centers for Disease Control and Prevention and Department of Health and Human Services. Motion is Opposed. [9709993-1]* [22-11532]--[Edited 07/11/2022 by TLR] (ECF: Brian Springer) [Entered: 07/08/2022 11:23 AM]
07/11/2022	1 pg, 53.17 KB	ORDER: "Appellant's Unopposed Time-Sensitive Motion to Exceed Word Limits for Opening Brief & Reply Brief" is DENIED. Within 21 days after the date of this order, Appellant must file an initial brief that complies with the Court's rules, including the applicable type-volume limitation. [9698949-2] KCN (See attached order for complete text) [Entered: 07/11/2022 10:09 AM]
07/11/2022	26 pg, 718.4 KB	Notice of receipt: Motion for extension to file Appellee brief as to Appellee Centers for Disease Control and Prevention. NO ACTION WILL BE TAKEN Appellee's brief is not currently due. See 7/11/22, Order as to appellant's brief. [Entered: 07/11/2022 10:45 AM]

Exhibit 2

Filing Amicus Curiae Brief of 313 Airline Workers in Wall v. CDC

From: Shellie Carlin (jshellie@charter.net)

To: eleanor_dixon@ca11.uscourts.gov; tonya_richardson@ca11.uscourts.gov

Cc: lucas.wall@yahoo.com; alisa.klein@usdoj.gov; brian.j.springer@usdoj.gov

Date: Tuesday, July 5, 2022 at 08:42 PM EDT

Dear Ms. Dixon and Ms. Richardson:

Please accept this *amicus curiae* brief for filing in *Wall v. Centers for Disease Control & Prevention*, No. 22-11532-BB. Four paper copies are also being mailed as required. There is a Court Order from May 11 in this case requiring you to file *amici* briefs submitted by e-mail since you have not allowed us to use the Court's CM/ECF system to file electronically.

Thanks!

Janviere Carlin, lead *amicus curiae* for 313 Airline Workers

Amcicus Brief of Airline Workers.pdf
3.2MB

Exhibit 3

Re: Wall v. CDC #22-11532-BB Amicus Brief Submission Notification

From: Lucas Wall (lucas.wall@yahoo.com)

To: tonya_richardson@ca11.uscourts.gov

Cc: alisa.klein@usdoj.gov; eleanor_dixon@ca11.uscourts.gov; michael.faris@blueskycopters.com; brian.j.springer@usdoj.gov

Date: Tuesday, July 5, 2022 at 01:37 PM EDT

Dear Ms. Richardson:

As noted in my prior message, please note there is a Court Order in effect for this case requiring the Clerk's Office to file amicus curiae briefs received by e-mail. Please see the Order dated May 11, 2022. Amici earlier tried filing via ECF but were unable to do so because they are not parties to the case.

*Lucas Wall, appellant

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

> On Tuesday, July 5, 2022 at 01:34:37 PM EDT, Tonya Richardson <tonya_richardson@ca11.uscourts.gov> wrote:
>
> Good afternoon,
>
> We do not accept email filings. You my sign-up for e-filing in order to file your documents via ECF. Otherwise, your documents can be submitted to the Clerk's Office via mail.
>
> Sincerely,
>
> Tonya Richardson
>
> Case Administrator
>
> 11th Circuit Court of Appeals

56 Forsyth Street N.W.

Atlanta, GA 30303

Phone: (404) 335-6174

From: Michael Faris <michael.faris@blueskycopters.com>
Sent: Friday, July 1, 2022 12:11 PM
To: Eleanor Dixon <Eleanor_Dixon@ca11.uscourts.gov>; Tonya Richardson <tonya_richardson@ca11.uscourts.gov>
Cc: Lucas Wall <Lucas.Wall@yahoo.com>; Alisa.Klein@usdoj.gov; Brian.J.Springer@usdoj.gov
Subject: Wall v. CDC #22-11532-BB Amicus Brief Submission Notification

CAUTION - EXTERNAL:

Dear Ms. Dixon and Ms. Richardson:

I will be filing on or before July 5 a *pro se amicus curiae* brief supporting the appellant in the case of Wall v. CDC, No. 22-11532-BB, on behalf of myself and about 20 other disabled airline passengers.

We understand from other friends of the court who have already participated in this case that the 11th Circuit does not allow *pro se* parties to use CM/ECF to file *amicus* briefs. Therefore we will e-mail the electronic version of our brief to you two for uploading to CM/ECF, unless there is another clerk who will handle that. If so, please provide his/her e-mail address.

We understand that four paper copies of our brief must be mailed and we will be taking care of that early next week once e-filed.

Thanks for your help with this matter.

--

Michael Faris

UH-60 MX Supervisor

2015 Mckinley Ave Ste. F4

Laverne, CA 91750

Exhibit 4

Wall v. CDC -- Amicus Curiae Brief of 16 Disabled Passengers

From: Michael Faris (michael.faris@blueskycopters.com)

To: eleanor_dixon@ca11.uscourts.gov; tonya_richardson@ca11.uscourts.gov

Cc: lucas.wall@yahoo.com; alisa.klein@usdoj.gov; brian.j.springer@usdoj.gov

Date: Tuesday, July 5, 2022 at 11:07 PM EDT

Dear clerks:

Please accept this *amicus curiae* brief for filing in *Wall v. Centers for Disease Control & Prevention*, No. 22-11532-BB. Four paper copies are also being mailed as required. There is a Court Order from May 11 in this case requiring you to file *amici* briefs submitted by e-mail since you have not allowed us to use the Court's CM/ECF system to file electronically.

Thanks you for your kind assistance.

--

Michael Faris
UH-60 MX Supervisor
2015 Mckinley Ave Ste. F4
Laverne, CA 91750
270-723-4944

Amcicus Brief of Disabled Passengers.pdf
1.1MB

Exhibit 5

Re: Wall v. CDC - Amicus Brief of 3 Industrial Hygiene Experts

From: Lucas Wall (lucas.wall@yahoo.com)

To: tgabriel@premierrm.com

Cc: alisa.klein@usdoj.gov; brian.j.springer@usdoj.gov; spetty@eesgroup.us; dhoward@premierrm.com; eleanor_dixon@ca11.uscourts.gov; tonya_richardson@ca11.uscourts.gov

Date: Tuesday, July 5, 2022 at 01:38 PM EDT

Dear Ms. Richardson:

As noted in my prior message, please note there is a Court Order in effect for this case requiring the Clerk's Office to file amicus curiae briefs received by e-mail. Please see the Order dated May 11, 2022. Amici earlier tried filing via ECF but were unable to do so because they are not parties to the case.

*Lucas Wall, appellant

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

On Tuesday, July 5, 2022 at 01:37:38 PM EDT, Tonya Richardson <tonya_richardson@ca11.uscourts.gov> wrote:

Good afternoon,

We do not accept email filings. You my sign-up for e-filing in order to file your documents via ECF. Otherwise, your motion and amicus brief can be submitted to the Clerk's Office via mail.

Sincerely,

Tonya Richardson

Case Administrator

11th Circuit Court of Appeals

56 Forsyth Street N.W.

Atlanta, GA 30303

Phone: (404) 335-6174

From: Tyson Gabriel <tgabriel@premierrm.com>
Sent: Tuesday, July 5, 2022 11:43 AM
To: Eleanor Dixon <Eleanor_Dixon@ca11.uscourts.gov>; Tonya Richardson <tonya_richardson@ca11.uscourts.gov>
Cc: Lucas Wall <lucas.wall@yahoo.com>; Alisa.Klein@usdoj.gov; Brian.J.Springer@usdoj.gov; Stephen Petty <spetty@eesgroup.us>; Dave Howard <dhoward@premierrm.com>; Glenda Heath <gheath@premierrm.com>; mrradioactive@protonmail.com
Subject: Wall v. CDC - Amicus Brief of 3 Industrial Hygiene Experts

CAUTION - EXTERNAL:

Dear 11th Circuit clerks:

Please accept this *amicus curiae* brief for filing in *Wall v. Centers for Disease Control & Prevention*, No. 22-11532-BB. Four paper copies are being mailed as required.

Thanks much,

Tyson Gabriel, IH, OEHS Pro

Risk Manager

www.premierrm.com

PREMIER RISK MANAGEMENT

623-243-7263 I 800-980-RISK

4501 North 22nd Street | Suite 190 | Phoenix, AZ 85016

Exhibit 6

Re: Submission of Wall v. CDC -- Amicus Brief of Dual Citizens

From: Lucas Wall (lucas.wall@yahoo.com)

To: tonya_richardson@ca11.uscourts.gov

Cc: alisa.klein@usdoj.gov; uri@ntcf.org; eleanor_dixon@ca11.uscourts.gov; brian.j.springer@usdoj.gov; mrradioactive@protonmail.com

Date: Tuesday, July 5, 2022 at 01:35 PM EDT

Dear Ms. Richardson:

Please note there is a Court Order in effect for this case requiring the Clerk's Office to file amicus curiae briefs received by e-mail. Please see the Order dated May 11, 2022. Amici earlier tried filing via ECF but were unable to do so because they are not parties to the case.

*Lucas Wall, appellant

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

On Tuesday, July 5, 2022 at 01:30:41 PM EDT, Tonya Richardson <tonya_richardson@ca11.uscourts.gov> wrote:

Good afternoon,

We do not accept email filings. You my sign-up for e-filing in order to file your documents via ECF. Otherwise, your motion and amicus brief can be submitted to the Clerk's Office via mail.

Sincerely,

Tonya Richardson

Case Administrator

11th Circuit Court of Appeals

56 Forsyth Street N.W.

Atlanta, GA 30303

Phone: (404) 335-6174

From: Uriel ben-Mordechai <uri@ntcf.org>
Sent: Tuesday, July 5, 2022 12:32 AM
To: Eleanor Dixon <Eleanor_Dixon@ca11.uscourts.gov>; Tonya Richardson <tonya_richardson@ca11.uscourts.gov>
Cc: Lucas.Wall@yahoo.com; Klein, Alisa (CIV) <Alisa.Klein@usdoj.gov>; Brian.J.Springer@usdoj.gov; mrradioactive@protonmail.com
Subject: Submission of Wall v. CDC -- Amicus Brief of Dual Citizens

CAUTION - EXTERNAL:

Shalom 11th Circuit Staff:

Please accept this amicus curiae brief for filing in Wall v. Centers for Disease Control & Prevention, No. 22-11532-BB.

Four paper copies are being mailed as required.

Uri Marcus

Exhibit 7

RE: Submission of Wall v. CDC -- Amicus Brief of Dual Citizens

From: Tonya Richardson (tonya_richardson@ca11.uscourts.gov)

To: lucas.wall@yahoo.com

Cc: alisa.klein@usdoj.gov; brian.j.springer@usdoj.gov; mrradioactive@protonmail.com

Date: Tuesday, July 5, 2022 at 03:24 PM EDT

Good afternoon,

In response to your email, please contact Andrea Ware, Case Administration Manager at (404) 335-6218.

From: Uriel ben-Mordechai <uri@ntcf.org>
Sent: Tuesday, July 5, 2022 3:20 PM
To: Tonya Richardson <tonya_richardson@ca11.uscourts.gov>
Cc: Klein, Alisa (CIV) <alisa.klein@usdoj.gov>; Eleanor Dixon <Eleanor_Dixon@ca11.uscourts.gov>; Brian.J.Springer@usdoj.gov; mrradioactive@protonmail.com
Subject: Re: Submission of Wall v. CDC -- Amicus Brief of Dual Citizens

CAUTION - EXTERNAL:

Shalom Ms. Richardson:

We had the same trouble last time, back in May.

A Court Order was issued requiring the Clerk's Office to file amicus curiae briefs received by e-mail. See the attached.

No matter what we did, the ECF rejected us filing our amicus curiae briefs because we were not parties to the case.

It seems much easier for the clerk to upload the PDF than have to scan the mailed paper version.

How would you like us to proceed? Can we e-file via pacer?

Uri Marcus

>>>>>>>>>>>>>>>>>>>>>>>>>>>>>

On Tuesday, July 5, 2022 at 01:30:41 PM EDT, Tonya Richardson <tonya_richardson@ca11.uscourts.gov> wrote:

Good afternoon,

We do not accept email filings. You my sign-up for e-filing in order to file your documents via ECF. Otherwise, your motion and amicus brief can be submitted to the Clerk's Office via mail.

Sincerely,

Tonya Richardson

Case Administrator

11th Circuit Court of Appeals

56 Forsyth Street N.W.

Atlanta, GA 30303

Phone: (404) 335-6174

From: Uriel ben-Mordechai <uri@ntcf.org>
Sent: Tuesday, July 5, 2022 12:32 AM
To: Eleanor Dixon <Eleanor_Dixon@ca11.uscourts.gov>; Tonya Richardson <tonya_richardson@ca11.uscourts.gov>
Cc: Lucas.Wall@yahoo.com; Klein, Alisa (CIV) <Alisa.Klein@usdoj.gov>; Brian.J.Springer@usdoj.gov; mrradioactive@protonmail.com
Subject: Submission of Wall v. CDC -- Amicus Brief of Dual Citizens

CAUTION - EXTERNAL:

Shalom 11th Circuit Staff:

Please accept this amicus curiae brief for filing in Wall v. Centers for Disease Control & Prevention, No. 22-11532-BB.

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Uri Marcus

Exhibit 8

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United States Court of Appeals for the Eleventh Circuit

File a Document

Case Number

22-11532 Lucas Wall v. Centers for Disease Control and Prevention, et al

Filed

07/05/2022

Type of Document	Category
amicus brief filed by government entity or with consent of all parties	All
Addendum to Brief Filed	Briefing
Administrative Agency Record on Appeal Filed	Miscellaneous
Agency Record Extracts	Briefing
Amend, Correct or Supplement Motion	
Amicus Brief Filed by Government Entity or by Consent of All Parties	
Amicus Brief Filed in Support of Rehearing - Gov't or by Consent	
Amicus Brief Filed in Support of Rehearing by Leave of Court	
Anders Brief Filed	Briefing
Appearance of Counsel Form Filed	Appearance of Counsel Form

Filing Restrictions

You do not have permission to file in case 22-11532.

OK

Continue

Parties/Attorneys

22-11532
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Centers for Disease Control and
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Klein, Alisa Beth
Pezzi, Stephen Michael
Sowles, Marcia Kay
Springer, Brian James
Central Florida Regional Transp
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Wood, David S.
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Transportation Security Administ
Attorneys
Freidah, Andrew F.
Pezzi, Stephen Michael
Sowles, Marcia Kay

No. 21-11532-BB

United States Court of Appeals for the 11th Circuit

LUCAS WALL,
Appellant/Plaintiff

v.

CENTERS FOR DISEASE CONTROL & PREVENTION, DEPARTMENT OF HEALTH & HUMAN SERVICES, TRANSPORTATION SECURITY ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY, & DEPARTMENT OF TRANSPORTATION,
Appellees/Defendants

Appeal from the United States District Court
for the Middle District of Florida
No. 6:21-cv-975

BRIEF OF *AMICI CURIAE* 313 AIRLINE WORKERS IN SUPPORT OF APPELLANT URGING REVERSAL

JANVIERE CARLIN *et al.*
93 Londonderry Way
Uxbridge, MA 01569
757-274-3406
jshellie@charter.net

I. CERTIFICATE OF INTERESTED PERSONS

Pursuant to 11th Cir. R. 26.1-2(b), we certify that the CIP contained in Appellant's Opening Brief (Brief at 1-32) is correct and complete.

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IV. *AMICI'S* INTEREST IN THE CASE

Friends of the Court are 313 airline workers from 35 states employed by 16 commercial airlines who were subject to Appellee Transportation Security Administration ("TSA")'s three "Security Directives"[1] and Emergency Amendment that make up the enforcement scheme of Appellee Centers for Disease Control & Prevention ("CDC")'s Federal Transportation Mask Mandate ("FTMM" or "Mask Mandate"). We were subject to the Mask Mandate every hour worked, with an exception only for pilots on duty in the cockpit due to safety reasons.[2]

We support Appellant Lucas Wall's arguments that the Mask Mandate is *ultra vires* and should remain vacated worldwide pursuant to the decision in the related case of *Health Freedom Defense Fund v. Biden*, No. 8:21-cv-1693 (M.D. Fla. April 18, 2022). While passengers only have to endure forced masking when traveling on public transportation, we are expected to obstruct our oxygen intake nearly all the time while at work. This endangers

[1] We agree with appellant that TSA's Mask Mandate has zilch to do with transportation security, therefore we adopt the moniker of "Health Directives" throughout the remainder of this brief to more appropriately describe TSA's orders.

[2] At some airlines, pilots who aren't vaccinated against COVID-19 for medical, religious, or other reasons are required to wear a mask even while flying the aircraft.

our health and imperils aviation safety. The Court should reverse the district court's judgment in this case, affirm the judgment in *HFDF*, and issue a permanent injunction prohibiting the government appellees from ever reissuing a Mask Mandate or International Traveler Testing Requirement ("ITTR") ever again.

We focus this brief on our opposition to the Mask Mandate due to the constraint of FRAP's 6,500-word argument limit, which does not provide us space to address both issues. However, we also object to the ITTR. Although crew members were exempt from the Testing Requirement when working, we had to endure virus testing when traveling abroad as passengers. The ITTR massively reduced our companies' revenue due to Americans' refusal to fly abroad (and foreigners not flying to visit the United States) due to the substantial additional financial and time burdens the requirement imposed, thereby lowering our salary increases. Numerous Americans did not fly abroad while the ITTR was in effect due to the risk of being detained overseas by CDC if they could not find a rapid COVID-19 test within a day of departure or received a false positive result. Tens of thousands of our colleagues were laid off or placed on long-term unpaid leave due to the economic devastation caused by the ITTR, FTMM, and other government travel restrictions related to COVID-19 that did nothing to stop the virus' spread.

The ITTR contains an exemption for "Crew members of airlines or other aircraft operators if they follow industry standard protocols for the prevention of COVID-19…" 86 Fed. Reg. 69,258. So if we were working flights to/from a foreign country, it did not apply to us as long as our airline followed "protocols." However, most of us were still impacted by the ITTR.

First, a major part of our compensation package as airline workers is flight benefits. All airlines offer free or extremely low-cost standby tickets for employees and our families. This allows us to take frequent international trips that most of us could not ordinarily afford if we had to pay full price for the tickets. But because of the ITTR, most of us were unable to travel abroad because it's too risky. Obtaining tests within the prescribed one-day timeframe was not easy or guaranteed. We might be in a country with a shortage of rapid tests. If we couldn't find one, we would be prohibited from flying home to our country of citizenship in violation of international law. This could result in us missing work, risking our jobs. Where available, rapid testing can be quite expensive, forcing us to pay extra costs to travel abroad. Rapid testing is also unreliable, so we'd run the risk of finding a test but receiving a false positive, which would also leave us detained abroad until we could get a negative test. Finally, if we did become infected with COVID-19,

we would be unlawfully quarantined and detained by CDC in a foreign nation, which it lacks the power to do.

Second, our salaries are a reflection of the financial health of the companies we work for. Many of us had to take unpaid leave and/or compensation reductions due to the massive impact COVID-19 had on the travel industry. Foreign travel remains extremely depressed compared to 2019 pre-pandemic levels in great part due to the ITTR. The Testing Requirement was detrimental to our industry's ability to generate profits. International flights are generally more lucrative for airlines than domestic flights.

We submit this brief pursuant to FRAP 29. We consulted with Appellant Lucas Wall and appellees' counsel Alisa Klein, who both consented to this filing.

No party's counsel authored this brief in whole or part. No party or their counsel contributed money that was intended to fund preparing or submitting the brief. No person other than those signing this brief contributed money that was intended to fund preparing or submitting this document.

V. ARGUMENT SUMMARY

The airline industry was perhaps the #1 sector of the economy hardest hit by COVID-19 panic and the ensuing crippling travel restrictions imposed by the federal government including the FTMM, ITTR, and bans on foreign travelers entering the United States. CDC and TSA refused to hear comments such as those made by hundreds of transportation, travel, and tourism businesses and organizations:

> "[M]any of these same policies also came with the ***devastating*** … consequences of severely limiting and discouraging travel. … Since the start of the pandemic, the federal government's advisories, policies, and public messaging have focused on *discouraging or actively restricting* domestic and international travel. It is time for high-level officials within the Administration to publicly encourage travel to and within the U.S. Doing so would send a clear message to U.S. businesses, trading partners, and travelers alike that America is once again open for business." App. 1,076-1,077 (emphasis added).

CDC and TSA failed to consider the enormous harms these two policies would impose on our industry, including that we as crew members would be on the frontlines of enforcement. We never signed up to be the mask police or to verify virus test results before allowing passengers to board a plane. The federal government unlawfully commandeered us to become its enforcers, a job we never signed up for.

> "Regardless of how serious the problem an administrative agency seeks to address, however, it may not exercise its authority 'in a manner that is inconsistent with the administrative structure

> that Congress enacted into law.' ... "[A]n administrative agency's power to regulate in the public interest must always be grounded in a valid grant of authority from Congress. ... Courts must be guided by a degree of common sense as to the manner in which Congress is likely to delegate a policy decision of such economic and political magnitude to an administrative agency." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 125, 151 (2000).

The Mask Mandate in particular created chaos in the sky as hundreds of thousands of Americans stood up for their inherent right to breathe freely, make their own medical decisions, and be in control of their bodies. CDC and TSA did not consider that depriving passengers of oxygen by obstructing their breathing would lead to thousands of altercations because the pressurized air in plane cabins contains much less oxygen than where most people live at sea level. This diminished O2 in the brain led to hundreds of incidents of flight attendants being assaulted by passengers wanting to remove their masks, or by other paranoid customers demanding that a disabled person with a medical exemption or another customer experiencing breathing difficulties should cover his/her face.

Since Judge Mizelle struck down the Mask Mandate 2½ months ago, we have seen many wonderful results:

1. The number of "unruly" passengers reported to the Federal Aviation Administration ("FAA") since April 18, 2022, has gone

way down (Ex. 17);

2. The number of passengers wanting to fly now that don't have to block their breathing has skyrocketed. Our companies now have such high demand for tickets that they don't have enough workers and we are being asked to work lots of overtime to keep all the planes in the air; and
3. There have been no reports of increased COVID-19 spread in the aviation sector as a result of the *vacatur* of the FTMM in *HFDF*. This proves our arguments that masks do not reduce the spread of a respiratory disease such as coronavirus and airplane cabins contain perhaps the best air circulation – a critical tool to curtailing virus transmission – than anywhere else you could be. The government falsely claimed in briefing below that "even temporary (or partial) *vacatur* of these orders could have disruptive and dangerous consequences." Doc. 263 at 25, FN 18. Now the entire country knows that was nothing but a fearmongering fib to advance President Biden's political agenda, which had nothing whatsoever to do with science. App. 1,020-1,032.

Judge Mizelle properly recognized how illicit the FTMM was:

> "Under this reading of [42 USC] § 264(a), the CDC claims a power to regulate how individuals behave in such diverse places as airplanes train stations marinas, and personal vehicles used in ridesharing services across town. *See* 86 Fed. Reg. at 8028. Along with the power to require that owners operators, and employees of transit facilities use their best efforts to enforce the CDC's commands on the public. And all this with the threat of civil and criminal penalties-or at a minimum ejection from the conveyance or transportation hub." *HFDF*.

We concur with all of the arguments made by Mr. Wall in Appellant's Opening Brief. But we also want to give the Court our unique perspective on the illegal Mask Mandate from the eyes of those who had to deal with its negative consequences every day at work. We urge reversal and a permanent injunction against reinstituting the FTMM and ITTR (as CDC and TSA so desperately desire).

> "EPA's interpretation is also unreasonable because it would bring about an enormous and transformative expansion in EPA's regulatory authority without clear congressional authorization. When an agency claims to discover in a long-extant statute an unheralded power to regulate a significant portion of the American economy, we typically greet its announcement with a measure of skepticism. We expect Congress to speak clearly if it wishes to assign to an agency decisions of vast economic and political significance. … An agency has no power to tailor legislation to bureaucratic policy goals by rewriting unambiguous statutory terms. … We reaffirm the core administrative-law principle that an agency may not rewrite clear statutory terms to suit its own sense of how the statute should operate." *Utility Air Regulatory Group v. EPA*, 573 U.S. 302 (2014) (cleaned up).

VI. ARGUMENT

A. The Mask Mandate must be vacated because it violates Federal Aviation Administration safety regulations.

We have serious concerns about the safety implications of the Mask Mandate, none of which were studied by CDC, TSA, or any other agency as the policy was rushed into place only 12 days after the inauguration of a new president who made a national mask dictate a top campaign promise – even though he acknowledged it was likely unconstitutional. App. 1,020-1,032.

As pilots, our health is strictly governed by regulations issued by FAA. We are prohibited from operating an aircraft during any period of medical deficiency. However, we are required to comply with the Mask Mandate, which causes known medical deficiencies.

> "[N]o person who holds a medical certificate issued under part 67 of this chapter may act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person: … (1) Knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation…" 14 CFR § 61.53(a).

Pilots must wear a mask before and after flight, causing us numerous medical deficiencies. "[A] person shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person knows or has reason to know of any medical condition that would make the person unable to operate the aircraft in a safe manner." 14 CFR § 61.53(b).

Wearing a mask before we work a flight causes us to feel we are unable to operate the aircraft in a safe manner. Yet due to the Mask Mandate and our companies' enforcement thereof, we are expected to comply and fly anyway.

TSA's role has always been limited to ***security*** issues, i.e. preventing ***intentional attack*** on our transportation system. The pre-eminent goal of the agency is to prevent another Sept. 11, 2001. TSA has never been granted authority or funding to conduct a general ***safety*** mission such as preventing accidents from happening – much less a ***public health*** mission.

Although FAA medical regulations apply to pilots, other regulations govern flight attendants as well. A "flight crew" consists of the pilots in the cockpit and the flight attendants working in the passenger cabin. "Each flight crew member must report for any flight duty period rested and prepared to perform his or her assigned duties." 14 CFR § 117.5(a). As flight attendants, our jobs are designated safety-critical because we are responsible for ensuring cabin safety and security while in flight. If there's an emergency in the cabin, we are the first responders. But all of the health problems mentioned below reduce our ability to ensure flight safety.

Wearing a mask before a flight (for example, while on a shuttle bus from our hotel to the airport and in the terminal) makes us feel like we are not fully prepared to perform our assigned duties, including due to fatigue. "Extended

wearing of [a] mask, which has become a part of routine life, has led to the emergence of 'mask fatigue.' Mask fatigue is defined as the lack of energy that accompanies and/or follows prolonged wearing of a mask." App. 852. "There is published evidence which shows that extended wearing of a mask impairs functioning…" *Id*. Mask fatigue causes at least 24 significant harms to human health. *Id.*

"The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public…," according to FAA's Guide for Aviation Medical Examiners. Ex. 1.

All aviators must see an FAA certified doctor ("Aviation Medical Examiner") 1-2 times each year. Pilots are all obligated by law (49 USC § 46310) to disclose any disqualifying condition pertaining to obtaining or maintaining our medical certificate. If we know that masks are unhealthy for us and their continued use can cause cumulative harm (as evidenced by years of unbiased scientific studies prior to COVID-19 politicization), we are morally and legally obligated to abstain and/or report.

The number of hours pilots and flight attendants may work in a day is controlled by law. This can be as long as 16 hours per shift – double a normal workday. "A Flight Duty Period includes the duties performed by the flight

crew member on behalf of the certificate holder that occur before a flight segment or between flight segments without a required intervening rest period." 14 CFR § 117.3.

The Mask Mandate forces us to obstruct our oxygen intake, causing diminished mental and physical capacity, during our Flight Duty Period. Despite this diminution of our physical capacities, the government has not reduced the number of hours we may work per day to account for the numerous impairments masks cause.

> "Even for a good cause, including a cause that is intended to slow the spread of Covid-19, Defendants cannot go beyond the authority authorized by Congress. Congress must provide clear authorization if delegating the exercise of powers of vast economic and political significance, if the authority would significantly alter the balance between federal and state power, or if the administrative interpretation of a statute invokes the outer limits of Congress' power. Accordingly, the Court finds that the president exceeded his authority." *Kentucky v. Biden*, No. 3:21-cv-55 (E.D. Ky. Nov. 30, 2021) (cleaned up) (enjoining vaccine mandate for federal contractors). *See also Georgia v. Biden*, No. 1:21-cv-163 (S.D. Ga. Dec. 7, 2021) (same).

When we travel on a commercial flight as a passenger not paying for a ticket, we are referred to as "non-revs" or "jumpseaters" since we may occupy an additional seat in the cockpit or the cabin called a "jumpseat." If that seat is already taken or there are regular seats open in the cabin, we may be seated in a passenger seat. When we are on duty and flying in regular seat, this is referred to as "deadheading."

"Deadhead transportation means transportation of a flight crew member as a passenger or non-operating flight crew member by any mode of transportation, as required by a certificate holder, excluding transportation to or from a suitable accommodation. All time spent in deadhead transportation is duty and is not rest." *Id*. When we travel as a jumpseater and/or are deadheading, we are considered an additional crewmember. Ex. 2.

"Even when not in uniform, remember that you are still considered an additional crewmember and you may be required to assist on the flight deck or in the cabin in case of unusual or emergency circumstances. You must remain prepared to assist the flight crew should the need arise." *Id*.

However, we are forced to wear masks when traveling as a jumpseater and/or deadheader, which reduces our mental and physical capacities to be able to assist the on-duty flight crew should an emergency occur. "Since masking impairs our ability when conducting a flight as evidenced by the fact that we are not required to wear a mask when flying, it also impairs our fitness for flight when acting in other required capacities." *Id*.

Appellee Department of Transportation ("DOT"), which includes FAA, notes that "the failure to wear a face covering is not itself a federal violation," contradicting the Mask Mandate. *Id*. Yet some of us have been fined by TSA for failing to wear a mask in the airport terminal while we are on duty –

something that is forbidden by the Health Directives themselves since they exempt from mandatory masking "People for whom wearing a mask would create a risk to workplace health, safety, or job duty as determined by the relevant workplace safety guidelines or federal regulations." App. 495 & 516.

FAA recognizes the dangers of forced masking of flight crew: "Air carriers should complete a safety risk assessment and provide guidance to their crewmembers on procedures for the use of masks as they may affect the donning of oxygen masks or conducting other safety functions on the flight deck or in the cabin." FAA Safety Alert for Operators 20009 (May 25, 2021); Ex. 3.

A court must "hold unlawful and set aside agency action … found to be … in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 USC § 706(2)(C). Because CDC's and TSA's Mask Mandate violates FAA safety regulations, the Court should hold it unlawful and strike it down because the agencies acted short of statutory right. An agency in the Department of Health & Human Services ("HHS") or Department of Homeland Security ("DHS") may not override with an "order" or "directive" duly promulgated safety rules published in the Code of Federal Regulations by an agency (FAA) in another executive department (DOT) that Congress has tasked with ensuring the safety of flight, including the health of crewmembers.

"An agency's general rulemaking authority does not mean that the specific rule the agency promulgates is a valid exercise of that authority. Agencies are … bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes." *NAACP v. DeVos*, No. 20-cv-1996, 2020 WL 5291406 (D.D.C. Sept. 4, 2020) (quoting *Colo. River Indian Tribes v. Nat'l Indian Gaming Comm'n*, 466 F.3rd 134, 139 (D.C. Cir. 2006)). CDC's general rulemaking authority does not give it "*[c]arte blanche* authority" to promulgate any rule it deems necessary. *Merck & Co. v. HHS*, 385 F. Supp. 3d 81, 92 (D.D.C. 2019), aff'd 962 F.3d 531 (D.C. Cir. 2020). Grants of rulemaking authority often contain "capacious terms," but courts must still "tak[e] seriously, and apply[] rigorously, in all cases, statutory limits on agencies' authority." *Arlington v. FCC*, 569 U.S. 290, 307 (2013).

TSA, by regulation, limits its ability to issue Security Directives to when additional ***security measures*** are necessary. In no way does a mask constitute a "security measure." Since a rule/order/mandate is an offspring of the enabling act, a policy that cannot be harmonized with the statute is unlawful. *Dixon v. United States*, 381 U.S. 68 (1965).

B. The Mask Mandate must be vacated because it creates chaos in the sky, recklessly endangering aviation safety and security.

TSA, as its name suggests, is responsible for ensuring transportation security. But the Mask Mandate *endangers* aviation security. TSA, in continuing to extend the Mask Mandate indefinitely even though all 50 states do not require face coverings (App. 1,092), fails to take into account that in addition to the millions of Americans who can't safely obstruct their breathing because of a medical condition, tens of millions of Americans vehemently object to anyone ordering them to wear face masks. This is evidenced by 5,981 incidents of "unruly" behavior aboard airplanes reported to FAA during 2021, 4,290 of which related to the Mask Mandate.

2021 was "the worst year on record for buffoonish behavior on planes." Ex. 4. For 2022, until the Mask Mandate was vacated April 18, FAA received 814 reports of unruly passengers, 535 related to the FTMM. This conduct is understandable since the Food, Drug, & Cosmetic Act ("FDCA") protects all Americans' right to refuse administration of a Food & Drug Administration ("FDA") unauthorized or Emergency Use Authorization ("EUA") medical device such as a face covering. Masks make it difficult to breathe and function – especially in our workplace seven miles high in the sky, where airplane cabins are pressurized to an equivalent of 8,000 feet altitude, with oxygen

levels much lower than most passengers who live at or near sea level are accustomed to.

The Mask Mandate worsens transportation security as some people violently stand up for their right to breathe freely. And unfortunately some of our colleagues have become terribly hostile to any passenger who dares remove his/her mask for any reason, creating great fiction in the cabin.

"Despite coming with hefty fines and the threat of criminal prosecution, the [FTMM] has spawned an epidemic of shouting matches – and worse – between defiant passengers and flight crews. … But if airlines are the last place in America to require masks, the skies are likely to become even less friendly for flight crews." Ex. 4. "[T]he level of in-flight fracas has gotten exponentially worse in the past two years, with most cases involving disputes over masking." *Id.*

Airplanes, airports, and other transportation conveyances and terminals were among the last places in America where anyone was forced to block their breathing. Why should we have to suffer when the federal government doesn't require masking in any other sector of society?

"The current climate in the passenger cabin is highly stressed. We are experiencing a record high number of aggressive passenger incidents, many of

which are fueled by … refusal to comply with onboard mask rules," the president of a major flight-attendant union said. App. 280.

All of the "unruly" behavior we've seen aboard airplanes when airlines try to enforce the Mask Mandate is explained by science, none of which CDC or TSA considered:

> "Wearing masks, thus, entails a feeling of deprivation of freedom and loss of autonomy and self-determination, which can lead to suppressed anger and subconscious constant distraction, especially as the wearing of masks is mostly dictated and ordered by others. These perceived interferences of integrity, self-determination and autonomy, coupled with discomfort, often contribute to substantial distraction and may ultimately be combined with the physiologically mask-related decline in psychomotoric abilities, reduced responsiveness, and an overall impaired cognitive performance." App. 281.

Being forced to cover the nose and mouth, a person's only two sources of oxygen – breathing is of course essential to life – "leads to misjudging situations as well as delayed, incorrect, and inappropriate behavior and a decline in the effectiveness of the mask wearer." *Id*.

"[P]assengers have verbally abused and taunted flight attendants trying to enforce airline mask requirements…" Ex. 5. It is a miracle that the FTMM has not yet led to a major aviation safety incident.

> "A flight attendant reported being so busy seeking mask compliance that the employee couldn't safely reach a seat in time for landing. One airline captain, distracted by mask concerns, descended to the wrong altitude. The repeated talk of problem passengers in Row 12 led the captain to mistakenly head toward

> 12,000 feet, not a higher altitude given by air traffic control to keep planes safely apart." *Id.*

"It is no secret that the threats flight attendants face each day have dramatically increased," states a letter from Julie Hedrick, president of the Association of Professional Flight Attendants. "Every day, we are subjected to verbal and sometimes physical altercations, mainly centered around mask compliance." Ex. 6.

Carrying out mask rules also worsens the already strained position of flight attendants, who are frontline enforcers even as we keep our usual safety responsibilities. "Flight attendants are dealing with mask compliance issues on every single flight they work right now," said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, noting that those efforts range from friendly reminders to facing passengers "actively challenging the flight attendants' authority." Ex. 7.

"One in five flight attendants so far this year has been involved in physical altercations with unruly passengers and 85% of cabin crew members have dealt with disruptive passengers this year…" Ex. 8. "[M]any flight attendants reported … being subjected to yelling and swearing for federal mask mandate directions." *Id.*

> "My fear, however, is that the mandate is going to someday cause a far bigger problem while in the air than just some unruly passenger being eventually duct-taped to a seat. One of these days, a

> confrontation is going to escalate far further than the crew member who had a finger bitten or the flight attendant who caught an errant punch square in the face and had two teeth knocked out. Ask yourself, is it worth it to have a mandate that ostensibly is for your safety but only leads further to unsafe conditions?" Ex. 9.

"Even if not intended to bring the plane down, you can imagine the kind of pandemonium on planes that we've seen in some of these videos that people have taken that can cause an incredibly dangerous accident," said Attorney General Merrick Garland." Ex. 10. We predicted these incidents would just about vanish if a court vacated the FTMM – and we were right. Ex. 17.

"The tense situation in the air … has led many attendants to say that they feel exhausted, afraid for their personal safety and, in some cases, concerned that the situation could turn dangerous." Due to the unlawful Mask Mandate, "encountering unruly passengers, once rare, is now almost expected." Ex. 11.

Major airlines, including most of our employers, called for the abolition of the FTMM for 10 months, but CDC and TSA would not listen. App. 1,058-1,089. With forced masking "in place, there has been a rise in onboard incidents that have harmed flight attendants, delayed or cancelled flights … When this atmosphere is combined with tensions around mask policy, we have seen a summer with more onboard skirmishes and more people injured than ever before," wrote Ben Baldanza, former CEO of Spirit Airlines. Ex. 12.

We agree with Mr. Wall that CDC and TSA lack authority from Congress

to require masks. But even if they did possess such power, the policy is arbitrary and capricious because the Mask Mandate does the exact *opposite* of TSA's statutory mission to ensure transportation security by actually *endangering* our security.

The general thrust of the Supreme Court's recent decision in *NFIB v. Dept. of Labor*, 142 S.Ct. 661 (2022), is that the Occupational Safety & Health Administration ("OSHA") was charged by Congress with precisely what its name indicates: ***occupational*** safety-and-health-related matters. General public-health measures are outside of that scope. The justices held that a health matter that affects the general public at all times, whether or not they are at work, is not an "occupational" matter just because it also affects them on the job. The same is true here. COVID-19 is a "threat" to all segments of society, but that doesn't mean a transportation ***security*** agency has power to try to control it by requiring masks.

A public-health concern that affects all Americans at all times, whether or not they are in the transportation system, is not a "transportation security" matter just because it also happens while engaged in transport – and further, it is not a "security" matter whatsoever. Security and health are simply two different things. This Court must follow the high court's decision in *NFIB*.

Furthermore, TSA issued the challenged Health Directives and Emergency Amendment without giving notice and considering public comments. CDC's Mask Mandate was declared *ultra* vires for skipping notice and comment. *HFDF*. Had the agencies done so, thousands of pilots and flight attendants such as ourselves would have objected to the Mask Mandate because it conflicts with the FAA safety regulations under which we are governed and creates detrimental health effects to those of us who work in safety-critical jobs. It also distracts from our important duties by forcing us to become the "mask police," mandating that passengers obstruct their breathing as a condition of transport. Had comments been taken, FAA would have likely joined us in cautioning against adopting the dangerous FTMM.

Likewise, many of our unions would have submitted comments urging TSA not to adopt the Mask Mandate.

> "Serving onboard during these contentious times and enforcing mask compliance is one of the most difficult jobs we have ever faced as flight attendants. Not since September 11, 2001, has our job environment changed so drastically and quickly. The number of physical and verbal assaults in our workplace has increased dramatically, many of which are related to mask compliance. … It is important to note that a large portion of our membership has expressed that they would like the freedom to choose whether to wear a mask at work." App. 1,080-1,081

The Administrative Procedure Act ("APA") requires agencies to issue rules, orders, directives, etc. through a notice-and-comment process. 5 USC

§ 553. Good cause does not excuse CDC and TSA's failure to comply with the notice-and-comment process because the agency had 10½ months to give notice, solicit comments, respond to those comments, and publish a regulation in the Code of Federal Regulations from the date the World Health Organization declared COVID-19 a global pandemic (March 11, 2020) until the date the Mask Mandate took effect (Feb. 1, 2021). 5 USC § 553(b)(3)(B). *HFDF*.

"[T]he good cause exception does not apply when an alleged 'emergency' arises as the result of an agency's own delay." *Envt'l Def. Fund v. EPA*, 716 F.2d 915, 921 (D.C. Cir. 1983).

TSA's enabling act exempts it from notice-and-comment procedures when a sudden *threat to transportation security* develops and the agency must act rapidly. But as Mr. Wall rightly argues, COVID-19 poses no threat to transportation infrastructure, nor did TSA act rapidly. Even in the federal bureaucracy, nobody could claim waiting 10½ months and then suddenly issuing "Security Directives" regarding a public-health issue to fulfill a new president's campaign pledge is acting swiftly to a new "threat."

This is nothing more than a blanket and "unsupported assertion" that good cause excuses TSA's compliance with the APA. *Sorenson Commc'ns v. FCC*, 755 F.3rd 702, 707 (D.C. Cir. 2014). TSA's failure to explain its own

delay is telling.

"Notice and comment can only be avoided in truly exceptional emergency situations, which notably, cannot arise as a result of the agency's own delay. … an agency cannot show an emergency when it has been aware of the problem but nonetheless failed to take action." *Wash. All. of Tech. Workers v. DHS*, 202 F. Supp. 3rd 20, 26 (D.D.C. 2016) (cleaned up).

A tribunal must "hold unlawful and set aside agency action … found to be … without observance of procedure required by law." 5 USC § 706(2)(D). This Court should hold unlawful and set aside the Mask Mandate because it's arbitrary and capricious, and it violates the APA's notice-and-comment requirement.

C. The Mask Mandate must be vacated because CDC and TSA failed to take into account that airplane cabins pose little risk for coronavirus spread.

Another reason the Mask Mandate is arbitrary and capricious is because the federal government's only face-covering dictate applies to the sector of society that is at *least risk* for COVID-19 transmission. There's nothing in the administrative record showing that CDC or TSA considered the ample evidence provided by the aviation industry and others that masks aren't necessary and do nothing to reduce COVID-19 transmission, especially in the sterile environment of a jet aircraft.

Our employers commissioned a lengthy report "Assessment of Risks of SARS-CoV-2 Transmission During Air Travel & Non-Pharmaceutical Interventions to Reduce Risk" by the Harvard T.H. Chan School of Public Health as part of the Aviation Public Health Initiative. App. 1,094-1,115. The Court must consider these important findings.

> "Ventilation Systems on Aircraft: These sophisticated systems deliver high amounts of clean air to the cabin that rapidly disperses exhaled air, with displacement in the downward direction, reducing the risk of passenger-to-passenger spread of respiratory pathogens. Aircraft ventilation offers enhanced protection for diluting and removing airborne contagions in comparison to other indoor spaces with conventional mechanical ventilation and is substantially better than residential situations. This level of ventilation effectively counters the proximity travelers will be subject to during flights. The level of ventilation provided onboard aircraft would substantially reduce the opportunity for person-to-person transmission of infectious particles… Particular emphasis is placed on the effectiveness of aircraft ventilation systems, which are able to filter 99.97% of SARS-CoV-2 particles out of air found on aircraft." *Id.*

The study confirms what our employers have been promoting to customers: There is little-to-no risk of contracting COVID-19 aboard a plane. "After detailed analysis of these reports, it is the view of APHI that ***there have been a very low number of infections that could be attributed to exposure on aircraft during travel***." *Id.* (emphasis added). In short, CDC and TSA were trying to solve a problem that never existed.

CDC itself admitted "the risk of getting a contagious disease on an airplane

is low." *Id.* "Given the volume of commercial flights daily, carrying millions of passengers and crew worldwide, the number of documented incidents of infectious disease transmission occurring on board an aircraft remains infrequent." *Id.*

"[T]he risk of SARS-CoV-2 transmission onboard aircraft will be below that found in other routine activities during the pandemic, such as grocery shopping or eating out." *Id.* It's thus arbitrary and capricious for CDC and TSA to demand we wear masks at work when such a federal requirement is not placed on any other industry – even though our workplace is less prone to virus spread than nearly every other sector. "[T]he aircraft's environmental control systems effectively diluting and removing pathogens significantly reduce the risk of passengers and crewmembers from acquiring COVID-19…" *Id.*

Our employers continued lobbying the White House for abolition of the Mask Mandate because it is not only unnecessary but dangerous. "Airplanes are already equipped with advanced air filtration systems, and airports have made large investments in air filtration, sanitation, and layouts. COVID-19 hospitalization rates have decreased significantly and the mask mandate should be lifted to reflect the improved public health environment," accord-

ing to Airlines for America, a trade group that represents most of our companies. App. 1,077.

The International Air Transport Association called for an end to mask mandates aboard airplanes worldwide. The association notes on its website that "The risk of transmission in the modern cabin environment is low for a number of reasons: passengers face the same direction, seatbacks act as barriers, air flow is from the top to bottom, and the air is also very clean. Cabin air is refreshed 20-30 times an hour; About 10 times more than most office buildings." App. 1,091-1,093. "Most modern jet aircraft are equipped with High-Efficiency Particulate Air (HEPA) filters. These filters have similar performance to those used in hospital operating theatres and industrial clean rooms." *Id.*

The Department of Defense's Transportation Command conducted a study in October 2020 that found

> "aerosol particles were rapidly diluted by the high air exchange rates of a typical aircraft cabin. Aerosol particles remained detectable for a period of less than six minutes on average. Both aircraft models (B777 and B767) tested removed particulate matter 15 times faster than a typical home ventilation system and 5-6 times faster than the recommended design specifications for modern hospital operating or patient isolation rooms." *Id.*

Similar tests by aircraft manufacturers Airbus, Boeing, and Embraer also found miniscule risk of COVID-19 transmission. *Id.*

As most of our employers noted in a March 23, 2022, letter to President Biden: "It is critical to recognize that the burden of enforcing both the mask and predeparture testing requirements has fallen on our employees for two years now. ***This is not a function they are trained to perform and subjects them to daily challenges by frustrated customers. This in turn takes a toll on their own well-being***." App. 1,083 (emphasis added).

"We are requesting [abolition of the FTMM] not only for the benefit of the traveling public, but also for the thousands of airline employees charged with enforcing a patchwork of now-outdated regulations implemented in response to COVID-19." *Id.*

Congress has never imposed a mask mandate anywhere in the nation, despite having passed dozens of bills in response to the COVID-19 pandemic. All too often the Executive Branch attempts to circumvent the legislative process by imposing through "directives" rules that Congress fails to adopt through legislation. *See, e.g., U.S. House of Representatives v. Mnuchin*, 976 F.3rd 1, 4 (D.C. Cir. 2020). That is precisely what happened here. The only vote Congress has ever taken on the Mask Mandate was the Senate's 57-40 decision to kill it. App. 620-623.

The Court should hold unlawful and set aside the Mask Mandate because

it is arbitrary, capricious, and an abuse of discretion. 5 USC § 706(2)(A). *HFDF*.

D. The Mask Mandate must be vacated because TSA failed to consider that masks pose serious health risks to humans forced to wear them, including those who work in the transport sector.

In addition to the science showing that masks have proven totally ineffective in reducing coronavirus spread, there's nothing in the administrative record showing that CDC or TSA considered the serious health risks to human beings of forced masking nor the dangers of oxygen deprivation at high altitude such as in airplane cabins. Mr. Wall has compiled an extensive collection of hundreds of scientific and medical studies illustrating the frightening number of negative health consequences of covering your face – harms we were forced to endure for more than 14 months because of the Mask Mandate. https://bit.ly/masksarebad.

"It is not clear however, what the scientific and clinical basis is for wearing facemasks as a protective strategy, given the fact that facemasks restrict breathing, causing hypoxemia and hypercapnia, and increase the risk for respiratory complications, self-contamination, and exacerbation of existing chronic conditions," according to a paper published by the National Institutes of Health, part of HHS. App. 786.

The leading authority on this subject is a 42-page paper published April

20, 2021, by eight German doctors and scientists in the International Journal of Environmental Research & Public Health. App. 808-849. They found: "Up until now, there has been no comprehensive investigation as to the adverse health effects masks can cause." These German doctors and scientists coined a new disease: Mask-Induced Exhaustion Syndrome. *Id*. We all suffer from this syndrome when forced to mask at work by CDC and TSA.

Symptoms include

> "an increase in breathing dead space volume, increase in breathing resistance, increase in blood carbon dioxide, decrease in blood oxygen saturation, increase in heart rate, increase in blood pressure, decrease in cardiopulmonary capacity, increase in respiratory rate, shortness of breath and difficulty breathing, headache, dizziness, feeling hot and clammy, decreased ability to concentrate, decreased ability to think, drowsiness, decrease in empathy perception, impaired skin barrier function with itching, acne, skin lesions and irritation, overall perceived fatigue and exhaustion." *Id*.

The government has no right to cause us pain and suffering just for doing our jobs. The Mask Mandate not only endangers transportation security but also our health. Some of us have taken extended medical leaves because we can't continue working with our natural breathing blocked. This has caused enormous financial hardship. We know many colleagues who quit working for airlines so they could find a job in every other part of the economy that the federal government doesn't force upon employees a dangerous, experimental, unproven medical device.

"The public interest is also served by maintaining our constitutional structure and maintaining the liberty of individuals to make intensely personal decisions according to their own convictions – even, or perhaps ***particularly***, when those decisions frustrate government officials." *BST Holdings v. OSHA*, No. 21-60845 (5th Cir. Nov. 12, 2021) (emphasis original).

Mr. Wall cites the Food, Drug, & Cosmetic Act's requirement that a person has the legal right to refuse to use any medical device approved by the Food & Drug Administration under an Emergency Use Authorization – as nearly all face coverings are. Like Mr. Wall, we want to exercise our right to refuse administration of the product. 21 USC § 360bbb-3(e)(1)(A)(ii)(III). However, doing so has resulted in some of us being fined by TSA and others being reprimanded and/or suspended by our companies due to the FTMM.

The Court should hold unlawful and set aside the Mask Mandate because it violates the Food, Drug, & Cosmetic Act, making it "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 USC § 706(2)(C).

E. The Mask Mandate must be vacated because it recklessly endangers transportation workers by failing to comply with Occupational Safety & Health Administration rules for face coverings.

"Breathing is one of the most important physiological functions to sustain life and health. Human body requires a continuous and adequate oxygen

(O2) supply to all organs and cells for normal function and survival. … Long-term practice of wearing facemasks has strong potential for devastating health consequences." App. 786.

"Scientists have found evidence that some face masks which are on sale and being used by members of the general public are laced with toxic chemicals. … Experts are concerned that the presence of these chemicals in masks which are being worn for prolonged periods of time could cause unintended health issues." App. 986. In no other aspect of workplace safety would the government ever allow workers to be exposed to these types of toxic chemicals.

Indeed, the Department of Labor has an agency that regulates workplace safety (OSHA). That agency sets standards for respiratory protection. 29 CFR § 1910.134. None of our employers are following these legal requirements as the Mask Mandate does not mention them. Ex. 13. Due to the dangers of obstructing a person's breathing, OSHA requires that a Respirator Medical Evaluation Questionnaire be completed by anyone who will be required to wear a mask at work. Ex. 14. But none of us have ever been asked to complete the questionnaire.

If any company demands someone wear a mask, OSHA requires it "Must provide respirators, training, and medical evaluations at no cost…" Ex. 15. In

enforcing the Mask Mandate, none of our employers have provided training or medical evaluations.

"All oxygen-deficient atmospheres (less than 19.5% O2 by volume) [such as airplane cabins] shall be considered IDLH," according to OSHA. IDLH stands for "immediately dangerous to life or health." *Id.*

OSHA requires companies mandating masks to

> "provide effective training to respirator users, including: why the respirator is necessary and how improper fit, use, or maintenance can compromise the protective effect of the respirator; limitations and capabilities of the respirator; use in emergency situations; how to inspect, put on and remove, use and check the seals; procedures for maintenance and storage; recognition of medical signs and symptoms that may limit or prevent effective use; and general requirements of this standard." *Id.*

None of our employers have provided the required training.

"[T]he meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand." *Brown & Williamson* at 132-133. "The Act empowers the Secretary to set workplace safety standards, not broad public health measures. *See* 29 USC §655(b) (directing the Secretary to set 'occupational safety and health standards'); §655(c)(1) (authorizing the Secretary to impose emergency temporary standards necessary to protect 'employees' from grave danger in the workplace)." *NFIB*.

Based on this precedent, it's clear error that the district court determined

CDC has the legal authority to force workplace safety measures. But *NFIB* makes obvious that a general public-health matter's tangential effect on something within an agency's purview simply does not give the agency the authority to regulate. Just as OSHA strayed too far with its vaccination or mask/test requirement and CDC too far with its Eviction Moratorium, CDC and TSA both meandered well past the boundaries of their statutory authority by imposing the Mask Mandate.

TSA's interpretation of its enabling act (49 USC § 114) ignores Congress' important and deliberate context and structure that reveals a variety of specific, listed steps that TSA may take to protect transportation security. Nowhere did Congress provide authority for TSA to regulate health matters. "A statute must be read as a whole, and individual terms or phrases should not be interpreted in isolation." *Sealed Appellee 1 v. Sealed Appellant 1*, 767 F.3rd 418 (5th Cir. 2013). "It is a cardinal principle of statutory construction that a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant." *Asadi v. G.E. Energy*, 720 F.3rd 620 (5th Cir. 2013).

Allowing TSA to adopt broad definitions of its authority without being confined by the statute's context, structure, and history does not meaningfully constrain its discretion. If Congress meant to give TSA such unlimited

power, it needed to "provide substantial guidance." *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 475 (2001). "Our system does not permit agencies to act unlawfully even in pursuit of desirable ends." *Ala. Ass'n of Realtors v. HHS*, 141 S. Ct. 2485, 2490 (2021).

The Court should hold unlawful and set aside the Mask Mandate because it violates OSHA workplace safety regulations and exceeds TSA's statutory authority to protect transportation security, making it "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 USC § 706(2)(C).

F. This case is not moot.

The fifth extension of TSA's Health Directives and Emergency Amendment (Version "E") were set to expire May 3, 2022. But April 18, after the decision in *HFDF* was issued, the White House announced a suspension of TSA's mask enforcement since the CDC FTMM Order was vacated. But the government appealed Judge Mizelle's ruling to this Court and CDC continues to advise Americans to wear masks when flying and using other modes of mass transit. And TSA has told the D.C. Circuit it retains the right to force masking again at any time it deems necessary.

CDC Director Rochelle Walensky, in announcing revised mask guidance

Feb. 25, 2022, clearly stated the agency could change its masking recommendations/mandates at any time. "None of us know what the future may hold for us and for this virus and we need to be prepared and we need to be ready for whatever comes next. We wanna give people a break from things like mask wearing when our levels are low and then have the ability to reach for them again, should things get worse in the future," Walensky told reporters during a media briefing releasing new guidelines that most Americans should not wear masks. Ex 16.

Likewise Dr. Greta Massetti, a senior epidemiologist at CDC, said the agency will always be updating its mask guidelines, indicating that the Mask Mandate could be reinstated at any time if the agency prevails on these two appeals. "Public-health prevention strategies can be dialed up when our communities are experiencing more severe disease and dialed down when things are more stable," Massetti said. *Id.*

The Supreme Court has made clear that a government agency may not revoke a pandemic mandate (such as the ITTR) in an attempt to moot a court case, then be allowed to reimpose it again later.

> "There is no justification for that proposed course of action. It is clear that this matter is not moot. *See Federal Election Comm'n v. Wisconsin Right to Life, Inc.*, 551 U.S. 449, 462 (2007); *Friends of the Earth, Inc. v. Laidlaw Environmental Services (TOC), Inc.*, 528 U.S. 167, 189 (2000). And injunctive relief is still called for because the applicants remain under a constant threat

... *See, e.g., Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014)." *Roman Catholic Diocese of Brooklyn v. Cuomo*, No. 20A87 (U.S. Nov. 25, 2020).

VII. CONCLUSION

This Court should not allow such a broad reading of 49 USC § 114 that would permit TSA to force all air travelers to wear masks, nor an expansive construction of 42 USC § 264(a) that permits CDC to do the same. This would create a slippery slope for future "Security Directives" that have nothing to do with the TSA's sole mission of protecting transportation security from attack. TSA does not have such broad sweeping powers that it may regulate health matters such as what types of food may be served at airports or mandating that passengers jog 3 miles on a treadmill before boarding a plane since they will be sedentary on a long flight.

We join Mr. Wall in urging the Court to declare the three challenged Health Directives and one Emergency Amendment *ultra vires*, set them aside in their entirety, and permanently enjoin TSA from requiring masks be worn on any form of transportation unless Congress enacts specific authority for the agency to do so. The only proper decision here is worldwide *vacatur*. *HFDF*. Judge Byron's opinion in this case must be reversed and Judge Mizelle's ruling in *HFDF* needs to be affirmed. A permanent injunction must issue to all appellees to block them from ever reimposing the FTMM or ITTR.

"The Constitution vests the [Judicial Branch] with the judicial Power of the United States. That power is not limited to the [circuit] wherein the court

sits but extends across the country. It is not beyond the power of a court, in appropriate circumstances, to issue a nationwide injunction." *Texas v. United States*, 809 F.3rd 134, 188 (5th Cir. 2015). As was the case in *Ala. Ass'n of Realtors* and *HFDF*, when a court determines that a mandate that applies to all Americans is illegal, relief should extend to everyone. It also needs to be prospective, especially since the status quo today is the Mask Mandate and Testing Requirement are not being enforced. We want to ensure it stays that way well into the future so our industry is not decimated again by these damaging restrictions Congress never approved.

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Respectfully submitted this 5th day of July 2022.

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IX. CERTIFICATE OF COMPLIANCE

We certify that this brief complies with FRAP 29(a)(5) & 32(a)(5)(A) because it has been prepared in 14-point Georgia, a proportionally spaced font, and this document complies with the 6,500-word limit because the Argument contains 6,451 words as measured by Microsoft Word.

X. CERTIFICATE OF SERVICE

I certify that on July 5, 2022, I e-mailed this brief to these Court clerks for uploading into the 11th Circuit's Case Management/Electronic Case Filing system:

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I also certify that I am mailing four paper copies to the Court as required.

I also certify that I e-mailed this brief July 5 to the parties:

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Exhibit 1

faa.gov

Guide for Aviation Medical Examiners

4-5 minutes

Application Process for Medical Certification

General Information - Legal Responsibilities of Designated Aviation Medical Examiners

Title 49, United States Code (U.S.C.) (Transportation), sections 109(9), 40113(a), 44701-44703, and 44709 (1994) formerly codified in the Federal Aviation Act of 1958, as amended, authorizes the FAA Administrator to delegate to qualified private persons; i.e. designated Examiners, matters related to the examination, testing, and inspection necessary to issue a certificate under the U.S.C. and to issue the certificate. Designated Examiners are delegated the Administrator's authority to examine applicants for airman medical certificates and to issue or deny issuance of certificates.

Approximately 450,000 applications for airman medical certification are received and processed each year. The vast majority of medical examinations conducted in connection with these applications are performed by physicians in private practice who have been designated to represent the FAA for this purpose. An Examiner is a designated representative of the FAA Administrator with important duties and responsibilities. It is essential that Examiners recognize the responsibility associated with their appointment.

At times, an applicant may not have an established treating physician and the Examiner may elect to fulfill this role. You must consider your responsibilities in your capacity as an Examiner as well as the potential conflicts that may arise when performing in this dual capacity.

The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public, for the Government, and for the Examiner. If the examination is cursory and the Examiner fails to find a disqualifying defect that should have been discovered in the course of a thorough and careful examination, a safety hazard may be created and the Examiner may bear the responsibility for the results of such action.

Of equal concern is the situation in which an Examiner deliberately fails to report a disqualifying condition either observed in the course of the examination or otherwise known to exist. In this situation, both the applicant and the Examiner in completing the application and medical report form, may be found to have committed a violation of Federal criminal law which provides that:

> "Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both" (Title 18 U.S. Code.
> Secs. 1001; 3571).

Cases of falsification may be subject to criminal prosecution by the Department of Justice. This is true whether the false statement is made by the applicant, the Examiner, or both. In view of the pressures sometimes placed on Examiners by their regular patients to ignore a disqualifying physical defect that the physician knows to exist, it is important that all Examiners be aware of possible consequences of such conduct.

In addition, when an airman has been issued a medical certificate that should not have been issued, it is frequently necessary for the FAA to begin a legal revocation or suspension action to recover the certificate. This procedure is time consuming and costly. Furthermore, until the legal process is completed, the airman may continue to exercise the privileges of the certificate, thereby compromising aviation safety.

Exhibit 2

References Pertaining to Pilots & Masks Violating Industry Regulations

Compiled by Janviere Carlin. Highlighted to emphasize key points, followed by my commentary.

14 CFR § 61.53 – Prohibition on Operations During Medical Deficiency

(a) Operations that require a medical certificate. Except as provided for in paragraph (b) of this section, no person who holds a medical certificate issued under part 67 of this chapter may act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person:

(1) Knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation; or

(2) Is taking medication or receiving other treatment for a medical condition that results in the person being unable to meet the requirements for the medical certificate necessary for the pilot operation.

(b) Operations that do not require a medical certificate. For operations provided for in § 61.23(b) of this part, a person shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person knows or has reason to know of any medical condition that would make the person unable to operate the aircraft in a safe manner.

Commentary: Pretty cut and dry. Masks are harmful to me and I know it because I have read the data and I have experienced the effects on me personally; therefore, I cannot in good faith operate as a pilot or even as a crewmember deadheading or jumpseating since I am always considered a required or additional crewmember, and my very ability to be certified as a pilot medically relies upon my true attestation of my fitness (see all below).

14 CFR § 117.5 – Fitness for Duty

(a) Each flight crew member must report for any flight duty period rested and prepared to perform his or her assigned duties.

(b) No certificate holder may assign and no flight crew member may accept assignment to a flight duty period if the flight crew member has reported for a flight duty period too fatigued to safely perform his or her assigned duties.

(c) No certificate holder may permit a flight crew member to continue a flight duty period if the flight crew member has reported him or herself too fatigued to continue the assigned flight duty period.

(d) As part of the dispatch or flight release, as applicable, each flight crew member must affirmatively state he or she is fit for duty prior to commencing flight.

Commentary: The CFRs clearly define fit for duty. If we are aware of the hazardous implications of masking with respect to fatigue, we are obligated to avoid wearing them or to self-report. The NIH National Library of Medicine contains the following article addressing Mask Fatigue: https://pubmed.ncbi.nlm.nih.gov/33475571 and the CDC also recognizes the effects of long-term mask use and workplace fatigue: https://www.cdc.gov/coronavirus/2019-ncov/hcp/managing-workplace-fatigue.html.

FAA 2022 Guide for Aviation Medical Examiners (Page 8)
https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide

The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public, for the Government, and for the AME. If the examination is cursory and the AME fails to find a disqualifying defect that should have been discovered in the course of a thorough and careful examination, a safety hazard may be created and the AME may bear the responsibility for the results of such action.

Of equal concern is the situation in which an AME deliberately fails to report a disqualifying condition either observed in the course of the examination or otherwise known to exist. In this situation, both the applicant and the AME in completing the application and medical report form may be found to have committed a violation of Federal criminal law which provides that:

"Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both" (Title 18 U.S. Code. Secs. 1001; 3571).

49 USC § 46310 – Reporting & Recordkeeping

(a) General Criminal Penalty.—An air carrier or an officer, agent, or employee of an air carrier shall be fined under title 18 for intentionally—
(1) failing to make a report or keep a record under this part;
(2) falsifying, mutilating, or altering a report or record under this part; or
(3) filing a false report or record under this part.

(b) Safety Regulation Criminal Penalty.— An air carrier or an officer, agent, or employee of an air carrier shall be fined under title 18, imprisoned for not more than 5 years, or both, for intentionally falsifying or concealing a material fact, or inducing reliance on a false statement of material fact, in a report or record under section 44701(a) or (b) or any of sections 44702-44716 of this title.

Commentary: We see an FAA certified medical doctor 1-2 times each year and we are both obligated BY LAW (cited above) to disclose any disqualification condition pertaining to obtaining OR maintaining our medical certificate. If we know that masks are unhealthy for us and their continued use can cause cumulative harm (as evidenced by years of unbiased scientific studies prior to COVID politicization), we are obligated by moral, legal, and punitive implications to abstain and/or report.

14 CFR § 117.3 – Definitions

Flight Duty Period ("FDP") means a period that begins when a flight crew member is required to report for duty with the intention of conducting a flight, a series of flights, or positioning or ferrying flights, and ends when the aircraft is parked after the last flight and there is no intention for further aircraft movement by the same flight crew member. A Flight Duty Period includes the duties performed by the flight crew member on behalf of the certificate holder that occur before a flight segment or between flight segments without a required intervening rest period. Examples of tasks that are part of the Flight Duty Period include deadhead transportation, training conducted in an aircraft or flight simulator, and airport/standby reserve, if the above tasks occur before a flight segment or between flight segments without an intervening required rest period.

Commentary: ONLY allowing us to remove the mask WHILE we control the plane violates the definition of the FDP. According to the FDP, we should not be wearing it before, during, or after our intention to conduct a flight, a series of flights, or positioning or ferrying flights. This also includes, as defined above, deadheading in the cabin or riding in the jumpseat.

AIRLINE PILOTS ASSOCIATION JUMPSEAT GUIDE (July 2018)

While you are exercising the privileges afforded you by FAR 121.547 or 121.583 (i.e., jumpseating regulations), you are considered an additional crewmember and the alcohol limitations of FAR 91 apply. Having a seat in the back does not relieve you of this responsibility. Even when not in uniform, remember that you are still considered an additional crewmember and you may be required to assist on the flight deck or in the cabin in case of unusual or emergency circumstances. You must remain prepared to assists the flight crew should the need arise.

Commentary: While the above guidance pertains to alcohol, it makes a blanket statement about our overall responsibilities when riding in a jumpseat or non-reving in the back of the plane. Our union's own jumpseat guide references the CFRs requiring pilots to always maintain their health and fitness for duty. Since masking

impairs our ability when conducting a flight as evidenced by the fact that we are not required to wear a mask when flying, it also impairs our fitness for flight when acting in other required capacities.

DEPARTMENT OF TRANSPORTATION FAQs

https://www.transportation.gov/flyhealthy/frequently-asked-questions

What happens if a passenger does not comply with an airline's mask policies and/or causes an inflight disruption or distraction for the crew?

While the failure to wear a face covering is not itself a federal violation, federal law prohibits physically assaulting or threatening to physically assault aircraft crew or anyone else on a civil aircraft. Passengers are subject to civil penalties for such misconduct, which can threaten the safety of the flight by disrupting or distracting cabin crew from their safety duties. Additionally, federal law provides for criminal fines and imprisonment of passengers who interfere with the performance of a crewmember's duties by assaulting or intimidating that crewmember. U.S. airlines have policies about wearing face coverings in the airplane cabin. Please be sure to check with your airline prior to flight for further guidance

Commentary: Masking is NOT, in fact, a federal law on a plane. So if you do not escalate the situation, you cannot be forced to wear a mask and you are violating no federal law. You might be violating the airline's policy, but not an actual law. The minute you pushback is when they would then use other actual laws to say that you are interfering with a flight so they charge you by proxy. This is deceptive and makes the airlines the mask police and the government is acting through businesses to enforce its will upon the patrons.

Exhibit 3

U.S. Department of Transportation
Federal Aviation Administration

SAFO

Safety Alert for Operators

SAFO 20009
DATE: 05/25/21

Flight Standards Service
Washington, DC

http://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/safo

A SAFO contains important safety information and may include recommended action. Besides the specific action recommended in a SAFO, an alternative action may be as effective in addressing the safety issue named in the SAFO. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

Subject: COVID-19: Updated Interim Occupational Health and Safety Guidance for Air Carriers and Crews.

Purpose: This SAFO updates SAFO 20009 and provides updated interim occupational health and safety guidance by the Centers for Disease Control and Prevention (CDC) and the Federal Aviation Administration (FAA) for air carriers and crewmembers regarding Coronavirus Disease 2019 (COVID-19). The CDC and FAA are providing this additional occupational health and safety guidance for air carriers and their crews to reduce crewmembers' risk of exposure to COVID-19, decrease the risk of transmission of COVID-19 on board aircraft and to destination communities through air travel, and provide guidance for fully vaccinated[1] crewmembers.

Background: SARS-CoV-2, the virus that causes COVID-19, has spread throughout the world and to all States and territories of the United States (U.S.). Air carriers and crews conducting flight operations having a nexus to the United States, including both U.S. and foreign air carriers, should follow CDC's occupational health and safety guidance, as outlined in the Appendix below.

Discussion: On January 30, 2020, the World Health Organization (WHO) declared that the outbreak of COVID-19 constituted a Public Health Emergency of International Concern. On January 31, 2020, the Secretary of Health and Human Services declared COVID-19 to be a public health emergency in the United States under section 319 of the Public Health Service Act.[2] On March 11, 2020, WHO characterized the outbreak of COVID-19 as a pandemic. On March 13, 2020, the President declared a national emergency concerning the COVID-19 outbreak.

Because air travel remains essential, including transportation of personnel and supplies necessary to support COVID-19 response and recovery efforts, it is critical to protect the health and safety of crews

[1] People are considered fully vaccinated for COVID-19 two weeks after they have received the second dose in a 2-dose series, or two weeks after they have received a single-dose vaccine. CDC's guidance applies to COVID-19 vaccines currently authorized for emergency use by the FDA: Pfizer-BioNTech, Moderna, and Johnson and Johnson (J&J)/Janssen COVID-19 vaccines. CDC's guidance can also be applied to COVID-19 vaccines that have been authorized for emergency use by WHO (e.g. AstraZeneca/Oxford).
[2] This public health emergency has been renewed several times since January 31, 2020, most recently on April 15, 2021.

while ensuring that essential flight operations can continue. The FAA and CDC recommend that air carriers and crewmembers take precautions to avoid exposure of crewmembers to SARS-CoV-2. Crewmembers should not work while symptomatic with fever, cough, or shortness of breath, or other symptoms of COVID-19 or after having tested positive for SARS-CoV-2. They may return to work only after they are no longer considered infectious according to CDC's criteria for Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings.

The CDC continues to recommend a 14-day quarantine for individuals with known exposure to COVID-19; however, shorter quarantine periods may be considered. Crewmembers with known exposure should not work on aircraft until they meet CDC's criteria for release from quarantine. The CDC has issued guidance for exposed workers in critical infrastructure who might need to return to work before these criteria are met, available in COVID-19 Critical Infrastructure Sector Response Planning. While air travel is a vital economic activity, CDC does not recommend allowing crewmembers with known exposures to continue to work until they have met criteria for release from quarantine, even if asymptomatic, because of the inability of crewmembers to remove themselves from the workplace if they develop symptoms during a flight and the challenges involved in effectively isolating a symptomatic person on board an aircraft. Crewmembers who are fully vaccinated against COVID-19 or who recovered from COVID-19 in the past 3 months do not need to quarantine, be tested, or be excluded from work following an exposure unless they have symptoms of COVID-19. However, they should still self-monitor for symptoms of COVID-19 until 14 days after their last known exposure. Those who develop symptoms should self-isolate and be tested, regardless of vaccination status or previous recovery from COVID-19.

COVID-19 vaccines authorized for emergency use by the U.S. Food and Drug Administration (FDA) are available across the United States, and everyone 16 years of age and older is eligible to get a COVID-19 vaccination. These vaccines are effective against COVID-19, including severe disease, and a growing body of evidence suggests that fully vaccinated people are less likely to have asymptomatic infection or to transmit SARS-CoV-2 to others, although further investigation is ongoing. Wide-spread vaccination is a critical tool to help stop the pandemic, and air crewmembers are recommended to get vaccinated as soon as possible and in compliance with FAA direction on flight duties after vaccination.

Recent CDC Actions: In order to slow the worldwide spread of SARS-CoV-2 and its highly contagious variants, on January 12, 2021, CDC issued an Order requiring all air passengers, including those who are fully vaccinated, traveling to the United States from a foreign country to present a negative result of a SARS-CoV-2 test or documentation of recovery from COVID-19 before boarding their flight. While the Order includes a limited exemption for crewmembers under the conditions outlined in CDC's Frequently Asked Questions, CDC and FAA recommend that air carriers consider implementing routine testing of crewmembers to minimize the likelihood of crewmembers working on aircraft while asymptomatically or pre-symptomatically infected with SARS-CoV-2. It is also recommended that fully vaccinated people with no COVID-19-like symptoms and no known exposure should be exempt from routine screening

testing programs, if feasible.[3] Crewmembers who recovered from COVID-19 in the past 3 months should also be exempt.[4]

To further slow the spread of the virus, the CDC issued an Order effective February 2, 2021, requiring the use of masks on public conveyances (including aircraft) traveling into, within, or out of the United States, and in U.S. transportation hubs including airports. Wearing masks helps people who may have COVID-19 avoid transmitting the virus to others. Masks also provide some protection to the wearer. While the wearing of masks on aircraft is required, the Order includes an exemption if wearing a mask would create a risk to workplace health, safety, or job duty as determined by the relevant workplace safety guidelines or federal regulations. See CDC's Guidance and Frequently Asked Questions for the most up-to-date information about the mask requirement. Air carriers and crewmembers should be mindful of the regulations regarding the use of oxygen masks where the operation requires an oxygen mask to be rapidly placed on the face, properly secured, sealed, and supplying oxygen upon demand.[5] CDC's Order does not apply if wearing of oxygen masks is needed on an aircraft when a loss of cabin pressure or other event affecting aircraft ventilation occurs. Air carriers should complete a safety risk assessment and provide guidance to their crewmembers on procedures for the use of masks as they may affect the donning of oxygen masks or conducting other safety functions on the flight deck or in the cabin.

Recommended Action: The FAA and CDC recommend and expect that all U.S.-based air carriers and crewmembers, all non-U.S.-based air carriers operating flights with a U.S. nexus, and all non-U.S.-based crewmembers on flights with a U.S. nexus implement and use their company-developed COVID-19 preparedness plans and procedures in conjunction with the FAA and CDC occupational health and safety guidance in the attached appendix regarding practices for limiting the spread of COVID-19. The FAA and CDC will update or supplement this SAFO as more information becomes available. Air carriers and crewmembers should also review and incorporate into their COVID-19 preparedness plans and procedures, CDC's Updated Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 (COVID-19).

CDC has additionally provided fact sheets for the transportation industry and a communications toolkit for airlines.

Contact: Questions or comments regarding this SAFO should be directed to the Air Transportation Division, at 202-267-8166. Urgent questions pertaining to the Appendix below should be directed to the CDC Emergency Operations Center at 770-488-7100. Non-urgent questions or comments may be directed to 800-CDC-INFO (800-232-4636.

[3] See CDC guidance for fully vaccinated people with no COVID-19-like symptoms and no known exposure to someone with suspected or confirmed COVID-19

[4] People who have recovered from COVID-19 may continue to test positive for three months or more without being contagious to others. For this reason, crewmembers who tested positive for SARS-CoV-2 in the past 3 months should be tested only if they develop new symptoms of possible COVID-19. Getting tested again should be discussed with a healthcare provider, especially if the crewmember has been in close contact with another person who has tested positive for COVID-19 in the last 14 days. The healthcare provider may work with an infectious disease expert at the local health department to determine when the crewmember can be around others.

[5] See e.g., 14 C.F.R. § 121.333.

Exhibit 4

businessinsider.com

Airline passengers who refuse to wear masks have turned violent — and now that the TSA has extended the mask mandate, it's going to get even uglier

Max Ufberg

9-11 minutes

3-1-22; updated 3-10-22

Across the US, mask mandates are being lifted by retailers, colleges, theme parks, music festivals, and even state governments. But that's not the case on airplanes, where the Transportation Security Administration is still enforcing a mask requirement on all commercial flights. Despite coming with hefty fines and the threat of criminal prosecution, the policy has spawned an epidemic of shouting matches — and worse — between defiant passengers and flight crews.

The mandate was set to expire March 18 but has just been extended by a month. A major union of flight attendants had pushed for another extension, citing safety for the flight attendants, the immunocompromised, and children under 5, the only age group still ineligible for vaccination in the US. This marks the third time the TSA has extended the mandate (which also covers buses, trains, and transportation hubs), and it may not be the last. "The data and potential for the emergence of new variants points to retaining the mandate until the summer, at least," says Bob Mann, an airline-industry analyst.

But if airlines are the last place in America to require masks, the skies are likely to become even less friendly for flight crews. Last year the Federal Aviation Administration reported 5,981 instances of unruly passengers, 71% of which were related to the mask mandate. There was the guy who threatened to break the neck of a fellow passenger who intervened during a mask-related confrontation with a United Airlines attendant. The woman who slapped and spit on a fellow Delta passenger who scolded her for not wearing a mask. The man who refused to mask up on a Delta flight and decided to expose himself to a flight attendant instead. It was the worst year on record for buffoonish behavior on planes — and that was before the Centers for Disease Control and Prevention lifted indoor mask restrictions across most of the US. Imagine the fury among anti-mask passengers if the federal government continues to enforce a mask requirement on airlines into the late spring and even the summer summer, when no one's making people mask up anywhere else.

That's why flight attendants, along with Delta Air Lines, are proposing a bold new maneuver in the mask war: prohibit unruly passengers from flying. Earlier this month, Delta CEO Ed

Bastian sent a letter to the Justice Department asking for the creation of a national "no fly" list that would bar passengers with a history of unruly behavior from boarding *any* commercial flight, not just the one where they transgressed. Bastian wrote that such a list would "help prevent future incidents and serve as a strong symbol of the consequences of not complying with crew member instructions on commercial aircraft."

People were acting like idiots on airplanes long before the pandemic, of course. (Remember this guy?) Research points to a host of explanations for in-flight aggression: Planes are cramped spaces, passengers often feel uncomfortable or anxious, and there's no exit when the going gets rough. There's a highly visible social ladder between the haves and the have-nots, with first-class passengers receiving far better treatment and way more space than those stuck in coach. And alcohol is freely available to soothe — or inflame — all these fears and frustrations.

But the level of in-flight fracas has gotten exponentially worse in the past two years, with most cases involving disputes over masking. The political divisions over the coronavirus pandemic are amplified on flights, where Americans who would normally be separated by vast swaths of culture and geography are thrown together in the close quarters of an airplane cabin. "As the nation has become more divided, we've seen more and more of such cases," says Mann, the analyst.

To make matters worse, many US passengers hail from parts of the country that take the pandemic far less seriously than others. And the mask opponents often assume, falsely, that the mask requirement is an airline policy, not a federal regulation. "They don't even think it's a law," Mann says. "They think it's an advisory of some sort."

That's part of the reason flight attendants had pushed to extend the mask mandate and back it up with a no-fly list: to bring the formality of federal authority to a realm that many passengers dismiss as ignorable corporate policy. Last October, Transportation Secretary Pete Buttigieg told CNN that the idea for a no-fly list "should be on the table" after an American Airlines flight attendant had several bones in her face broken during a mask-related altercation with a passenger.

Still, the list is a long shot, with opposition across the political spectrum. Eight Republican senators have written a letter to Attorney General Merrick Garland, arguing that a no-fly list would equate unruly passengers with "terrorists" for whom the FBI already maintains a no-fly list. And the senators have an unlikely ally in the American Civil Liberties Union. Though the ACLU has lobbied for mask mandates, it has also challenged the FBI's terrorism no-fly list in court, and it's already questioning the lack of due process for unruly passengers.

"The proposals I've seen would allow airlines to put people on the list," Jay Stanley, a senior policy analyst at the ACLU, told me. "Better proposals would require that you actually be convicted in court of interfering with aviation or the like on an aircraft."

Moreover, it's not even clear that most airlines want a no-fly list. Other than Delta, they've been mum on the subject, referring questions to Airlines for America, an industry trade group.

Katherine Estep, the group's spokeswoman, told me only that airlines "remain in communication with the FAA, TSA, and other relevant agencies to identify ways to further mitigate this ongoing challenge." (The TSA did not respond to a request for comment, and a representative for the Justice Department said it would be referring Delta's letter to "appropriate departments.")

Should the mask mandate continue into the summer and beyond, airlines could expect the bad behavior to increase, as customers grow accustomed to going maskless everywhere else. Through mid-February of this year, according to FAA data, airlines have reported 607 cases of unruly passengers — far higher than pre-pandemic levels. A few weeks ago, a Portland, Oregon, man was charged with trying to open an emergency door while on a Delta flight en route from Salt Lake City. The reason for his disturbance? An affidavit filed in support of the arrest warrant says he wanted to get other passengers to film the incident, "thereby giving him the opportunity to share his thoughts on COVID-19 vaccines."

All of which means airlines are likely to be stuck in the worst of all possible worlds: requiring masks in the midst of a nationwide war over masks, without any means to prevent unruly passengers with a record of lashing out from doing so again. "There are some very legitimate reasons why airlines may want to have the mask requirement extended," says Henry Harteveldt, the president of the travel consultancy Atmosphere Research Group. "Unfortunately, even though we know COVID is not over, a lot of people are over COVID."

This article, originally published on March 1, has been updated to reflect that on March 10 the Transportation Security Administration extended the airplane mask mandate.

Exhibit 5

washingtonpost.com

Sneezed on, cussed at, ignored: Airline workers battle mask resistance with scant government backup

Michael Laris

13-17 minutes

Other passengers have verbally abused and taunted flight attendants trying to enforce airline mask requirements, treating the potentially lifesaving act as a pandemic game of cat-and-mouse. A loophole allowing the removal of masks while consuming food and beverages is a favorite dodge.

Asked to mask up, one passenger pulled out a large bag of popcorn and nibbled her way through it, kernel by kernel, stymieing the cabin crew for the length of the flight. Others blew off requests by chomping leisurely on apple slices, between occasional coughs, or lifting an empty plastic cup and declaring: “I am drinking!”

The displays of rule-bucking intransigence are described in more than 150 aviation safety reports filed with the federal government since the start of the pandemic and reviewed by The Washington Post. The reports provide an unguarded accounting of bad behavior by airline customers, something executives hit by a steep drop in travel and billions in pandemic-related losses are loath to share themselves.

Some reports raise safety concerns beyond the risk of coronavirus infection. A flight attendant reported being so busy seeking mask compliance that the employee couldn’t safely reach a seat in time for landing.

One airline captain, distracted by mask concerns, descended to the wrong altitude. The repeated talk of problem passengers in Row 12 led the captain to mistakenly head toward 12,000 feet, not a higher altitude given by air traffic control to keep planes safely apart. The error was caught, and “there was no conflicting traffic,” the captain wrote.

The Boeing 737 Max was grounded for 20 months following two crashes that killed 346 people. Now, after design changes, the aircraft is returning to service. (The Washington Post)

Some passengers are portrayed as oblivious, obstinate, foul-mouthed and, at times, dangerous. One called a flight attendant a “Nazi.” Another “started to rant how the virus is a political hoax and that she doesn’t wear a mask,” a flight attendant reported.

With millions of passengers ignoring warnings from the Centers for Disease Control and Prevention to refrain from holiday travel, the reports offer an X-ray into the country’s deeper failures against the coronavirus — and insights into the pitfalls and possibilities facing a new presidential administration.

While the White House under President Trump has, at times, been dismissive or hostile toward masks, President-elect Joe Biden is making a patriotic appeal to “mask up for 100 days,” whatever people’s politics. Biden has said he will sign an order on his first day requiring masks for “interstate travel on planes, trains and buses.” How well those efforts will work remains to be seen.

Experts in psychology and decision-making say hostility toward wearing masks, even within the shared confines of a passenger jet, has been fueled by politicization — but also by skewed incentives and inconsistent messaging.

“The reinforcement principles are backward,” said Paul Slovic, who studies the psychology of risk at the University of Oregon.

The usual signs of danger, and rewards for following potentially bothersome rules, are thrown off by a virus that is spread easily by people who don’t know they have it, Slovic said.

“You get an immediate benefit for not following the guidelines because you get to do what you want to do,” Slovic said. “And you don’t get punished for doing the wrong thing” because it’s not immediately clear who is being harmed.

The “squishiness of the requirement” to wear masks on planes also undermines the message that they are critical for public health, Slovic said. In contrast, he cites the rigid clarity of the ban on flying with a firearm. “It’s not, ‘You can carry it as long as you don’t use it,’ ” Slovic said.

But passengers are allowed to drop their masks to snack and sip beverages. “When you start opening it up to eating, the whole thing kind of weakens,” Slovic said.

Applying mask rules also worsens the already strained position of flight attendants, who are front-line enforcers even as they keep their usual safety responsibilities, experts said.

“Flight attendants are dealing with mask compliance issues on every single flight they work right now,” said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, noting that those efforts range from friendly reminders to facing passengers “actively challenging the flight attendants’ authority.”

The Department of Transportation in October rejected a petition to require masks on airplanes, subways and other forms of transportation, with Secretary Elaine Chao’s general counsel saying the department “embraces the notion that there should be no more regulations than necessary.”

The nation’s aviation regulator has deferred to airlines on masks, with Federal Aviation Administration chief Stephen Dickson telling senators at a June hearing “we do not plan to provide an enforcement specifically on that issue.”

Such matters are more appropriately left to federal health authorities, Dickson argued. “As Secretary Chao has said, we believe that our space is in aviation safety, and their space is in public health,” Dickson said, referring to the CDC and other health officials.

Airline representatives say they take mask usage seriously and the overwhelming majority of customers comply. Some airlines have banned passengers for the length of the pandemic for refusing to mask up. Many have eliminated medical exemptions in their mask requirements.

“Of the hundreds of thousands of passengers who have flown with us, we have only needed to ban

about 370 customers for not complying," United Airlines spokeswoman Leslie Scott said. Delta said its mask-related no-fly list includes about 600 people, despite carrying about 1 million people each week.

Resistance by some passengers prompted Alaska Airlines to begin issuing yellow cards, akin to the warnings in soccer, to problem passengers.

The initial yellow card said employees would file a report that could result in a passenger being suspended. A later version was more aggressive, saying continued defiance would lead to a flight ban "immediately upon landing," even if the customer had a connecting flight.

Alaska Airlines has barred 237 passengers since August, and "in more than half of these incidents we also canceled onward or returning travel," spokeswoman Cailee Olson said.

American Airlines declined to release numbers of banned customers, as did Southwest, which said in a statement it appreciates "the ongoing spirit of cooperation among customers and employees as we collectively take care of each other while striving to prevent the spread of COVID-19."

Yet a small, uncooperative minority can wreak outsize havoc, safety reports show.

The anonymous reports are collected in a National Aeronautics and Space Administration database, part of a program meant to increase aviation safety by encouraging employees to provide candid descriptions of emerging problems without fear of reprisal. Names of people filing the reports, and their airlines, are removed by NASA before they are made available to regulators at the FAA and the public.

NASA analysts screen the reports to weed out irrelevant filings and may call back filers to clarify safety points. But its analysts do not try to verify people's identities or the accuracy of the reports.

The database shows some fliers treat airline mask requirements as a seemingly asinine rule to evade, akin to sneaking a late look at text messages after phones are supposed to be in airplane mode. Passengers berate flight attendants about their noncompliant cabin mates. Some reports read like cries for help.

"It all has to stop," pleaded one flight attendant.

"In the future I would like to feel safe while doing my job," said another.

● A woman refused to wear her mask as the plane rolled away from the terminal, saying it made her ill, and the pilot pulled over temporarily to try to avoid returning to the gate. She continued to resist but finally agreed.

"As soon as we took off, she took it off again and kept it off the entire flight," the flight attendant reported.

● A man started down the aisle, pausing about 18 inches from a flight attendant.

"He sneezed directly in my face, making no attempt to cover his mouth, pull up his mask or turn towards the row 1 window," the employee wrote. The flight attendant, who was wearing a face covering, judged the act unintentional and tried to blot away the remnants.

● A woman propped her foot up and painted her toenails with her mask below her chin, despite

several requests to wear it properly. After another passenger appealed for more to be done, the woman acquiesced, then loudly instructed the flight attendant to “go away!”

After landing, she cut in line to rush off the plane. “Although we understand the importance of wanting to retain customer loyalty, this kind of behavior should not be tolerated for the sake of one over an entire cabin of guests and employees,” the flight attendant wrote.

● An immunocompromised passenger was furious at the lack of enforcement as another customer snacked incessantly on chocolate. The concerned passenger then removed his mask to complain to the flight attendant.

● A passenger claimed discrimination, arguing he was singled out for enforcement because of his tattoos. “He said ‘I am complying, #%$^!’ His nostrils were clearly visible,” the flight attendant wrote.

● A pilot flouted the mask requirement with what appeared to be a passive-aggressive display, donning a flimsy, see-through veil described as useless for containing airborne particles.

● Flight attendants made an exception and allowed a distraught mother, whose daughter may have had a disability and screamed about the mask requirement, to remain on the plane. They tried cookies, which didn’t help, then moved the family to seats three rows from other passengers, who were supportive.

● A customer, after earlier warnings, stuck his mask-free head in the aisle during the safety demonstration, “making a total mockery out of me,” a flight attendant wrote. He repeated his taunt when the plane was fourth in line for takeoff. The captain turned around, and the man was taken off the plane.

The obstinacy cuts against basic health precautions. Experts in cabin air say masks are critical tools for safety. Cabin air is run through powerful filters, mixed with outside air and recirculated. But it takes several minutes for all air to be vented out of the cabin, giving the coronavirus and other viruses the opportunity to spread.

A Harvard study funded by the aviation industry said flying can be done with a relatively low risk of coronavirus infection if precautions are followed. It said masks are “perhaps the most essential layer” among measures to reduce transmission.

The study said removing masks to eat should be kept to an “absolute minimum,” and straws should be used when feasible. “When one passenger briefly removes a mask to eat or drink, other passengers in close proximity should keep their masks on,” researchers said.

Trump and some of his advisers, meanwhile, have stoked divisions over masks.

The president mocked Biden’s frequent mask use, presided over White House events that flouted mask guidelines and relied on a former pandemic adviser who wrongly argued masks were ineffective. The White House also blocked a nationwide order, drafted by the CDC, that would have required masks on all forms of public transportation.

“Masks have been made a political issue from the start of the pandemic, and people don’t believe they need to wear them,” said Garland, whose union represents about 50,000 flight attendants.

“We do not have a president who tells people to wear a mask, and the federal government, not just in aviation but across the board, has declined to mandate it in any way, shape or form,” she added, saying her members are eager to see a Biden administration set a different tone.

An FAA spokesman declined to answer questions about the risks involved with passengers refusing to wear masks.

After inquiries from The Post about enforcement, the agency distributed a news release touting its role in pursuing civil penalties in two assault cases but reiterated that “the failure to wear a face covering is not itself a federal violation.”

The cases show how mask disputes can escalate.

On an Allegiant Air flight in August, a passenger hit a flight attendant, yelled obscenities at him and grabbed his phone as he described a mask-related dispute to the captain, according to the FAA. The agency said it is pursuing a $15,000 civil penalty for assault and interfering with a flight attendant.

Allegiant declined to say whether anyone was arrested or charged.

On a SkyWest Airlines flight to Chicago in August, a passenger took off a mask, “continually bothered” fellow customers and “at one point, grabbed a flight attendant’s buttock as she walked by the passenger’s row of seats,” according to the FAA, which is seeking a $7,500 penalty.

Beyond addressing such extreme cases, some outside experts say federal and corporate leaders have fallen short.

“Both industry and government have failed the people on the front line who need to administer these rules,” said Baruch Fischhoff, a psychologist and professor at Carnegie Mellon University who researches decision-making.

Politics often has driven responses to the pandemic, while critical public health communication on things like masks has not been tested to make sure it hits the right notes or is convincing, Fischhoff said. “Neither have fulfilled that responsibility for clear, consistent, tested communications,” he said.

Fischhoff said that with 330 million people in the United States, it’s not surprising the safety reports received by NASA reveal examples of poor behavior.

“Part of the reason they stand out is, I think, the vast majority of people are polite and civil to one another,” Fischhoff said. Still, the reports probably represent a dramatic undercount because it takes time and initiative for busy employees to file them.

“If you see 100, there are probably 1,000 or 10,000. This is a widespread enough phenomenon that it needs to be taken seriously,” he said. “You have to give credit to people who lodge just complaints and recognize they’re just a fraction of the people who are observing things that threaten our health and our economy.”

Exhibit 6

dallasnews.com

American Airlines joins Southwest in delaying alcoholic beverage sales due to bad passenger behavior

By Kyle Arnold6:50 PM on May 29, 2021 CDT

4-5 minutes

American Airlines will delay selling alcoholic beverages this summer to main cabin passengers due to the uptick in bad passenger behavior in recent months that includes refusing to wear masks and several assaults on flight attendants.

Fort Worth-based American Airlines told crew members that it won't reintroduce the sale of beer, wine and spirits to main cabin class passengers until at federal government officials drop the mask mandate aboard aircraft and airports. The mask mandate is currently set to expire Sept. 14. American was scheduled to bring back alcohol sales Tuesday.

Featured on Dallas News

Researchers evaluating how District Attorney John Creuzot's relaxing marijuana enforcement affects…

American Airlines joins Dallas-based Southwest Airlines in pushing back the reintroduction of the sale of alcoholic beverages after flight attendants expressed concern about the recent increase in bad passenger behavior. The concerns peaked after the bloody assault of a Southwest flight attendant last week on a flight landing in San Diego.

"Over the past week we've seen some of these stressors create deeply disturbing situations on board aircraft," said American Airlines vice president of flight safety Brady Byrnes said in a letter to crew members Saturday. "Let me be clear: American Airlines will not tolerate assault or mistreatment of our crews.

"We also recognize that alcohol can contribute to atypical behavior from customers on board, and we owe it to our crew not to potentially exacerbate what can already be a new and stressful situation for our customers."

American Airlines dropped alcoholic beverage service in March 2020 to create less contact between flight attendants and passengers during the COVID-19 pandemic. It also cut back service of soft drinks, juices, snacks and foods. Airlines are beginning to bring those services back, and American started selling alcohol to some premium class customers earlier this year.

But for everyone else, alcohol will have to wait a few more months.

“It is no secret that the threats flight attendants face each day have dramatically increased,” said a letter to union members from Julie Hedrick, president of the Association of Professional Flight Attendants, which represents American’s 13,400 flight attendants. “Every day, we are subjected to verbal and sometimes physical altercations, mainly centered around mask compliance. These altercations are often exacerbated when customers have consumed alcohol in the airport or alcohol they have brought on board.”

Airlines and federal officials have noted an uptick in passenger misbehavior. Flight attendant union leaders have attributed much of the uptick in passengers refusing to wear masks, a COVID-19 precaution that took on deep political symbolism after the November presidential election and the Jan. 6 storming of the U.S. Capitol by Trump supporters who refused to accept Electoral College results.

The Federal Aviation Administration has noted more than 2,500 reports of passenger misbehavior this year, and a spokesman for the agency said there was a sharp uptick starting late last year.

Flight attendants have often been caught in the middle of the issue and heavily lobbied for a federal mandate for face masks on planes. President Joe Biden made a federal face mask rule on planes one of his first executive orders after he took office.

But passenger misbehavior has continued throughout the year despite numerous fines against passengers proposed by the FAA. Several of those fines stemmed from passengers drinking alcohol they had bought in airports.

Airlines are now dealing with their largest crowds since the pandemic began. Nearly 2 million passengers passed through Transportation Security Administration checkpoints on Friday, nearly 80% as many as did on the same date in 2019.

Atlanta-based Delta Airlines began serving alcohol to passengers again in July 2020. Chicago-based United is scheduled to resume sales of alcoholic beverages in June, and a company spokesman said United hasn’t made a decision to change that.

Exhibit 7

cnbc.com

Unruly behavior from plane passengers has never been this bad, says flight attendant union chief

Kevin Stankiewicz

3-4 minutes

Incidents of unruly behavior from airplane passengers has risen to an unprecedented level this year, union leader Sara Nelson told CNBC on Friday, the start of the Memorial Day holiday weekend.

"This is an environment that we just haven't seen before, and we can't wait for it to be over," the president of the Association of Flight Attendants-CWA said on "Squawk Box."

The behavior has become "complete nuts," added Nelson, whose union represents around 50,000 cabin crew members across more than a dozen carriers. "It's a constant combative attitude. ... It's got to stop."

Nelson's comments follow a recent violent confrontation that resulted in a Southwest Airlines flight attendant sustaining facial injuries and losing two teeth. In a statement to NBC News earlier this week, Southwest said the passenger "repeatedly ignored standard inflight instructions and became verbally and physically abusive upon landing."

A 28-year-old woman has been charged with felony battery in the incident, which occurred on a Sacramento to San Diego flight.

The Federal Aviation Administration said Monday it has received around 2,500 reports of unruly passenger behavior since Jan. 1, roughly three-quarters of which involve failure to adhere to the federal face mask mandate that has been instituted due to the coronavirus pandemic.

That's more than 20 times higher than what's normally recorded in an entire year, Nelson told CNBC. She noted the role masks are playing in the surge and expressed disappointment that health protocols on planes are seen as "a political issue."

The federal mask requirement is on the books until Sept. 14, and the FAA intends to keep its zero-tolerance policy for passenger disturbances in place as long as the mandate applies.

While airline travel has picked up in recent months as Covid vaccinations become more available, TSA checkpoint data shows travel is still notably below 2019 levels.

"Typically what flight attendants will do, when we see a conflict arise on the plane, we're trained to deescalate. We look for our helpers," Nelson said. However, she said the passenger mix is different than pre-Covid.

"It's very difficult when you don't have people on the plane who are regularly flying, who sort of know the program, who are our typical people that we'd go to, at least, create peer pressure but also help to try to calm down these incidents," she said.

Nelson said increased messaging around the consequences for passengers who act out — such as FAA fines — would be helpful. That includes not only on-board messages from the flight captain, but also throughout airports, she said.

Temporary restrictions on alcohol sales also would be beneficial, Nelson said.

"A lot of times these events are exacerbated by alcohol, so we've been asking the government and the airlines to make sure they're not selling alcohol right now because that's only adding to the problem that is clearly out of control."

Exhibit 8

skift.com

1 in 5 Flight Attendants Have Had Physical Altercations With Unruly Passengers so Far This Year

— Ruthy Muñoz

5-6 minutes July 29, 2021

One in five flight attendants so far this year has been involved in physical altercations with unruly passengers and 85 percent of cabin crew members have dealt with disruptive passengers this year as more are returning to travel, a survey released by the Association of Flight Attendants-CWA (AFA) revealed on Thursday.

The online survey of 5,000 flight attendants across 30 airlines found more than half have experienced at least five incidents with unruly passengers, with flight attendants reporting incidents of swearing, yelling, aggressive behaviors, racial and homophobic slurs, and physical assaults.

Unwilling to accept this new normal, the AFA is calling on the Federal Aviation Administration and the U.S. Department of Justice to make the 'zero tolerance' policy permanent.

"This survey confirms what we all know, the vitriol, verbal and physical abuse from a small group of passengers is completely out of control, and is putting other passengers and flight crew at risk. This is not just about masks as some have attempted to claim. There is a lot more going

on here and the solutions require a series of actions in coordination across

aviation," said Sara Nelson, President of AFA-CWA.

In response to the rise of disruptive passengers, the Federal Aviation Administration in January enacted new security measures for airlines by issuing a temporary "zero tolerance" policy, making bad behavior an enforceable federal offense and extending it at the end of March.

But union officials representing 50,000 flight attendants across 17 airlines, feel it's not enough. The AFA said existing measures in place are failing to address the problem and wants the FAA and DOJ to protect passengers and crew from verbally, physically abusive, and disruptive travelers.

One survey respondent reported being on the ground at the back of the aircraft without the other crew members noticing until after the attacker had deplaned.

"We tell them (passengers) that it is a federal offense to not comply with crew member instructions, use foul and/or threatening language onboard, and then the plane is met by airline supervisors or airport law enforcement and the passenger gets a slap on the wrist and sent on their way," wrote one flight attendant in the survey.

The flight attendant who said she's been threatened, yelled, and cursed at countless times in the last year and has only seen at most a temporary suspension of travel for the passenger.

"We need real consequences if flight attendants are ever going to feel safe at work again," the unnamed flight attendant said.

For airline frontline workers, the incessant rise of bad behavior inflight is taking a toll with many flight attendants feeling unheard and unprotected.

Survey data found 71 percent of flight attendants who filed incident reports with their management didn't receive a follow-up and a majority didn't observe efforts by the airlines to address issues with unruly passengers.

"It is time to make the FAA 'zero tolerance' policy permanent, the Department of Justice to utilize existing statute to conduct criminal prosecution, and implement a series of actions proposed by our union to keep problems on the ground and respond effectively in the event of incidents," Nelson said.

Flight attendants cite multiple factors contributing to disruptive incidents and

point to mask compliance, flight delays, routine safety reminders, alcohol, and cancelations as common factors when dealing with unruly passengers, an AFA spokesperson said.

To date, the FAA has received 3,615 unruly passenger complaints, more than half of them mask-related incidents. The agency has initiated 610 investigations and 95 enforcement cases, said the FAA's website.

Additionally, many flight attendants reported facing extensive verbal abuse from visibly drunk passengers, being subjected to yelling and swearing for federal mask mandate directions. Survey respondents also reported being aggressively challenged by unruly passengers in other ways including kicking seats, shoving, being thrown thrash at and passengers defiling a restroom in defiance of instructions, it said.

The FAA has been enforcing some cases and issuing historic fines for unruly passengers.

AFA said its union has fought discrimination and prejudice for decades, and won't allow this moment to set it back.

"Aviation is about bringing people together, not tearing us apart," it said.

Airlines joined unions asking the U.S. Attorney General to prosecute unruly passengers in June.

Photo Credit: Passengers and flight attendant on an aircraft. StockSnap / Pixabay

Exhibit 9

travelpulse.com

Is It Time to End the Mask Mandate in Airports and on Planes?

4-5 minutes July 15, 2021

The Centers for Disease Control and Prevention (CDC) and the Biden Administration have a difficult decision to make in two months.

The federal mask mandate expires on Sept. 13. The mandate requires passengers on public transportation to wear a mask at all times, including while in airports and during flight – whether that flight is 50 minutes or five hours.

It's time.

It's time to stop enforcing this policy.

And I understand this is likely an unpopular opinion but, then again, I have hundreds of those. Like, Van Halen was better with Sammy Hagar as the lead singer instead of David Lee Roth, or Reggie Jackson wasn't a true Yankee because he only played five years in New York, or Skor is the better toffee candy bar than Heath.

Trending Now

Or, the CDC should let the deadline on the mask mandate pass without further action.

The mandate is in place to better prevent the spread of the COVID-19 virus, and for the better part of a year that has been a worthy goal.

But it has also proven problematic.

Physical confrontations on airplanes have dramatically increased this year, and of the 3,000+ that have been recorded by the Federal Aviation Administration so far in 2021, nearly three-quarters of them have been a direct result of arguments over wearing a face mask – whether between crew members and passengers, or passengers vs. passengers.

The whole idea of face masks was that it was something the airlines encouraged in the summer of 2020, at the height of the pandemic – they wanted a uniform policy mandated by the federal government instead of having various, or differing, policies set by each airline.

Here we are a year later, and the irony has set in. The airlines see the unintended consequence of face masks in every disagreement aboard a flight; they see the efficacy that the vaccines are having; they have noted that nearly 70 percent of the country has had at least one shot against the virus, and now they want the CDC to let the mandate quietly expire on Sept. 13 without being renewed for another four months.

For many reasons, I believe this is the best course of action.

People who are vaccinated can now come and go as they please, except for some stores and businesses that still require a mask. The vaccinated still have their reasons and still have the option to wear a mask if they so choose. You don't need a mandate to wear one if you believe it protects you.

The unvaccinated have their reasons. And they, too, have the option to not wear a mask if they so choose. See, the thing is, anti-vaxxers are not going to have their minds changed. But should they be denied the privilege of flying over a mask?

That's the touchy question.

When first proposed a year ago, we can't deny that the idea of wearing a mask was a comfort zone for an airline industry struggling with the dramatic loss of customers. Simply put, having the entire plane wear a mask encouraged more people to fly. It made them feel safer.

To be blunt, while I say it's time to rescind the mask mandate, I still regard it as a minor inconvenience. Honestly, wearing a mask is about as big a problem to me as having to take my shoes and belt off. And we've been doing that for the better part of 20 years now.

My fear, however, is that the mandate is going to someday cause a far bigger problem while in the air than just some unruly passenger being eventually duct-taped to a seat.

One of these days, a confrontation is going to escalate far further than the crew member who had a finger bitten or the flight attendant who caught an errant punch square in the face and had two teeth knocked out.

Ask yourself, is it worth it to have a mandate that ostensibly is for your safety but only leads further to unsafe conditions?

That's not something I want to find out.

Exhibit 10

washingtonpost.com

Unruly airplane passengers are straining the system for keeping peace in the sky

Michael Laris, Lori Aratani

17-21 minutes July 18, 2021

Both men were arrested earlier this year in Denver, charged with the same broad federal crime: interference with flight crew members and attendants.

They were, in many ways, the exceptions.

The system for keeping the peace in America's skies is creaking under the pressure of what airlines and regulators say is an unprecedented proliferation of misbehavior.

The Federal Aviation Administration has received more than 3,400 reports of "unruly" passengers this year. But despite launching a "zero-tolerance" enforcement policy in January — amid a rise in conflicts often tied to mask requirements in the air — the agency said that as of mid-July it had "completely closed" just seven cases.

The sprawling, multitiered system for enforcing regulations and federal laws covering passengers can take years to play out. As travel rebounds, that structure is being strained by confrontations fueled by alcohol, hostility to mask mandates and small conflicts that careen out of control. One passenger hit a woman holding an infant amid an apparent dispute over a window shade. Another ran through business class and stomped on a flight attendant's foot after the power outlet at her seat wouldn't charge her phone, according to court records.

The system involves airline employees, FAA inspectors and lawyers, Transportation Department judges, local authorities, state and federal courts, FBI agents and U.S. attorneys, who all have roles in a sometimes messy and protracted process.

An escalation in 'air rage'

The incidents that take place miles high in pressurized cabins are filled with many of the same pathologies and clashes that occur on the ground.

A review of federal cases by The Washington Post points to alcohol, drug use and mental illness as key factors in outbursts that have terrified passengers and crew members,

sometimes leaving them hospitalized. The tools for dealing with those problems in the air are more limited than on land.

Court records describe ad hoc policing teams made up of passengers recruited by flight attendants to help subdue rampaging fellow fliers using plastic handcuffs and seat belt straps. The records detail several instances of passengers trying to pry open doors on planes, leading to scenes of panic and violence.

“I am waiting for a signal,” a distressed passenger declared on a Hawaiian Airlines flight from Los Angeles in October before lunging for the emergency door and smashing a flight attendant’s head against it, causing a “ping pong ball sized hematoma” on her temple, federal prosecutors said.

After the third lunge, passengers and crew members zip-tied the man’s ankles to a seat. His lawyer said he “was in an altered state of mind when he tried to exit a commercial aircraft mid-flight. … This activity was not violent and was not driven by anger towards any other person.”

The flight attendant’s injuries, after she “properly blocked him,” were minor, the lawyer added. Authorities said that after the man’s arrest, he choked a nurse at a Hawaii hospital until he lost consciousness. The passenger, in his early 30s, was detained for eight months and released to his parents with an order that he take medication pending a March trial.

Earlier this month, a woman tried to open an airplane door on a flight from Dallas, then bit a flight attendant, according to American Airlines. She was duct-taped to her seat. In May, a Southwest Airlines flight attendant had two teeth knocked out, allegedly by a passenger who refused to remain seated.

Aviation experts say cases of “air rage” are nothing new, but verbal attacks are turning physical more quickly.

“What we’re really seeing is an increased level of hostility on the aircraft, which is something I don’t think we’ve ever seen before in this industry,” said Paul Hartshorn, spokesman for the Association of Professional Flight Attendants, which represents American Airlines employees. “It’s just incredibly dangerous.”

‘My life is changed forever’

Federal prosecutions in cases where “interference with flight crew members and attendants” is the lead charge were down sharply in the past decade following a rise after the Sept. 11, 2001, terrorist attacks, according to a Post examination of federal prosecution data housed at Syracuse University, raising questions about resources and priorities.

For most of the 2000s, there were more than 50 such prosecutions annually, with case counts sometimes topping 70, according to data compiled by the university’s Transactional

Records Access Clearinghouse. Over the past decade, that number has been in the teens and 20s each year, according to the research center, which built a vast database through decades of public records requests.

The Justice Department said prosecutions under the “interference” statute — by its count there were 20 in fiscal year 2019, 16 in 2020 and 14 through this month in 2021 — do not reflect the scope of its efforts because other charges are also used. At a Senate hearing in June, Attorney General Merrick Garland said the Justice Department takes the recent onboard assaults “extremely seriously.”

“Even if not intended to bring the plane down, you can imagine the kind of pandemonium on planes that we’ve seen in some of these videos that people have taken that can cause an incredibly dangerous accident,” Garland said.

In a June letter to Garland, a consortium of airline industry and labor groups called on the Justice Department to “direct federal prosecutors to dedicate resources for egregious cases.” It noted inconsistencies in which cases are prosecuted in different jurisdictions, and said more criminal prosecutions are needed. The department is reviewing the letter, an agency spokesman said.

In selecting which airborne cases to pursue, federal prosecutors said they weigh damage to victims, airlines and threats to public safety. Considerations include whether flights were diverted, lives were endangered, the quality of the evidence and a suspect’s mental health status, federal prosecutors said.

In Congress, some lawmakers want the Justice Department to create a new “no-fly list” for passengers convicted of assault or who have paid civil penalties in such cases. Airlines, which have banned more than 2,700 customers for refusing to wear masks, don’t share information about customers who cause problems. Someone barred by one carrier can simply book a flight on another airline.

The incidents can leave a lasting mark.

Delta Air Lines flight attendant Eunice DePinto was shoved after trying to pull a first-class passenger off the airplane door he was fighting to open on a 2017 flight from Seattle. A second flight attendant was punched in the face, prosecutors said. The raging passenger — and another customer who aided flight attendants — were smashed in the head with bottles of red wine during the struggle, according to court records. Airline employees said the pressure at high altitude would have kept the door from opening, but it could have opened as the plane descended.

“In the galley there were flying objects, toppled galley equipment, yelling, physical blows and blood,” DePinto told a federal court in Washington state.

Six passengers eventually cuffed and subdued the Florida man, Joseph Hudek IV, who

pleaded guilty to interfering with a flight crew and assault resulting in serious bodily injury. Hudek was sentenced to two years in prison and barred from commercial flights until next year.

“My life is changed forever,” the assaulted flight attendant told the court. “I am always aware of passengers — where they are and what they are doing at times — to the point of distrust.”

Airlines have sought restitution from convicted passengers, although results have been mixed.

Hudek, whose consulting doctor said he had a psychotic episode after eating cannabis gummies, was ordered to pay restitution of $67,000, including $60,000 to Delta. As of January, a court report indicated he still owed the airline $59,000 and was making regular payments of $171.

A passenger on a 2019 flight from Las Vegas falsely told a flight attendant that a woman on the plane had a knife, prompting the pilot to make an emergency landing in Denver. He pleaded guilty to interfering with a flight crew and was sentenced to the nearly six months he had served. American Airlines asked a judge to order him to pay $32,800 in restitution. Among the costs cited by American: $6,119 for fuel, $13,623 for “passenger inconvenience,” including vouchers, and $2,497 for “goodwill lost,” according to court filings.

The Illinois man’s lawyer said he earned $125 a week collecting scrap before his father’s truck broke down and that he wouldn’t be able to pay. The judge rejected the airline’s request and ordered him to pay $100.

Passengers are on edge

As flight attendants endured taunts and abuse last year over airline mask requirements, the FAA resisted calls to help with enforcement, reflecting the Trump administration’s approach to the pandemic. But after increasing reports of conflicts and rowdy groups returning home from the Jan. 6 riot at the Capitol, FAA Administrator Stephen Dickson ordered stricter enforcement to tame the behavior, marking the start of a more aggressive approach.

Over the past six months, the FAA has taken “much quicker and transparent [action] on this issue than we have seen in decades,” said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, the nation’s largest flight attendants union. “It’s the first time flight attendants feel like there are real consequences on the ground for unruly behavior on our planes.”

Still, the vast number of cases and messy mechanics of trying to ensure those consequences stick have, at times, overwhelmed the agency.

Part of the FAA’s latest strategy to combat the rise in airplane incidents is to publicize large

proposed penalties and promote a message of deterrence on social media. “You could have spent $35,000 on a brand new truck. But instead you are paying a fine because you punched a flight attendant,” said one agency tweet.

The FAA said three-quarters of its 3,400 unruly passenger reports are related to a federal mask requirement on planes and public transportation, even though it often takes more than refusing to wear a mask for the FAA to take action.

Sara Nelson, international president of the Association of Flight Attendants-CWA, said that after more than a year grappling with the global pandemic, flight attendants’ stress levels are high and passengers are on edge.

“People get on a plane and they’re taking it out on each other, or most commonly, on the flight attendants,” she said. “And what we’re really seeing is that you’re having like entire airplanes full of people who are aggressive rather than the one-off passenger.”

Rick Domingo, who oversees onboard safety as executive director of the FAA’s Flight Standards Service, echoed that sentiment.

“It used to be individual events,” Domingo said during a recent FAA forum. Now, “it’s group events. You have a number of people exhibiting that same behavior on aircraft.”

As of July 13, the FAA had opened 555 investigations in unruly passenger cases — triple its total for all of last year. It has taken action against passengers in 80 cases.

That’s just the beginning of a labyrinthine process written into FAA regulations, in which the agency sends a Notice of Proposed Civil Penalty. Passengers can try to demonstrate they did not violate FAA regulations; seek a shrunken penalty; or request an informal or formal hearing and an appeal.

While international aviation groups for years have noted concerns about passenger problems aboard aircraft, the recent U.S. surge appears to be an outlier.

In Canada, where passengers who refuse to comply with crew member instructions face fines up to $100,000 (about $80,000 in U.S. dollars) and as much as five years’ imprisonment, the nation had recorded 14 reports of unruly passengers through May. In 2020, 73 incidents were reported.

“Canadian airlines have not seen a significant uptick in the number of passengers acting out on flights,” said Frederica Dupuis, a spokeswoman for Transport Canada.

Willie Walsh, director general of the International Air Transport Association, a trade group that represents nearly 300 carriers worldwide, said “it’s not completely isolated to the U.S., but it is predominantly a U.S. domestic issue that we’re witnessing at the moment.”

In addition to masks, alcohol has been a contributor to bad behavior. Some airlines aren’t serving alcohol during the pandemic, so some passengers are drinking before boarding or

bringing their own, which is against federal rules.

Of the 43 enforcement cases this year for which the FAA has made some details public, nearly one-third involved alcohol. About the same number involved alleged assaults. A flight had to be diverted from its original destination in eight cases.

Some aviation industry officials said there are early signs that the frequency of incidents could be falling, but it's too soon to know whether that signals a downward trend.

'Reaching for the hammer'

In the past, the FAA might rely on warning letters or counseling to deal with passenger misbehavior. But under its "zero-tolerance" policy toward passengers interfering with crew members, aviation safety inspectors are required to fill out investigative reports that could lead to sanctions.

"It's one strike and you're out," said Arjun Garg, a former chief counsel at the FAA who is a partner at law firm Hogan Lovells. "There's no more of just counseling an offending passenger about behaving better. They are immediately reaching for the hammer."

Behind the scenes, the agency is struggling to keep up with the barrage. FAA officials are seeking to better prioritize the torrent of reports coming from airlines and rushing to train personnel on the basics of building cases that can stand up to challenge. The investigative process can be slow.

"We have to collect evidence, do due diligence to prove our case," the FAA said in a statement. "This takes time."

An FAA document tracking potential cases shows that information provided by airline employees sometimes falls short, undercutting would-be investigations.

The FAA has issued public statements touting more than $680,000 in proposed penalties this year. But the agency has sometimes struggled to force passengers to pay more limited amounts in the past, raising questions about the success of its enforcement push.

The FAA is seeking $10,500 from a Southwest Airlines passenger who allegedly made a maskless phone call while the plane sat on a runway in February, then swore at flight attendants before being removed.

But in a case resolved in June, a D.C. man made a call one hour into a November 2018 flight to Minneapolis. The FAA sought a $5,000 penalty, but after pursuing the case for more than 18 months — and an appeal by the passenger to the U.S. Court of Appeals for the D.C. Circuit — the FAA agreed to settle for an undisclosed amount.

Following an unfavorable ruling by an administrative law judge last year, the FAA settled another case — a proposed $10,000 penalty for alleged abusive behavior on a 2009 flight

from Miami — 10 years after the incident.

Other rulings and arguments made by the same judge, J.E. Sullivan, challenged the FAA's interpretation of what it means for someone to "interfere" with a flight crew. As one of a handful of judges in the Transportation Department's Office of Hearings, Sullivan provides interpretations that help shape how the FAA can enforce its rules, including its push to control unruly passengers.

In a case involving vaping on a plane, a passenger on a flight to Portland, Ore., set off a lavatory smoke alarm in 2019. The FAA charged the passenger with smoking — and also with violating a rule against interfering with a crew member performing their duties.

By putting on oxygen masks, making queries to gauge the threat and communicating with dispatchers over the incident, the flight crew was distracted from its regular safety preparations, an FAA lawyer argued. "We consider that an interference with their duties," the lawyer said.

Sullivan countered that "there's no interference," adding, "the activity that they engaged in is the activity that they're trained to engage in as part of their flight crew duties."

It's unclear whether mask-related cases working through the system could encounter similar issues. An internal FAA memo in February said persistent refusals to wear masks, requiring multiple instructions from a flight attendant, could be considered interference because of "the consequent distraction from safety-related duties." Sullivan declined to be interviewed.

Regulators have given little attention to some onboard safety concerns raised years ago.

Congress passed a law in October 2018 giving the FAA administrator one year to issue an order requiring the installation of a "secondary cockpit barrier" on new planes as added protection against would-be intruders. Nearly three years later, the FAA is still working on it.

The legislation was named after Capt. Victor J. Saracini, who was killed on United Airlines Flight 175, which terrorists crashed into the South Tower of the World Trade Center on Sept. 11, 2001. The barriers are meant to be installed between the cabin and cockpit door to block passengers from rushing in when the door is opened for food or restroom breaks.

Beyond addressing hijacking fears, a 2020 advisory report to the FAA noted that the barriers also could stop disturbed and impaired passengers. The Biden administration put the barriers on its "priority list for 2021," the FAA said.

On June 4, a passenger on a Delta Air Lines flight from Los Angeles to Nashville allegedly rushed up and started pounding on the cockpit door, forcing the plane to divert to Albuquerque. He was charged in U.S. District Court for New Mexico with interfering with a member of a flight crew.

Exhibit 11

nytimes.com

Flight Attendants' Hellish Summer: 'I Don't Even Feel Like a Human'

Tacey Rychter

13-16 minutes

8-26-21

For cabin crews, the peak travel season has turned into a chronic battle involving frequent delays, overwork and unruly passengers that leaves them feeling battered by the public and the airlines.

Credit...Michelle Litvin for The New York Times

Aug. 26, 2021

As stranded Spirit Airlines travelers grew desperate at San Juan Airport in Puerto Rico during a chaotic night of cancellations on Aug. 1, banging on a gate door and yelling at staff, police officers rounded up the airline's cabin crews to hide them.

A 28-year-old flight attendant recounted being rushed to a jet bridge, behind a secure metal door, and then later to an office on the tarmac.

There, about 35 Spirit employees were told by a manager to change out of their uniforms for their safety.

"We were scared," said the attendant, who asked not to be identified by name because of the airline's media policy. "I've seen some crazy stuff, but this moved into number one."

Air travelers have faced an unusually high number of disruptions this summer because of widespread labor shortages, bad weather and technical problems. Nearly a quarter of U.S. passenger planes between June and mid-August were delayed, while almost 4 percent of flights were canceled in the first half of August, according to data from Flight Aware, a flight tracking service. Spirit alone canceled nearly 2,500 flights between Aug. 1 and 15.

Flight attendants across the country say they are struggling to cope, facing not only these prolonged operational issues, but also an increase in aggressive passenger behavior. Nearly 4,000 unruly passenger incidents have been reported to the Federal Aviation Administration in 2021, a figure described by the agency as "a rapid and significant increase."

Most of those reports deal with attendants enforcing rules on proper masking in the cabin, with passengers who range from careless to belligerent, and at times verbally or physically abusive. Shaky, vertical footage of brawls and insults are now a familiar staple on social media.

A 28-year-old American Airlines flight attendant who asked not to be identified for fear of losing her job said she had law enforcement called following verbal assaults twice since June, after six years of flying with no incidents. Both confrontations were related to mask

enforcement.

“What really hurts are the people who won’t even look at you in the eye,” she said. “I don’t even feel like a human anymore.”

In interviews with more than a dozen attendants from major and regional carriers, crew members said they were getting squeezed on both sides — from passengers and the airlines. They described regularly working shifts of more than 14 hours, being assigned up to four or five flights a day, not being given sufficient time to sleep and being deterred from taking leave if fatigued or unwell.

The tense situation in the air this summer has led many attendants to say that they feel exhausted, afraid for their personal safety and, in some cases, concerned that the situation could turn dangerous.

A spokeswoman for Airlines for America, a trade group, said its member airlines “recognize the importance of prioritizing the safety and well-being of all employees, who are the backbone of our industry,” and “comply fully with robust F.A.A. regulations, which include stringent rest requirements and limitations on duty, as well as with all federal policies.”

Image

Credit...Tom Williams/CQ Roll Call

Sara Nelson, president of the Association of Flight Attendants union that represents nearly 50,000 flight attendants at 17 airlines, noted that the difference in passenger response to the pandemic compared with the Sept. 11 terrorist attacks has been “night and day.”

Twenty years ago, “every single person who came on our plane was completely on our team,” she said. But now, flight attendants have become “punching bags for the public.”

Staffing can’t keep up with demand

This spring, as vaccination rates increased, coronavirus cases dropped and restrictions melted away, demand for summer travel rebounded more quickly than many had expected. On July 1, 2.1 million air travelers passed through Transportation Security Administration airport checkpoints, even more than on the same day in 2019. Many airlines ramped up their scheduling and added new routes.

But while airlines are eager to capitalize on the demand, many appear to lack the staffing to keep up.

Bureau of Transportation Statistics data show that the number of full-time-equivalent employees at U.S. scheduled passenger airlines was nearly 14 percent lower in June 2021 than in March 2020. Tens of thousands of flight attendants took leave during the pandemic, the A.F.A. union said. American Airlines said about 3,300 flight attendants have yet to return from leave.

“So many people were let go so quickly on extended leave of absence, early retirement, that they’re struggling to meet the travel demand,” said Paul Hartshorn, a flight attendant and spokesman for the Association of Professional Flight Attendants, which represents about 24,000 American Airlines attendants. “And staffing is tight, there’s not a lot of wiggle room for storms and maintenance delays.”

At Southwest Airlines, the chief operating officer, Mike Van de Ven, shared a message with staff on Aug. 20, saying that the increase in bookings has “taken a toll on our operation and put a significant strain on all of you. And for that, I am sincerely sorry.” He also said that “historical staffing models have not been effective in this pandemic environment.”

“There’s not enough people,” said Nas Lewis, a flight attendant with a major U.S. airline and founder of th|AIR|apy, a website and Facebook group that addresses flight attendants’ mental health. Ms. Lewis, who asked that the name of her airline not be published because of its media policy, said the situation generates anxiety for attendants “because we don’t know what we’re going to deal with on any given day.”

A shortage of pilots is another critical pain point for air travel, as is inadequate numbers of gate agents, baggage handlers and delivery drivers, all of which can easily throw a wrench into getting a flight out on time.

When a cabin is short staffed, the airlines depend on on-call, or “reserve,” flight attendants. This summer, airlines have been stretching their reserves to the maximum, to the point where they are running low or out of available attendants before the day has even begun.

American Airlines’ staff scheduling system for Chicago on Aug. 10, which a flight attendant for the company described as an average day this summer, showed that by 7 a.m. every reserve attendant based there was either already scheduled or unavailable.

When an airline runs out of reserves, flight attendants who are already assigned to a flight can be abruptly rescheduled to work hours longer than expected, which attendants and union representatives say occurs more frequently now and adds to their fatigue.

Long days, minimum rest

Jacqueline Petzel, a Chicago-based flight attendant with American Airlines who is currently working on reserve, said that during the first week of August, she was woken up repeatedly at 2 a.m. by American and had only two hours to race to the airport and then work a 15-hour shift.

Between some recent shifts, Ms. Petzel, 34, said she had been given only the minimum 10 hours of rest at the hotel.

During that time, she had to get dinner, shower, call family, wind down, sleep, eat breakfast and get ready for the next shift, leaving just four or five hours for actual sleep, Ms. Petzel said.

“It’s hard to keep your eyes open when you’re up that early and it’s a long flight,” Ms.

Petzel said. On a recent layover in Las Vegas after a 15-hour day, she fell asleep in her uniform.

A 30-year-old flight attendant who works with United Airlines, who asked not to be identified for fear of jeopardizing her job, said she had to work a double red-eye during a four-day trip in July.

“I actually felt kind of tipsy, almost kind of drunk,” she said. “I was slow, and I know that even if something comes up the adrenaline will kick in, but I know that my decisions aren’t going to be the best.”

In response, Rachael Rivas, a spokeswoman for United, said: “We have what we believe is an industry-leading, safety-focused Fatigue Risk Management Program, which includes a strong collaboration between union representatives and in-flight management.”

Flight attendants have a maximum number of hours that they can be assigned to work, although many say scheduling teams are increasingly pressuring them to accept longer and longer shifts. When an attendant exceeds the maximum hours, it’s known colloquially as “going illegal.”

Attendants say it has become difficult to push back.

“They have it in the computer that you’re getting to the gate at 14 hours and 59 minutes, but it’s obvious that’s not going to happen,” said the 28-year-old attendant with American, where domestic shifts are limited to 15 hours.

“There’s this saying: fly now, grieve later,” she said. “You fly the illegal reassignment now, and you grieve it with your union later.”

Whitney Zastrow, a spokeswoman for American Airlines, said, “we’ve taken and continue to take steps to materially improve the quality of our flight attendants’ work life, including working closely with our hotel and limo vendor.”

Facing conflict and discouraged from taking leave

A video circulating online earlier this month of Frontier flight attendants duct taping a belligerent passenger to his seat made news reports and shocked viewers. While this is an extreme incident, attendants and unions say that encountering unruly passengers, once rare, is now almost expected.

Image

Credit...

An F.A.A. spokeswoman said that before 2021, the numbers of disturbances were fairly consistent year over year, with the agency investigating on average less than 150 incidents annually. As of Aug. 23, the F.A.A. has launched investigations into 693 incidents in 2021.

“You would think a pandemic affecting a ton of people would cause people to maybe pause and be more compassionate to each other,” said Ms. Petzel, the American Airlines attendant. “For whatever reason, it’s made it go the complete other way.”

Flight attendants across many airlines say the situation is wearing on their mental health and physical well-being.

“I have never experienced this level of anxiety, depression in my entire life,” said the 28-year-old flight attendant who works for American. “We’re really breaking down.”

“We’re used to getting B.S. from the company, from the passengers, we’re used to weather — but not all at the same time for an extended period of time. It’s every single day, it’s every single trip,” she said.

Many attendants say they fear retribution for taking leave, especially now.

Some airlines have a point-based attendance policy, whereby if a flight attendant has an unplanned absence when scheduled to work (say, because they call in sick), they accrue a point. Too many points can trigger an investigation or even termination.

JetBlue warned crew members that they would incur double attendance points if they took an unplanned absence over a weekend between July 23 through to Labor Day weekend.

One JetBlue flight attendant, who requested anonymity for fear of losing his job, said that last month he worked more than 17 hours on a shift and had been given only the legal minimum amount of rest, eight hours, between some flights.

He has called in sick a number of times but worries that he may accrue too many attendance points and face termination.

“When you try to talk to people about it, they say, ‘This is what you signed up for,’” he said, referring to a conversation he had with his manager.

“Our attendance policy is similar to most airlines, and on peak periods (like holidays) it’s especially important that crew members show up for assigned trips so that customers can get where they plan on going,” said Derek Dombrowski, a JetBlue spokesman. JetBlue is also offering financial incentives to encourage crews to take shifts.

Normally, Southwest Airlines is contractually obliged to let attendants call in sick without requiring a physician’s note. But the company can invoke an “emergency sick-call procedure,” requiring staff to verify their illness with a company doctor. Southwest has invoked this policy three times this summer.

“It should not be used as a usual or normal way of controlling the operation,” said Lyn Montgomery, the president of Transport Workers Union Local 556, which represents Southwest Airlines flight attendants. The last time this procedure was used was in 2017.

“While never a desired option, Southwest may, when operationally necessary, enact emergency sick call procedures to protect the airline’s schedule and support working flight attendants,” said Brian Parrish, a spokesman for Southwest Airlines. “Southwest Airlines supports employees’ physical, emotional and mental health with a variety of programs and offerings — including free employee assistance services that are available 24/7.”

The union and attendants said they felt that these doctors could be dismissive of symptoms. Staff also may not feel comfortable seeing the airline’s doctor, especially if dealing with mental health concerns.

“Our mental health has never been more disrupted than now, obviously since 9/11,” said a 30-year-old flight attendant for Southwest, who asked not to be identified for fear of losing her job. “You can’t even call out sick if you’re having major anxiety or depression episodes. It doesn’t matter.”

Ms. Lewis, of th|AIR|apy, said in May she was shoved by a hostile passenger who was upset about an overbooked flight. She did not report the incident, she said, because she was too exhausted.

“As flight attendants, we are at our wits’ end,” she said.

Exhibit 12

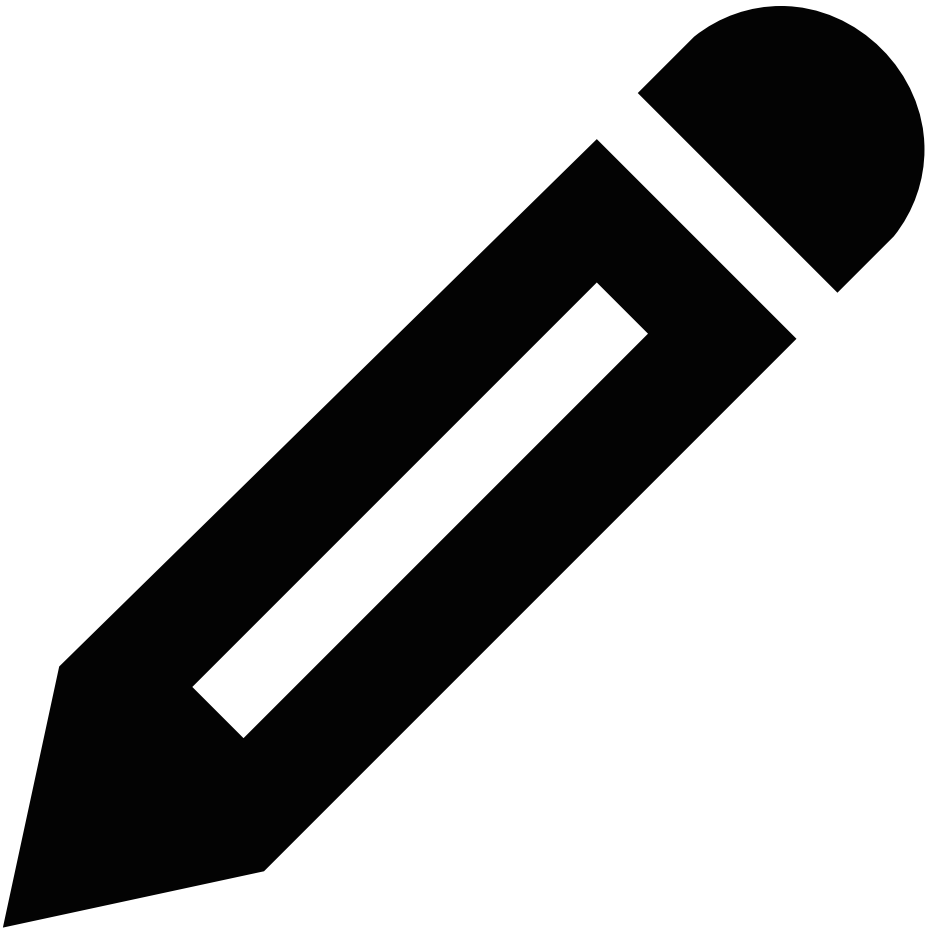
forbes.com

Why Some In The Airline Industry Want To End The Mask Mandate On Planes

Ben Baldanza

8-7-21

6-7 minutes



Edit Story

Aug 7, 2021,03:40pm EDT|6,517 views

I write about airlines and travel to explain this crazy industry.

The airline mask mandate is scheduled to expire in September, and some in the airline industry agree ... [+] with this though others feel it should be extended.

getty

The airline mask mandate is scheduled to expire on September 13, 2021. With this mandate in place, there has been a rise in onboard incidents that have harmed flight attendants, delayed or cancelled flights, and shown some of the worst of how society can behave.

In July, Southwest Airlines CEO Gary Kelly, the chairman of the industry group Airlines For America, indicated that U.S. airlines would like to see the mandate mandate lapse. Not extending the mandate would prevent some risks, mostly from onboard aggression and what people will continue to see as unfair and inconsistent policy application, some in the airline industry believe. When combined with the relatively safe environment of an aircraft cabin and an upcoming seasonal drop in travel, it makes sense to some to let the mandate end as scheduled in September.

Yet the rapid spread of the Delta variant of the coronavirus is making everyone re-think what the next steps should be – Airlines For America is not taking a public position on the issue — and certainly the federal government will consider extending the mask mandate on airplanes if it determines that the Delta variant presents too much risk.

Airplanes Are Safer Than Most Places

By now, it's old news that airplane air flows vertically and is replaced with new outside air every few minutes. Thanks to this, several studies have suggested that the transmission of viruses onboard a plane is rare, which is one key point that proponents of dropping the

mask mandate on planes point to. Yet the higher rate of contagion with the Delta variant will challenge this view. Letting the mask mandate expire on its current chosen date with the Delta variant active poses some risk not found with the original virus.

Emotions Run High When Flying

Flying is a stressful time for many flyers. People who normally have a lot of control in their lives give up all control, and are subject to delays, unexpected events, and more and must adapt. Not everyone is good at this. When this atmosphere is combined with tensions around mask policy, we have seen a summer with more onboard skirmishes and more people injured than ever before. The FAA has suggested big fines in some cases, but these will take years to go through the courts and likely be dropped or settled for pennies on the dollar. The fines make good headlines and may deter some otherwise bad behaviors, but the root cause of most of these incidents has been the mandated mask policy. It's not the policy itself, but the inconsistency of that policy with other parts of life. While many of us may be able to clearly understand why we must wear a mask on a plane but don't have to in restaurant, to others this makes no sense. Put that view in the stressful and emotional environment of an airline flight and the results we've seen this summer are not totally surprising.

Many Flight Attendants Are Vaccinated

Flight attendants are on the front line of the abusive behavior by passengers, and the national flight attendant unions supported the initial mask mandate and its extension to September. That is understandable, but also during the summer vaccinations are continuing and now 70% of adults in the U.S. have had at least one shot of a vaccine. Further, United Airlines is now requiring all employees to be vaccinated and so it's reasonable to assume that more flight attendants are vaccinated than the population as a whole. As travel reduces naturally in the fall, letting the mandate expire would lower the tensions onboard significantly and greatly reduce the number of potentially dangerous confrontations that flight attendants must face.

But then there's the health risks to passengers and those they come into contact with after their trip.

The fairly widespread distribution of vaccines in the U.S. and Europe has made a huge difference. Today, nearly all of the deaths related to Covid are in people who have chosen not to be vaccinated.

However, the delta variant is far more contagious than previous forms of the coronavirus – research suggests it's anywhere from 40% to 60% more transmissible than the alpha variant and twice more than the original Wuhan form of the virus. And research that showed that vaccinated people who are infected pose as much of a risk to spread the

virus to others as unvaccinated people led the Centers for Disease Control to recommend last week that vaccinated people wear masks in areas where the virus is spreading rapidly – which is most of the U.S. right now.

A number of cities and businesses have moved to reinstate mask mandates. All this may make it less likely that the federal government will let the mask mandate on airplanes lapse.

Managing risk does not mean eliminating risk. Managing risk means mitigating the most significant risk, and finding a good balance between different types of risk. There would be no inflight incidents or onboard transmission if we made it illegal to fly, for example, but the cost of that to society is far worse than the risk of onboard incidents. In a similar way, we know that the mask mandate upsets enough customers to have created a difficult summer for flight attendants and airlines. We also know that more people are vaccinated each day, and that travel will seasonally drop once we hit September. Given these balancing forces, there will be arguments to both let the mandate expire and to extend it. In either case, clearly the answer is to get more people vaccinated!

Follow me on LinkedIn. Check out my website.

I am the former CEO of Spirit Airlines, where my strong team transformed the company into the highest margin airline in North America and created a new model for air

…

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SpaceX Launches Its 'Operational' Flight To The ISS

Exhibit 13

- **Part Number:** 1910
- **Part Number Title:** Occupational Safety and Health Standards
- **Subpart:** 1910 Subpart I
- **Subpart Title:** Personal Protective Equipment
- **Standard Number:** 1910.134
- **Title:** Respiratory Protection.
- **Appendix:** A; B-1; B-2; C; D
- **GPO Source:** e-CFR

Department of Labor
OSHA

1910.134(a)

Permissible practice.

1910.134(a)(1)

In the control of those occupational diseases caused by breathing air contaminated with harmful dusts, fogs, fumes, mists, gases, smokes, sprays, or vapors, the primary objective shall be to prevent atmospheric contamination. This shall be accomplished as far as feasible by accepted engineering control measures (for example, enclosure or confinement of the operation, general and local ventilation, and substitution of less toxic materials). When effective engineering controls are not feasible, or while they are being instituted, appropriate respirators shall be used pursuant to this section.

1910.134(a)(2)

A respirator shall be provided to each employee when such equipment is necessary to protect the health of such employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protection program, which shall include the requirements outlined in paragraph (c) of this section. The program shall cover each employee required by this section to use a respirator.

1910.134(b)

Definitions. The following definitions are important terms used in the respiratory protection standard in this section.

Air-purifying respirator means a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air-purifying element.

Assigned protection factor (APF) means the workplace level of respiratory protection that a respirator or class of respirators is expected to provide to employees when the employer implements a continuing, effective respiratory protection program as specified by this section.

Atmosphere-supplying respirator means a respirator that supplies the respirator user with breathing air from a source independent of the ambient atmosphere, and includes supplied-air respirators (SARs) and self-contained breathing apparatus (SCBA) units.

Canister or cartridge means a container with a filter, sorbent, or catalyst, or combination of these items, which removes specific contaminants from the air passed through the container.

Demand respirator means an atmosphere-supplying respirator that admits breathing air to the facepiece only when a

negative pressure is created inside the facepiece by inhalation.

Emergency situation means any occurrence such as, but not limited to, equipment failure, rupture of containers, or failure of control equipment that may or does result in an uncontrolled significant release of an airborne contaminant.

Employee exposure means exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

End-of-service-life indicator (ESLI) means a system that warns the respirator user of the approach of the end of adequate respiratory protection, for example, that the sorbent is approaching saturation or is no longer effective.

Escape-only respirator means a respirator intended to be used only for emergency exit.

Filter or air purifying element means a component used in respirators to remove solid or liquid aerosols from the inspired air.

Filtering facepiece (dust mask) means a negative pressure particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering medium.

Fit factor means a quantitative estimate of the fit of a particular respirator to a specific individual, and typically estimates the ratio of the concentration of a substance in ambient air to its concentration inside the respirator when worn.

Fit test means the use of a protocol to qualitatively or quantitatively evaluate the fit of a respirator on an individual. (See also Qualitative fit test QLFT and Quantitative fit test QNFT.)

Helmet means a rigid respiratory inlet covering that also provides head protection against impact and penetration.

High efficiency particulate air (HEPA) filter means a filter that is at least 99.97% efficient in removing monodisperse particles of 0.3 micrometers in diameter. The equivalent NIOSH 42 CFR 84 particulate filters are the N100, R100, and P100 filters.

Hood means a respiratory inlet covering that completely covers the head and neck and may also cover portions of the shoulders and torso.

Immediately dangerous to life or health (IDLH) means an atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

Interior structural firefighting means the physical activity of fire suppression, rescue or both, inside of buildings or enclosed structures which are involved in a fire situation beyond the incipient stage. (See 29 CFR 1910.155)

Loose-fitting facepiece means a respiratory inlet covering that is designed to form a partial seal with the face.

Maximum use concentration (MUC) means the maximum atmospheric concentration of a hazardous substance from which an employee can be expected to be protected when wearing a respirator, and is determined by the assigned protection factor of the respirator or class of respirators and the exposure limit of the hazardous substance. The MUC can be determined mathematically by multiplying the assigned protection factor specified for a respirator by the required OSHA permissible exposure limit, short-term exposure limit, or ceiling limit. When no OSHA exposure limit is available for a hazardous substance, an employer must determine an MUC on the basis of relevant available information and informed professional judgment.

Negative pressure respirator (tight fitting) means a respirator in which the air pressure inside the facepiece is negative during inhalation with respect to the ambient air pressure outside the respirator.

Oxygen deficient atmosphere means an atmosphere with an oxygen content below 19.5% by volume.

Physician or other licensed health care professional (PLHCP) means an individual whose legally permitted scope of practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by paragraph (e) of this section.

Positive pressure respirator means a respirator in which the pressure inside the respiratory inlet covering exceeds the ambient air pressure outside the respirator.

Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

Pressure demand respirator means a positive pressure atmosphere-supplying respirator that admits breathing air to the facepiece when the positive pressure is reduced inside the facepiece by inhalation.

Qualitative fit test (QLFT) means a pass/fail fit test to assess the adequacy of respirator fit that relies on the individual's response to the test agent.

Quantitative fit test (QNFT) means an assessment of the adequacy of respirator fit by numerically measuring the amount of leakage into the respirator.

Respiratory inlet covering means that portion of a respirator that forms the protective barrier between the user's respiratory tract and an air-purifying device or breathing air source, or both. It may be a facepiece, helmet, hood, suit, or a mouthpiece respirator with nose clamp.

Self-contained breathing apparatus (SCBA) means an atmosphere-supplying respirator for which the breathing air source is designed to be carried by the user.

Service life means the period of time that a respirator, filter or sorbent, or other respiratory equipment provides adequate protection to the wearer.

Supplied-air respirator (SAR) or airline respirator means an atmosphere-supplying respirator for which the source of breathing air is not designed to be carried by the user.

This section means this respiratory protection standard.

Tight-fitting facepiece means a respiratory inlet covering that forms a complete seal with the face.

User seal check means an action conducted by the respirator user to determine if the respirator is properly seated to the face.

1910.134(c)

Respiratory protection program. This paragraph requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use. The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator. The Small Entity Compliance Guide contains criteria for the selection of a program administrator and a sample program that

meets the requirements of this paragraph. Copies of the Small Entity Compliance Guide will be available on or about April 8, 1998 from the Occupational Safety and Health Administration's Office of Publications, Room N 3101, 200 Constitution Avenue, NW, Washington, DC, 20210 (202-219-4667).

1910.134(c)(1)

In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The employer shall include in the program the following provisions of this section, as applicable:

1910.134(c)(1)(i)

Procedures for selecting respirators for use in the workplace;

1910.134(c)(1)(ii)

Medical evaluations of employees required to use respirators;

1910.134(c)(1)(iii)

Fit testing procedures for tight-fitting respirators;

1910.134(c)(1)(iv)

Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations;

1910.134(c)(1)(v)

Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators;

1910.134(c)(1)(vi)

Procedures to ensure adequate air quality, quantity, and flow of breathing air for atmosphere-supplying respirators;

1910.134(c)(1)(vii)

Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations;

1910.134(c)(1)(viii)

Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and

1910.134(c)(1)(ix)

Procedures for regularly evaluating the effectiveness of the program.

1910.134(c)(2)

Where respirator use is not required:

1910.134(c)(2)(i)

An employer may provide respirators at the request of employees or permit employees to use their own respirators, if the employer determines that such respirator use will not in itself create a hazard. If the employer determines that any voluntary respirator use is permissible, the employer shall provide the respirator users with the information contained in Appendix D to this section ("Information for Employees Using Respirators When Not Required Under the Standard"); and

1910.134(c)(2)(ii)

In addition, the employer must establish and implement those elements of a written respiratory protection program necessary to ensure that any employee using a respirator voluntarily is medically able to use that respirator, and that the respirator is cleaned, stored, and maintained so that its use does not present a health hazard to the user. Exception: Employers are not required to include in a written respiratory protection program those employees whose only use of respirators involves the voluntary use of filtering facepieces (dust masks).

1910.134(c)(3)

The employer shall designate a program administrator who is qualified by appropriate training or experience that is commensurate with the complexity of the program to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness.

1910.134(c)(4)

The employer shall provide respirators, training, and medical evaluations at no cost to the employee.

1910.134(d)

Selection of respirators. This paragraph requires the employer to evaluate respiratory hazard(s) in the workplace, identify relevant workplace and user factors, and base respirator selection on these factors. The paragraph also specifies appropriately protective respirators for use in IDLH atmospheres, and limits the selection and use of air-purifying respirators.

1910.134(d)(1)

General requirements.

1910.134(d)(1)(i)

The employer shall select and provide an appropriate respirator based on the respiratory hazard(s) to which the worker is exposed and workplace and user factors that affect respirator performance and reliability.

1910.134(d)(1)(ii)

The employer shall select a NIOSH-certified respirator. The respirator shall be used in compliance with the conditions of its certification.

1910.134(d)(1)(iii)

The employer shall identify and evaluate the respiratory hazard(s) in the workplace; this evaluation shall include a reasonable estimate of employee exposures to respiratory hazard(s) and an identification of the contaminant's chemical state and physical form. Where the employer cannot identify or reasonably estimate the employee exposure, the employer shall consider the atmosphere to be IDLH.

1910.134(d)(1)(iv)

The employer shall select respirators from a sufficient number of respirator models and sizes so that the respirator is acceptable to, and correctly fits, the user.

1910.134(d)(2)

Respirators for IDLH atmospheres.

1910.134(d)(2)(i)
The employer shall provide the following respirators for employee use in IDLH atmospheres:

1910.134(d)(2)(i)(A)
A full facepiece pressure demand SCBA certified by NIOSH for a minimum service life of thirty minutes, or

1910.134(d)(2)(i)(B)
A combination full facepiece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.

1910.134(d)(2)(ii)
Respirators provided only for escape from IDLH atmospheres shall be NIOSH-certified for escape from the atmosphere in which they will be used.

1910.134(d)(2)(iii)
All oxygen-deficient atmospheres shall be considered IDLH. Exception: If the employer demonstrates that, under all foreseeable conditions, the oxygen concentration can be maintained within the ranges specified in Table II of this section (i.e., for the altitudes set out in the table), then any atmosphere-supplying respirator may be used.

1910.134(d)(3)
Respirators for atmospheres that are not IDLH.

1910.134(d)(3)(i)
The employer shall provide a respirator that is adequate to protect the health of the employee and ensure compliance with all other OSHA statutory and regulatory requirements, under routine and reasonably foreseeable emergency situations.

1910.134(d)(3)(i)(A)
Assigned Protection Factors (APFs) Employers must use the assigned protection factors listed in Table 1 to select a respirator that meets or exceeds the required level of employee protection. When using a combination respirator (e.g., airline respirators with an air-purifying filter), employers must ensure that the assigned protection factor is appropriate to the mode of operation in which the respirator is being used.

Table 1. -- Assigned Protection Factors[5]

Type of respirator[1], [2]	Quarter mask	Half mask	Full facepiece	Helmet/ hood	Loose-fitting facepiece
1. Air-Purifying Respirator	5	[3]10	50	.....	.....
2. Powered Air-Purifying Respirator (PAPR)	.....	50	1,000	[4]25/1,000	25
3. Supplied-Air Respirator (SAR) or Airline Respirator					
• Demand mode	.....	10	50	.....	.....
• Continuous flow mode	.....	50	1,000	[4]25/1,000	25
• Pressure-demand or other positive-pressure mode	.....	50	1,000	.....	.....
4. Self-Contained Breathing Apparatus (SCBA)					
• Demand mode					
• Pressure-demand or other positive-pressure mode	.....	10	50	50	.....
(e.g., open/closed circuit)	.....	.....	10,000	10,000	.....

Notes:

[1]Employers may select respirators assigned for use in higher workplace concentrations of a hazardous substance for

use at lower concentrations of that substance, or when required respirator use is independent of concentration.
[2]The assigned protection factors in Table 1 are only effective when the employer implements a continuing, effective respirator program as required by this section (29 CFR 1910.134), including training, fit testing, maintenance, and use requirements.
[3]This APF category includes filtering facepieces, and half masks with elastomeric facepieces.
[4]The employer must have evidence provided by the respirator manufacturer that testing of these respirators demonstrates performance at a level of protection of 1,000 or greater to receive an APF of 1,000. This level of performance can best be demonstrated by performing a WPF or SWPF study or equivalent testing. Absent such testing, all other PAPRs and SARs with helmets/hoods are to be treated as loose-fitting facepiece respirators, and receive an APF of 25.
[5]These APFs do not apply to respirators used solely for escape. For escape respirators used in association with specific substances covered by 29 CFR 1910 subpart Z, employers must refer to the appropriate substance-specific standards in that subpart. Escape respirators for other IDLH atmospheres are specified by 29 CFR 1910.134 (d)(2)(ii).

1910.134(d)(3)(i)(B)
Maximum Use Concentration (MUC)

1910.134(d)(3)(i)(B)(1)
The employer must select a respirator for employee use that maintains the employee's exposure to the hazardous substance, when measured outside the respirator, at or below the MUC.

1910.134(d)(3)(i)(B)(2)
Employers must not apply MUCs to conditions that are immediately dangerous to life or health (IDLH); instead, they must use respirators listed for IDLH conditions in paragraph (d)(2) of this standard.

1910.134(d)(3)(i)(B)(3)
When the calculated MUC exceeds the IDLH level for a hazardous substance, or the performance limits of the cartridge or canister, then employers must set the maximum MUC at that lower limit.

1910.134(d)(3)(ii)
The respirator selected shall be appropriate for the chemical state and physical form of the contaminant.

1910.134(d)(3)(iii)
For protection against gases and vapors, the employer shall provide:

1910.134(d)(3)(iii)(A)
An atmosphere-supplying respirator, or

1910.134(d)(3)(iii)(B)
An air-purifying respirator, provided that:

1910.134(d)(3)(iii)(B)(1)
The respirator is equipped with an end-of-service-life indicator (ESLI) certified by NIOSH for the contaminant; or

1910.134(d)(3)(iii)(B)(2)
If there is no ESLI appropriate for conditions in the employer's workplace, the employer implements a change schedule for canisters and cartridges that is based on objective information or data that will ensure that canisters and cartridges are changed before the end of their service life. The employer shall describe in the respirator program the information and data relied upon and the basis for the canister and cartridge change schedule and the basis for reliance on the data.

1910.134(d)(3)(iv)

For protection against particulates, the employer shall provide:

1910.134(d)(3)(iv)(A)

An atmosphere-supplying respirator; or

1910.134(d)(3)(iv)(B)

An air-purifying respirator equipped with a filter certified by NIOSH under 30 CFR part 11 as a high efficiency particulate air (HEPA) filter, or an air-purifying respirator equipped with a filter certified for particulates by NIOSH under 42 CFR part 84; or

1910.134(d)(3)(iv)(C)

For contaminants consisting primarily of particles with mass median aerodynamic diameters (MMAD) of at least 2 micrometers, an air-purifying respirator equipped with any filter certified for particulates by NIOSH.

TABLE I. -- ASSIGNED PROTECTION FACTORS

[RESERVED]

TABLE II

Altitude (ft.)	Oxygen deficient Atmospheres (% 0_2) for which the employer atmosphere-may rely on supplying respirators
Less than 3,001	16.0-19.5
3,001-4,000	16.4-19.5
4,001-5,000	17.1-19.5
5,001-6,000	17.8-19.5
6,001-7,000	18.5-19.5
7,001-8,000[1]	19.3-19.5.

[1]Above 8,000 feet the exception does not apply. Oxygen-enriched breathing air must be supplied above 14,000 feet.

1910.134(e)

Medical evaluation. Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. Accordingly, this paragraph specifies the minimum requirements for medical evaluation that employers must implement to determine the employee's ability to use a respirator.

1910.134(e)(1)

General. The employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace. The employer may discontinue an employee's medical evaluations when the employee is no longer required to use a respirator.

1910.134(e)(2)

Medical evaluation procedures.

1910.134(e)(2)(i)

The employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.

1910.134(e)(2)(ii)

The medical evaluation shall obtain the information requested by the questionnaire in Sections 1 and 2, Part A of Appendix C of this section.

1910.134(e)(3)

Follow-up medical examination.

1910.134(e)(3)(i)

The employer shall ensure that a follow-up medical examination is provided for an employee who gives a positive response to any question among questions 1 through 8 in Section 2, Part A of Appendix C or whose initial medical examination demonstrates the need for a follow-up medical examination.

1910.134(e)(3)(ii)

The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

1910.134(e)(4)

Administration of the medical questionnaire and examinations.

1910.134(e)(4)(i)

The medical questionnaire and examinations shall be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee. The medical questionnaire shall be administered in a manner that ensures that the employee understands its content.

1910.134(e)(4)(ii)

The employer shall provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP.

1910.134(e)(5)

Supplemental information for the PLHCP.

1910.134(e)(5)(i)

The following information must be provided to the PLHCP before the PLHCP makes a recommendation concerning an employee's ability to use a respirator:

1910.134(e)(5)(i)(A)

(A) The type and weight of the respirator to be used by the employee;

1910.134(e)(5)(i)(B)

The duration and frequency of respirator use (including use for rescue and escape);

1910.134(e)(5)(i)(C)

The expected physical work effort;

1910.134(e)(5)(i)(D)

Additional protective clothing and equipment to be worn; and

1910.134(e)(5)(i)(E)
Temperature and humidity extremes that may be encountered.

1910.134(e)(5)(ii)
Any supplemental information provided previously to the PLHCP regarding an employee need not be provided for a subsequent medical evaluation if the information and the PLHCP remain the same.

1910.134(e)(5)(iii)
The employer shall provide the PLHCP with a copy of the written respiratory protection program and a copy of this section.

Note to Paragraph (e)(5)(iii): When the employer replaces a PLHCP, the employer must ensure that the new PLHCP obtains this information, either by providing the documents directly to the PLHCP or having the documents transferred from the former PLHCP to the new PLHCP. However, OSHA does not expect employers to have employees medically reevaluated solely because a new PLHCP has been selected.

1910.134(e)(6)
Medical determination. In determining the employee's ability to use a respirator, the employer shall:

1910.134(e)(6)(i)
Obtain a written recommendation regarding the employee's ability to use the respirator from the PLHCP. The recommendation shall provide only the following information:

1910.134(e)(6)(i)(A)
Any limitations on respirator use related to the medical condition of the employee, or relating to the workplace conditions in which the respirator will be used, including whether or not the employee is medically able to use the respirator;

1910.134(e)(6)(i)(B)
The need, if any, for follow-up medical evaluations; and

1910.134(e)(6)(i)(C)
A statement that the PLHCP has provided the employee with a copy of the PLHCP's written recommendation.

1910.134(e)(6)(ii)
If the respirator is a negative pressure respirator and the PLHCP finds a medical condition that may place the employee's health at increased risk if the respirator is used, the employer shall provide a PAPR if the PLHCP's medical evaluation finds that the employee can use such a respirator; if a subsequent medical evaluation finds that the employee is medically able to use a negative pressure respirator, then the employer is no longer required to provide a PAPR.

1910.134(e)(7)
Additional medical evaluations. At a minimum, the employer shall provide additional medical evaluations that comply with the requirements of this section if:

1910.134(e)(7)(i)
An employee reports medical signs or symptoms that are related to ability to use a respirator;

1910.134(e)(7)(ii)

A PLHCP, supervisor, or the respirator program administrator informs the employer that an employee needs to be reevaluated;

1910.134(e)(7)(iii)

Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation; or

1910.134(e)(7)(iv)

A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on an employee.

1910.134(f)

Fit testing. This paragraph requires that, before an employee may be required to use any respirator with a negative or positive pressure tight-fitting facepiece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used. This paragraph specifies the kinds of fit tests allowed, the procedures for conducting them, and how the results of the fit tests must be used.

1910.134(f)(1)

The employer shall ensure that employees using a tight-fitting facepiece respirator pass an appropriate qualitative fit test (QLFT) or quantitative fit test (QNFT) as stated in this paragraph.

1910.134(f)(2)

The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter.

1910.134(f)(3)

The employer shall conduct an additional fit test whenever the employee reports, or the employer, PLHCP, supervisor, or program administrator makes visual observations of, changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.

1910.134(f)(4)

If after passing a QLFT or QNFT, the employee subsequently notifies the employer, program administrator, supervisor, or PLHCP that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator facepiece and to be retested.

1910.134(f)(5)

The fit test shall be administered using an OSHA-accepted QLFT or QNFT protocol. The OSHA-accepted QLFT and QNFT protocols and procedures are contained in Appendix A of this section.

1910.134(f)(6)

QLFT may only be used to fit test negative pressure air-purifying respirators that must achieve a fit factor of 100 or less.

1910.134(f)(7)

If the fit factor, as determined through an OSHA-accepted QNFT protocol, is equal to or greater than 100 for tight-fitting half facepieces, or equal to or greater than 500 for tight-fitting full facepieces, the QNFT has been passed with that respirator.

1910.134(f)(8)

Fit testing of tight-fitting atmosphere-supplying respirators and tight-fitting powered air-purifying respirators shall be accomplished by performing quantitative or qualitative fit testing in the negative pressure mode, regardless of the mode of operation (negative or positive pressure) that is used for respiratory protection.

1910.134(f)(8)(i)

Qualitative fit testing of these respirators shall be accomplished by temporarily converting the respirator user's actual facepiece into a negative pressure respirator with appropriate filters, or by using an identical negative pressure air-purifying respirator facepiece with the same sealing surfaces as a surrogate for the atmosphere-supplying or powered air-purifying respirator facepiece.

1910.134(f)(8)(ii)

Quantitative fit testing of these respirators shall be accomplished by modifying the facepiece to allow sampling inside the facepiece in the breathing zone of the user, midway between the nose and mouth. This requirement shall be accomplished by installing a permanent sampling probe onto a surrogate facepiece, or by using a sampling adapter designed to temporarily provide a means of sampling air from inside the facepiece.

1910.134(f)(8)(iii)

Any modifications to the respirator facepiece for fit testing shall be completely removed, and the facepiece restored to NIOSH-approved configuration, before that facepiece can be used in the workplace.

1910.134(g)

Use of respirators. This paragraph requires employers to establish and implement procedures for the proper use of respirators. These requirements include prohibiting conditions that may result in facepiece seal leakage, preventing employees from removing respirators in hazardous environments, taking actions to ensure continued effective respirator operation throughout the work shift, and establishing procedures for the use of respirators in IDLH atmospheres or in interior structural firefighting situations.

1910.134(g)(1)

Facepiece seal protection.

1910.134(g)(1)(i)

The employer shall not permit respirators with tight-fitting facepieces to be worn by employees who have:

1910.134(g)(1)(i)(A)

Facial hair that comes between the sealing surface of the facepiece and the face or that interferes with valve function; or

1910.134(g)(1)(i)(B)

Any condition that interferes with the face-to-facepiece seal or valve function.

1910.134(g)(1)(ii)

If an employee wears corrective glasses or goggles or other personal protective equipment, the employer shall ensure that such equipment is worn in a manner that does not interfere with the seal of the facepiece to the face of the user.

1910.134(g)(1)(iii)

For all tight-fitting respirators, the employer shall ensure that employees perform a user seal check each time they put on the respirator using the procedures in Appendix B-1 or procedures recommended by the respirator manufacturer that the employer demonstrates are as effective as those in Appendix B-1 of this section.

1910.134(g)(2)

Continuing respirator effectiveness.

1910.134(g)(2)(i)
Appropriate surveillance shall be maintained of work area conditions and degree of employee exposure or stress. When there is a change in work area conditions or degree of employee exposure or stress that may affect respirator effectiveness, the employer shall reevaluate the continued effectiveness of the respirator.

1910.134(g)(2)(ii)
The employer shall ensure that employees leave the respirator use area:

1910.134(g)(2)(ii)(A)
To wash their faces and respirator facepieces as necessary to prevent eye or skin irritation associated with respirator use; or

1910.134(g)(2)(ii)(B)
If they detect vapor or gas breakthrough, changes in breathing resistance, or leakage of the facepiece; or

1910.134(g)(2)(ii)(C)
To replace the respirator or the filter, cartridge, or canister elements.

1910.134(g)(2)(iii)
If the employee detects vapor or gas breakthrough, changes in breathing resistance, or leakage of the facepiece, the employer must replace or repair the respirator before allowing the employee to return to the work area.

1910.134(g)(3)
Procedures for IDLH atmospheres. For all IDLH atmospheres, the employer shall ensure that:

1910.134(g)(3)(i)
One employee or, when needed, more than one employee is located outside the IDLH atmosphere;

1910.134(g)(3)(ii)
Visual, voice, or signal line communication is maintained between the employee(s) in the IDLH atmosphere and the employee(s) located outside the IDLH atmosphere;

1910.134(g)(3)(iii)
The employee(s) located outside the IDLH atmosphere are trained and equipped to provide effective emergency rescue;

1910.134(g)(3)(iv)
The employer or designee is notified before the employee(s) located outside the IDLH atmosphere enter the IDLH atmosphere to provide emergency rescue;

1910.134(g)(3)(v)
The employer or designee authorized to do so by the employer, once notified, provides necessary assistance appropriate to the situation;

1910.134(g)(3)(vi)
Employee(s) located outside the IDLH atmospheres are equipped with:

1910.134(g)(3)(vi)(A)
Pressure demand or other positive pressure SCBAs, or a pressure demand or other positive pressure supplied-air

respirator with auxiliary SCBA; and either

1910.134(g)(3)(vi)(B)
Appropriate retrieval equipment for removing the employee(s) who enter(s) these hazardous atmospheres where retrieval equipment would contribute to the rescue of the employee(s) and would not increase the overall risk resulting from entry; or

1910.134(g)(3)(vi)(C)
Equivalent means for rescue where retrieval equipment is not required under paragraph (g)(3)(vi)(B).

1910.134(g)(4)
Procedures for interior structural firefighting. In addition to the requirements set forth under paragraph (g)(3), in interior structural fires, the employer shall ensure that:

1910.134(g)(4)(i)
At least two employees enter the IDLH atmosphere and remain in visual or voice contact with one another at all times;

1910.134(g)(4)(ii)
At least two employees are located outside the IDLH atmosphere; and

1910.134(g)(4)(iii)
All employees engaged in interior structural firefighting use SCBAs.

Note 1 to paragraph (g): One of the two individuals located outside the IDLH atmosphere may be assigned to an additional role, such as incident commander in charge of the emergency or safety officer, so long as this individual is able to perform assistance or rescue activities without jeopardizing the safety or health of any firefighter working at the incident.

Note 2 to paragraph (g): Nothing in this section is meant to preclude firefighters from performing emergency rescue activities before an entire team has assembled.

1910.134(h)
Maintenance and care of respirators. This paragraph requires the employer to provide for the cleaning and disinfecting, storage, inspection, and repair of respirators used by employees.

1910.134(h)(1)
Cleaning and disinfecting. The employer shall provide each respirator user with a respirator that is clean, sanitary, and in good working order. The employer shall ensure that respirators are cleaned and disinfected using the procedures in Appendix B-2 of this section, or procedures recommended by the respirator manufacturer, provided that such procedures are of equivalent effectiveness. The respirators shall be cleaned and disinfected at the following intervals:

1910.134(h)(1)(i)
Respirators issued for the exclusive use of an employee shall be cleaned and disinfected as often as necessary to be maintained in a sanitary condition;

1910.134(h)(1)(ii)
Respirators issued to more than one employee shall be cleaned and disinfected before being worn by different individuals;

1910.134(h)(1)(iii)

Respirators maintained for emergency use shall be cleaned and disinfected after each use; and

1910.134(h)(1)(iv)
Respirators used in fit testing and training shall be cleaned and disinfected after each use.

1910.134(h)(2)
Storage. The employer shall ensure that respirators are stored as follows:

1910.134(h)(2)(i)
All respirators shall be stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals, and they shall be packed or stored to prevent deformation of the facepiece and exhalation valve.

1910.134(h)(2)(ii)
In addition to the requirements of paragraph (h)(2)(i) of this section, emergency respirators shall be:

1910.134(h)(2)(ii)(A)
Kept accessible to the work area;

1910.134(h)(2)(ii)(B)
Stored in compartments or in covers that are clearly marked as containing emergency respirators; and

1910.134(h)(2)(ii)(C)
Stored in accordance with any applicable manufacturer instructions.

1910.134(h)(3)
Inspection.

1910.134(h)(3)(i)
The employer shall ensure that respirators are inspected as follows:

1910.134(h)(3)(i)(A)
All respirators used in routine situations shall be inspected before each use and during cleaning;

1910.134(h)(3)(i)(B)
All respirators maintained for use in emergency situations shall be inspected at least monthly and in accordance with the manufacturer's recommendations, and shall be checked for proper function before and after each use; and

1910.134(h)(3)(i)(C)
Emergency escape-only respirators shall be inspected before being carried into the workplace for use.

1910.134(h)(3)(ii)
The employer shall ensure that respirator inspections include the following:

1910.134(h)(3)(ii)(A)
A check of respirator function, tightness of connections, and the condition of the various parts including, but not limited to, the facepiece, head straps, valves, connecting tube, and cartridges, canisters or filters; and

1910.134(h)(3)(ii)(B)
A check of elastomeric parts for pliability and signs of deterioration.

1910.134(h)(3)(iii)

In addition to the requirements of paragraphs (h)(3)(i) and (ii) of this section, self-contained breathing apparatus shall be inspected monthly. Air and oxygen cylinders shall be maintained in a fully charged state and shall be recharged when the pressure falls to 90% of the manufacturer's recommended pressure level. The employer shall determine that the regulator and warning devices function properly.

1910.134(h)(3)(iv)

For respirators maintained for emergency use, the employer shall:

1910.134(h)(3)(iv)(A)

Certify the respirator by documenting the date the inspection was performed, the name (or signature) of the person who made the inspection, the findings, required remedial action, and a serial number or other means of identifying the inspected respirator; and

1910.134(h)(3)(iv)(B)

Provide this information on a tag or label that is attached to the storage compartment for the respirator, is kept with the respirator, or is included in inspection reports stored as paper or electronic files. This information shall be maintained until replaced following a subsequent certification.

1910.134(h)(4)

Repairs. The employer shall ensure that respirators that fail an inspection or are otherwise found to be defective are removed from service, and are discarded or repaired or adjusted in accordance with the following procedures:

1910.134(h)(4)(i)

Repairs or adjustments to respirators are to be made only by persons appropriately trained to perform such operations and shall use only the respirator manufacturer's NIOSH-approved parts designed for the respirator;

1910.134(h)(4)(ii)

Repairs shall be made according to the manufacturer's recommendations and specifications for the type and extent of repairs to be performed; and

1910.134(h)(4)(iii)

Reducing and admission valves, regulators, and alarms shall be adjusted or repaired only by the manufacturer or a technician trained by the manufacturer.

1910.134(i)

Breathing air quality and use. This paragraph requires the employer to provide employees using atmosphere-supplying respirators (supplied-air and SCBA) with breathing gases of high purity.

1910.134(i)(1)

The employer shall ensure that compressed air, compressed oxygen, liquid air, and liquid oxygen used for respiration accords with the following specifications:

1910.134(i)(1)(i)

Compressed and liquid oxygen shall meet the United States Pharmacopoeia requirements for medical or breathing oxygen; and

1910.134(i)(1)(ii)

Compressed breathing air shall meet at least the requirements for Grade D breathing air described in ANSI/Compressed Gas Association Commodity Specification for Air, G-7.1-1989, to include:

1910.134(i)(1)(ii)(A)
Oxygen content (v/v) of 19.5-23.5%;

1910.134(i)(1)(ii)(B)
Hydrocarbon (condensed) content of 5 milligrams per cubic meter of air or less;

1910.134(i)(1)(ii)(C)
Carbon monoxide (CO) content of 10 ppm or less;

1910.134(i)(1)(ii)(D)
Carbon dioxide content of 1,000 ppm or less; and

1910.134(i)(1)(ii)(E)
Lack of noticeable odor.

1910.134(i)(2)
The employer shall ensure that compressed oxygen is not used in atmosphere-supplying respirators that have previously used compressed air.

1910.134(i)(3)
The employer shall ensure that oxygen concentrations greater than 23.5% are used only in equipment designed for oxygen service or distribution.

1910.134(i)(4)
The employer shall ensure that cylinders used to supply breathing air to respirators meet the following requirements:

1910.134(i)(4)(i)
Cylinders are tested and maintained as prescribed in the Shipping Container Specification Regulations of the Department of Transportation (49 CFR part 180);

1910.134(i)(4)(ii)
Cylinders of purchased breathing air have a certificate of analysis from the supplier that the breathing air meets the requirements for Grade D breathing air; and

1910.134(i)(4)(iii)
The moisture content in the cylinder does not exceed a dew point of -50 deg.F (-45.6 deg.C) at 1 atmosphere pressure.

1910.134(i)(5)
The employer shall ensure that compressors used to supply breathing air to respirators are constructed and situated so as to:

1910.134(i)(5)(i)
Prevent entry of contaminated air into the air-supply system;

1910.134(i)(5)(ii)
Minimize moisture content so that the dew point at 1 atmosphere pressure is 10 degrees F (5.56 deg.C) below the ambient temperature;

1910.134(i)(5)(iii)
Have suitable in-line air-purifying sorbent beds and filters to further ensure breathing air quality. Sorbent beds and

filters shall be maintained and replaced or refurbished periodically following the manufacturer's instructions.

1910.134(i)(5)(iv)

Have a tag containing the most recent change date and the signature of the person authorized by the employer to perform the change. The tag shall be maintained at the compressor.

1910.134(i)(6)

For compressors that are not oil-lubricated, the employer shall ensure that carbon monoxide levels in the breathing air do not exceed 10 ppm.

1910.134(i)(7)

For oil-lubricated compressors, the employer shall use a high-temperature or carbon monoxide alarm, or both, to monitor carbon monoxide levels. If only high-temperature alarms are used, the air supply shall be monitored at intervals sufficient to prevent carbon monoxide in the breathing air from exceeding 10 ppm.

1910.134(i)(8)

The employer shall ensure that breathing air couplings are incompatible with outlets for nonrespirable worksite air or other gas systems. No asphyxiating substance shall be introduced into breathing air lines.

1910.134(i)(9)

The employer shall use only the respirator manufacturer's NIOSH-approved breathing-gas containers,marked and maintained in accordance with the Quality Assurance provisions of the NIOSH approval for the SCBA as issued in accordance with the NIOSH respirator-certification standard at 42 CFR part 84.

1910.134(j)

Identification of filters, cartridges, and canisters. The employer shall ensure that all filters, cartridges and canisters used in the workplace are labeled and color coded with the NIOSH approval label and that the label is not removed and remains legible.

1910.134(k)

Training and information. This paragraph requires the employer to provide effective training to employees who are required to use respirators. The training must be comprehensive, understandable, and recur annually, and more often if necessary. This paragraph also requires the employer to provide the basic information on respirators in Appendix D of this section to employees who wear respirators when not required by this section or by the employer to do so.

1910.134(k)(1)

The employer shall ensure that each employee can demonstrate knowledge of at least the following:

1910.134(k)(1)(i)

Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effect of the respirator;

1910.134(k)(1)(ii)

What the limitations and capabilities of the respirator are;

1910.134(k)(1)(iii)

How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions;

1910.134(k)(1)(iv)

How to inspect, put on and remove, use, and check the seals of the respirator;

1910.134(k)(1)(v)
What the procedures are for maintenance and storage of the respirator;

1910.134(k)(1)(vi)
How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators; and

1910.134(k)(1)(vii)
The general requirements of this section.

1910.134(k)(2)
The training shall be conducted in a manner that is understandable to the employee.

1910.134(k)(3)
The employer shall provide the training prior to requiring the employee to use a respirator in the workplace.

1910.134(k)(4)
An employer who is able to demonstrate that a new employee has received training within the last 12 months that addresses the elements specified in paragraph (k)(1)(i) through (vii) is not required to repeat such training provided that, as required by paragraph (k)(1), the employee can demonstrate knowledge of those element(s). Previous training not repeated initially by the employer must be provided no later than 12 months from the date of the previous training.

1910.134(k)(5)
Retraining shall be administered annually, and when the following situations occur:

1910.134(k)(5)(i)
Changes in the workplace or the type of respirator render previous training obsolete;

1910.134(k)(5)(ii)
Inadequacies in the employee's knowledge or use of the respirator indicate that the employee has not retained the requisite understanding or skill; or

1910.134(k)(5)(iii)
Any other situation arises in which retraining appears necessary to ensure safe respirator use.

1910.134(k)(6)
The basic advisory information on respirators, as presented in Appendix D of this section, shall be provided by the employer in any written or oral format, to employees who wear respirators when such use is not required by this section or by the employer.

1910.134(l)
Program evaluation. This section requires the employer to conduct evaluations of the workplace to ensure that the written respiratory protection program is being properly implemented, and to consult employees to ensure that they are using the respirators properly.

1910.134(l)(1)
The employer shall conduct evaluations of the workplace as necessary to ensure that the provisions of the current written program are being effectively implemented and that it continues to be effective.

1910.134(l)(2)
The employer shall regularly consult employees required to use respirators to assess the employees' views on program effectiveness and to identify any problems. Any problems that are identified during this assessment shall be

corrected. Factors to be assessed include, but are not limited to:

1910.134(l)(2)(i)
Respirator fit (including the ability to use the respirator without interfering with effective workplace performance);

1910.134(l)(2)(ii)
Appropriate respirator selection for the hazards to which the employee is exposed;

1910.134(l)(2)(iii)
Proper respirator use under the workplace conditions the employee encounters; and

1910.134(l)(2)(iv)
Proper respirator maintenance.

1910.134(m)
Recordkeeping. This section requires the employer to establish and retain written information regarding medical evaluations, fit testing, and the respirator program. This information will facilitate employee involvement in the respirator program, assist the employer in auditing the adequacy of the program, and provide a record for compliance determinations by OSHA.

1910.134(m)(1)
Medical evaluation. Records of medical evaluations required by this section must be retained and made available in accordance with 29 CFR 1910.1020.

1910.134(m)(2)
Fit testing.

1910.134(m)(2)(i)
The employer shall establish a record of the qualitative and quantitative fit tests administered to an employee including:

1910.134(m)(2)(i)(A)
The name or identification of the employee tested;

1910.134(m)(2)(i)(B)
Type of fit test performed;

1910.134(m)(2)(i)(C)
Specific make, model, style, and size of respirator tested;

1910.134(m)(2)(i)(D)
Date of test; and

1910.134(m)(2)(i)(E)
The pass/fail results for QLFTs or the fit factor and strip chart recording or other recording of the test results for QNFTs.

1910.134(m)(2)(ii)
Fit test records shall be retained for respirator users until the next fit test is administered.

1910.134(m)(3)

A written copy of the current respirator program shall be retained by the employer.

1910.134(m)(4)
Written materials required to be retained under this paragraph shall be made available upon request to affected employees and to the Assistant Secretary or designee for examination and copying.

1910.134(n)
Effective date. Paragraphs (d)(3)(i)(A) and (d)(3)(i)(B) of this section become effective November 22, 2006.

1910.134(o)
Appendices. Compliance with Appendix A, Appendix B-1, Appendix B-2, Appendix C, and Appendix D to this section are mandatory.

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 71 FR 16672, April 3, 2006; 71 FR 50187, August 24, 2006; 73 FR 75584, Dec. 12, 2008; 76 FR 33606, June 8, 2011]

Exhibit 14

By Standard Number / 1910.134 App C - OSHA Respirator Medical Evaluation Questionnaire (Mandatory).

- **Part Number:** 1910
- **Part Number Title:** Occupational Safety and Health Standards
- **Subpart:** 1910 Subpart I
- **Subpart Title:** Personal Protective Equipment
- **Standard Number:** 1910.134 App C
- **Title:** OSHA Respirator Medical Evaluation Questionnaire (Mandatory).
- **GPO Source:** e-CFR

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____

2. Your name:_____

3. Your age (to nearest year):_____

4. Sex (circle one): Male/Female

5. Your height: _____ ft. _____ in.

6. Your weight: _____ lbs.

7. Your job title:_____

8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____

9. The best time to phone you at this number: _____

10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s):_____
_____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you *ever had* any of the following conditions?

a. Seizures: Yes/No

b. Diabetes (sugar disease): Yes/No

c. Allergic reactions that interfere with your breathing: Yes/No

d. Claustrophobia (fear of closed-in places): Yes/No

e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?

a. Asbestosis: Yes/No

b. Asthma: Yes/No

c. Chronic bronchitis: Yes/No

d. Emphysema: Yes/No

e. Pneumonia: Yes/No

f. Tuberculosis: Yes/No

g. Silicosis: Yes/No

h. Pneumothorax (collapsed lung): Yes/No

i. Lung cancer: Yes/No

j. Broken ribs: Yes/No

k. Any chest injuries or surgeries: Yes/No

l. Any other lung problem that you've been told about: Yes/No

4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath: Yes/No

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No

c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No

d. Have to stop for breath when walking at your own pace on level ground: Yes/No

e. Shortness of breath when washing or dressing yourself: Yes/No

f. Shortness of breath that interferes with your job: Yes/No

g. Coughing that produces phlegm (thick sputum): Yes/No

h. Coughing that wakes you early in the morning: Yes/No

i. Coughing that occurs mostly when you are lying down: Yes/No

j. Coughing up blood in the last month: Yes/No

k. Wheezing: Yes/No

l. Wheezing that interferes with your job: Yes/No

m. Chest pain when you breathe deeply: Yes/No

n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you *ever had* any of the following cardiovascular or heart problems?

a. Heart attack: Yes/No

b. Stroke: Yes/No

c. Angina: Yes/No

d. Heart failure: Yes/No

e. Swelling in your legs or feet (not caused by walking): Yes/No

f. Heart arrhythmia (heart beating irregularly): Yes/No

g. High blood pressure: Yes/No

h. Any other heart problem that you've been told about: Yes/No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest: Yes/No

b. Pain or tightness in your chest during physical activity: Yes/No

c. Pain or tightness in your chest that interferes with your job: Yes/No

d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No

e. Heartburn or indigestion that is not related to eating: Yes/No

d. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you *currently* take medication for any of the following problems?

a. Breathing or lung problems: Yes/No

b. Heart trouble: Yes/No

c. Blood pressure: Yes/No

d. Seizures: Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

a. Eye irritation: Yes/No

b. Skin allergies or rashes: Yes/No

c. Anxiety: Yes/No

d. General weakness or fatigue: Yes/No

e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

11. Do you *currently* have any of the following vision problems?

a. Wear contact lenses: Yes/No

b. Wear glasses: Yes/No

c. Color blind: Yes/No

d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you *currently* have any of the following hearing problems?

a. Difficulty hearing: Yes/No

b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist: Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f. Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them:_____
_____
_____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No

b. Silica (*e.g.*, in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No

g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures:_____
_____
_____

4. List any second jobs or side businesses you have:_____
_____

5. List your previous occupations:_____
_____

6. List your current and previous hobbies:_____
_____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter

medications): Yes/No

If "yes," name the medications if you know them:_____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours *per week:* Yes/No

d. Less than 2 hours *per day:* Yes/No

e. 2 to 4 hours per day: Yes/No

f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing* while drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift:_____hrs._____mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling; standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment:_____
_____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):
_____
_____

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):
_____
_____

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the second toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
Name of the third toxic substance:_____
Estimated maximum exposure level per shift:_____
Duration of exposure per shift:_____
The name of any other toxic substances that you'll be exposed to while using your respirator:
_____
_____
_____

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):
_____

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

UNITED STATES
DEPARTMENT OF LABOR

Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

Exhibit 15

MAJOR REQUIREMENTS OF OSHA'S RESPIRATORY PROTECTION STANDARD 29 CFR 1910.134

OSHA Office of Training and Education
Rev. December 2006

MAJOR REQUIREMENTS OF 29 CFR 1910.134

Introduction

- This standard applies to General Industry (Part 1910), Shipyards (Part 1915), Marine Terminals (Part 1917), Longshoring (Part 1918), and Construction (Part 1926).

(a) Permissible Practice

- Paragraph (a)(1) establishes OSHA's **hierarchy of controls** by requiring the use of **feasible engineering controls** as the primary means to control air contaminants. Respirators are required when "effective engineering controls are not feasible, or while they are being instituted."

- Paragraph (a)(2) requires employers to provide employees with respirators that are "applicable and suitable" for the purpose intended "when such equipment is necessary to protect the health of the employee."

(b) Definitions

This paragraph contains definitions of important terms used in the regulatory text.

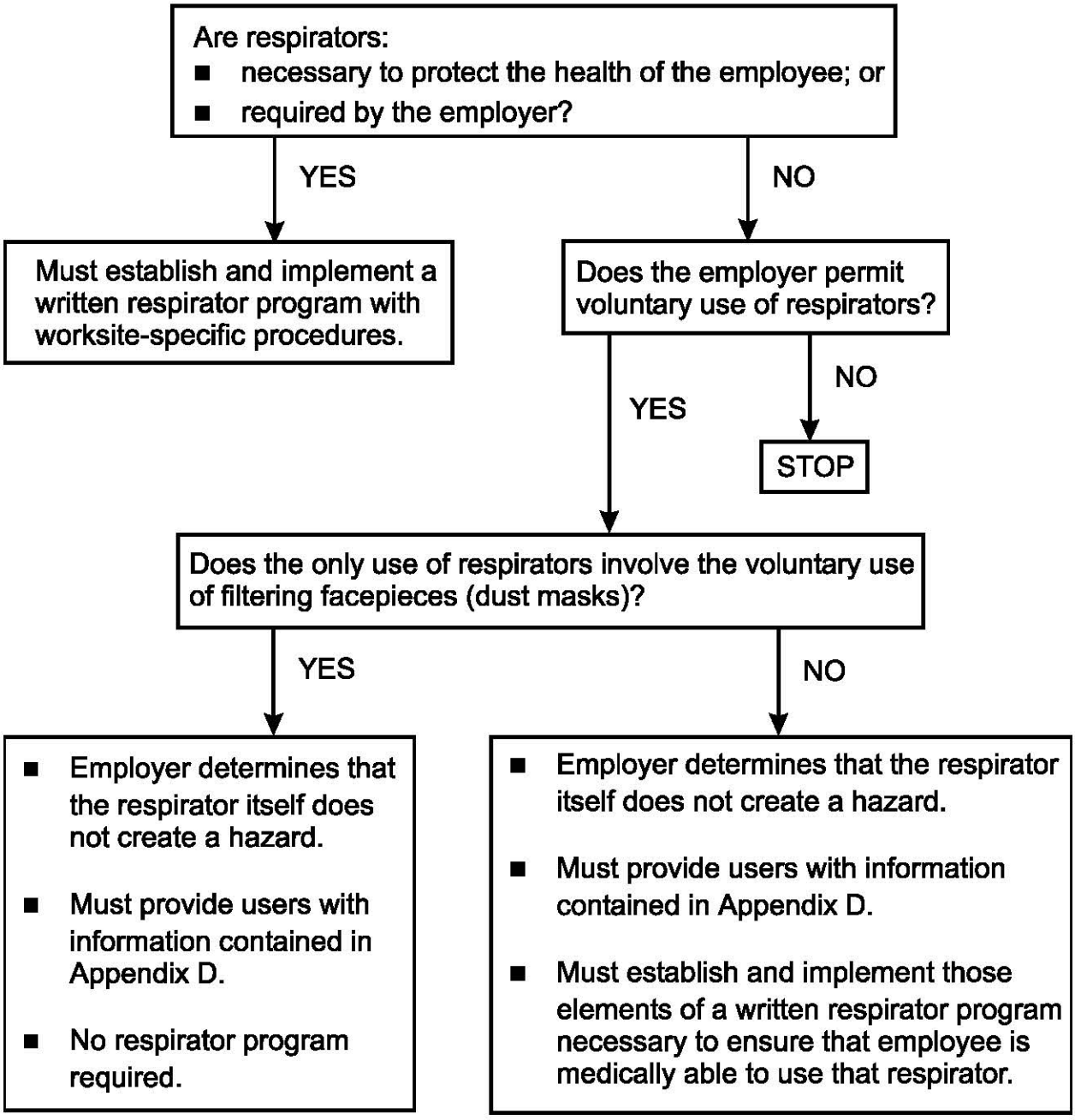
(c) Respiratory Protection Program

- Must designate a **qualified program administrator** to oversee the program.

- Must provide respirators, training, and medical evaluations **at no cost to the employee**.

- OSHA has prepared a *Small Entity Compliance Guide* that contains criteria for selection of a program administrator and a sample program.

Respirator-Use Requirements Flow Chart
29 CFR 1910.134(c)



(d) Selection of Respirators

- Must select a respirator **certified by the National Institute for Occupational Safety and Health (NIOSH)** which must be used in compliance with the conditions of its certification.

- Must identify and evaluate the respiratory hazards in the workplace, including a reasonable estimate of employee exposures and identification of the contaminant's chemical state and physical form.

- Where exposure cannot be identified or reasonably estimated, the atmosphere shall be considered immediately dangerous to life or health (IDLH).

- Respirators for IDLH atmospheres:
  - Approved respirators:
    - full facepiece pressure demand self-contained breathing apparatus (SCBA) certified by NIOSH for a minimum service life of thirty minutes, or
    - combination full facepiece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.
  - All **oxygen-deficient atmospheres (less than 19.5% O_2 by volume)** shall be considered IDLH.
    Exception: If the employer can demonstrate that, under all foreseeable conditions, oxygen levels in the work area can be maintained within the ranges specified in Table II (i.e., between 19.5% and a lower value that corresponds to an altitude-adjusted oxygen partial pressure equivalent to 16% oxygen at sea level), then *any* atmosphere-supplying respirator may be used.

- Respirators for non-IDLH atmospheres:
  - Employers must use the **assigned protection factors (APFs)** listed in Table 1 to select a respirator that meets or exceeds the required level of employee protection.
    - When using a combination respirator (e.g., airline respirators with an air-purifying filter), employers must ensure that the assigned protection factor is appropriate to the mode of operation in which the respirator is being used.
  - Must select a respirator for employee use that maintains the employee's exposure to the hazardous substance, when measured outside the respirator, at or below the **maximum use concentration (MUC)**.
    - Must not apply MUCs to conditions that are IDLH; instead must use respirators listed for IDLH conditions in paragraph (d)(2) of this standard.
    - When the calculated MUC exceeds the IDLH level or the performance limits of the cartridge or canister, then employers must set the maximum MUC at that lower limit.
    - The respirator selected shall be appropriate for the chemical state and physical form of the contaminant.

- For protection against gases and vapors, the employer shall provide:
  - an atmosphere-supplying respirator, or
  - an air-purifying respirator, provided that:
    - the respirator is equipped with an **end-of-service-life indicator (ESLI)** certified by NIOSH for the contaminant; or
    - if there is no ESLI appropriate for conditions of the employer's workplace, the employer implements a **change schedule** for canisters and cartridges that will ensure that they are changed before the end of their service life and describes in the respirator program the information and data relied upon and basis for the change schedule and reliance on the data.
- For protection against particulates, the employer shall provide:
  - an atmosphere-supplying respirator; or
  - an air-purifying respirator equipped with high efficiency particulate air (HEPA) filters certified by NIOSH under 30 CFR Part 11 or with filters certified for particulates under 42 CFR Part 84; or
  - an air-purifying respirator equipped with any filter certified for particulates by NIOSH for contaminants consisting primarily of particles with mass median aerodynamic diameters of at least 2 micrometers.

(e) Medical Evaluation

- Must provide a medical evaluation to determine employee's ability to use a respirator, **before fit testing and use**.

- Must identify a **physician or other licensed health care professional (PLHCP)** to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire (information required is contained in mandatory Appendix C).

- Must obtain a **written recommendation** regarding the employee's ability to use the respirator from the PLHCP.

- Additional medical evaluations are required under certain circumstances, e.g.:
  - employee reports medical signs or symptoms related to ability to use respirator;
  - PLHCP, program administrator, or supervisor recommends reevaluation;
  - information from the respirator program, including observations made during fit testing and program evaluation, indicates a need; or
  - change occurs in workplace conditions that may substantially increase the physiological burden on an employee.

- Annual review of medical status is not required.

(f) Fit Testing

- All employees using a **negative or positive pressure tight-fitting facepiece** respirator must pass an appropriate **qualitative fit test (QLFT**) or **quantitative fit test (QNFT).**

- Fit testing is required prior to initial use, whenever a different respirator facepiece is used, and **at least annually thereafter**. An additional fit test is required whenever the employee reports, or the employer or PLHCP makes visual observations of, changes in the employee's physical condition that could affect respirator fit (e.g., facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight).

- The fit test shall be administered using an OSHA-accepted QLFT or QNFT protocol, as contained in mandatory Appendix A.
  - QLFT Protocols:
    - Isoamyl acetate
    - Saccharin
    - Bitrex
    - Irritant smoke
  - QNFT Protocols:
    - Generated Aerosol (corn oil, salt, DEHP)
    - Condensation Nuclei Counter (PortaCount)
    - Controlled Negative Pressure (Dynatech FitTester 3000)
    - Controlled Negative Pressure (CNP) REDON

- QLFT may only be used to fit test negative pressure air-purifying respirators (APRs) that must achieve a fit factor of 100 or less.

- If the fit factor determined through QNFT is ≥100 for tight-fitting half facepieces, or ≥500 for tight-fitting full facepieces, the QNFT has been passed with that respirator.

Note: If a particular OSHA standard (e.g., 29 CFR 1910.1001 Asbestos) requires the use of a full facepiece APR capable of providing protection in concentrations up to 50 times the Permissible Exposure Limit (PEL), this respirator must be QNFT. This is because a protection factor of 50 (50 X PEL) multiplied by a standard safety factor of 10 is equivalent to a fit factor of 500.

The safety factor of 10 is used because protection factors in the workplace tend to be much lower than the fit factors achieved during fit testing. The use of a safety factor is a standard practice supported by most experts to offset this limitation. This is discussed in the record at 63 FR 1225.

(g) Use of Respirators

- Tight-fitting respirators shall not be worn by employees who have facial hair or any condition that interferes with the face-to-facepiece seal or valve function.

- Personal protective equipment shall be worn in such a manner that does not interfere with the seal of the facepiece to the face of the user.

- Employees shall perform a user seal check **each time they put on a tight-fitting respirator** using the procedures in mandatory Appendix B-1 or equally effective manufacturer's procedures.

- Procedures for respirator use in IDLH atmospheres are stated. In addition to these requirements, interior structural firefighting requires the use of SCBAs and a protective practice known as "2-in/2-out" — at least two employees must enter and remain in visual or voice contact with one another at all times, and at least two employees must be located outside. (Note that this is not meant to preclude firefighters from performing emergency rescue activities before an entire team has assembled.)

(h) Maintenance and Care of Respirators

Must clean and disinfect respirators using the procedures in Appendix B-2, or equally effective manufacturer's procedures at the following intervals:

- as often as necessary to maintain a sanitary condition for exclusive use respirators,
- before being worn by different individuals when issued to more than one employee, and
- after each use for emergency use respirators **and those used in fit testing and training**.

(i) Breathing Air Quality and Use

Compressed breathing air shall meet the requirements for Type 1-Grade D breathing air as described in ANSI/CGA *Commodity Specification for Air*, G-7.1-1989.

(j) Identification of Filters, Cartridges, and Canisters

- All filters, cartridges, and canisters used in the workplace must be labeled and color coded with the NIOSH approval label.
- The label must not be removed and must remain legible.

(k) Training and Information

- Must provide effective training to respirator users, including:
  - why the respirator is necessary and how improper fit, use, or maintenance can compromise the protective effect of the respirator
  - limitations and capabilities of the respirator
  - use in emergency situations
  - how to inspect, put on and remove, use and check the seals
  - procedures for maintenance and storage
  - recognition of medical signs and symptoms that may limit or prevent effective use
  - general requirements of this standard
- Training required prior to initial use, unless acceptable training has been provided by another employer within the past 12 months.
- **Retraining required annually** and when:
  - workplace conditions change,
  - new types of respirator are used, or
  - inadequacies in the employee's knowledge or use indicates need.

- The basic advisory information in Appendix D shall be provided to employees who wear respirators when their use is not required.

(l) Program Evaluation

Employer must conduct evaluations of the workplace as necessary to ensure proper implementation of the program, and consult with employees to ensure proper use.

(m) Recordkeeping

- Records of medical evaluations must be retained and made available per 29 CFR 1910.1020.

- A record of fit tests must be established and retained until the next fit test.

- A written copy of the current program must be retained.

Exhibit 16

cdc.gov

Coronavirus Disease 2019

34-43 minutes CDC Media Briefing 2-25-22

0:00 / 39:17

Operator:

Welcome and thank you for standing by. At this time, all participants are on listen only mode during the Q&A session. If you'd like to ask a question, you may press star one on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. Now I'd like, turn the call over to Mr. Benjamin Hayes. Sir, may begin.

Benjamin Haynes:

Thank you, Ted. And thank you all for joining us for today's COVID 19 update. We're joined by CDC Director, Dr. Rochelle Walensky and Dr. Greta Massetti from the COVID 19 Incident Management Team, both will provide opening remarks before taking your questions. I would now like to turn the call over to Dr. Walensky.

Dr. Walensky:

Thank you, Benjamin and thank you all for joining us today. Today, CDC is updating its framework to monitor the level of COVID 19 and communities. We're in a stronger place today as a nation with more tools to protect ourselves in our communities from COVID 19, like vaccination, boosters, broader access to testing, availability of high quality masks, accessibility to new treatments, and improved ventilation. Over 200 million people have received a primary vaccine series and nearly 100 million have been boosted and millions more have had prior disease. With widespread population immunity, the overall risk of severe disease is now generally lower. Now, as the virus continues to circulate in our communities, we must focus our metrics beyond just cases in the community and direct our efforts toward protecting people at high risk for severe illness and preventing COVID 19 from overwhelming our hospitals and our healthcare systems. This new framework moves beyond just looking at cases and test positivity to evaluate factors that reflect the severity of disease, including hospitalizations and hospital capacity, and helps to determine whether the level of COVID 19 and severe disease are low, medium, or high in a community.

Dr. Walensky:

The COVID 19 community level we are releasing today will inform CDC recommendations on prevention measures like masking and CDCs recommendations for layer prevention measures, and will depend on the COVID 19 level in the community. This updated approach focuses on directing our prevention efforts towards protecting people at high risk for severe illness and preventing hospitals and healthcare systems from being overwhelmed. To find your community level, we are

updating the CDC's website to reflect this framework. So people will be able to go to www.cdc.gov or call 1-800-CDC-INFO to find your community level and what prevention strategies are recommended, including where or when to mask. Please remember that there are people who remain at higher risk for COVID 19 and who may need additional protection. Those who are immunocompromised or have underlying health conditions, those who have disabilities, or those who live with people who are at risk. Those people might choose to take extra precautions regardless of what level their community is in. So with that, I'm going to turn things over now to Dr. Greta Massetti, who will walk us through this framework and the science behind it. Thank you.

Dr. Massetti:

Thank you, Dr. Walensky. The updated metrics in this framework provide a current picture of COVID 19 disease in a community. They also include strong predictors of the potential for strain on the healthcare system. A community's COVID 19 level is determined by a combination of three pieces of information: new hospitalizations for COVID 19, current hospital beds occupied by COVID 19 patients or hospital capacity, and new COVID 19 cases. These metrics will tell us if the level is low, medium, or high. Let me walk you through what we are recommending at each level. Regardless of level, we continue to recommend that people stay up to date on vaccines and get tested if they're sick.

Dr. Massetti:

At the low level, there is limited impact on the healthcare system and low amounts of severe disease in the community. People should stay up to date with their vaccines and get tested if they're sick. At the medium level, more people are experiencing severe disease in the community and they're starting to see more impact on the health healthcare system. At this level, CDC recommends that people who are high risk, such as someone who is immunocompromised, should talk to their healthcare provider about taking additional precautions and may choose to wear a mask. As communities enter into the high level, there is high amount of people experiencing severe disease and high potential for healthcare systems strains. At the high level, CDC recommends that everyone wear a mask indoors, in public, including in schools. Communities can use these metrics, along with their own local metrics, such as wastewater surveillance, emergency department visits, and workforce capacity, to update and further inform their local policies and ensure equity and prevention efforts. And these categories help individuals assess what impacts COVID 19 is having on their community so that they can decide if they need to take extra precautions, including masking based on their location, their health status, and their risk tolerance.

Dr. Massetti:

We should all keep in mind that some people may choose to wear a mask at any time based on personal preference. And importantly, people who wear high quality masks are well protected, even if others around you are not masking. And there are some situations where people should always wear a mask. For example, if they have symptoms, if they tested positive for COVID 19, or if they have been exposed to someone with COVID 19. Today, we're also updating our recommendations for schools. Since July, 2021, CDC recommended universal masking in schools, no matter what level of impact COVID 19 was having on the community. With this update, CDC will now only recommend universal school masking in communities at the high level. Importantly, COVID 19 community levels and public health prevention strategies can be dialed up when our communities

are experiencing more severe disease and dialed down when things are more stable. So what do these updated metrics mean for where we are as a country, as of today, more than half of counties representing about 70% of Americans are in areas with low or medium COVID 19 community levels. This is an increase from about one third of counties at low or medium community levels last week and we continue to see indicators improve in many communities. Thank you. And I will now hand it back to Dr. Walensky.

Dr. Walensky:

Thank you, Dr. Massetti, before we take your questions, I would like to leave you with a few final thoughts. None of us know what the future may hold for us and for this virus and we need to be prepared and we need to be ready for whatever comes next. We wanna give people a break from things like mask wearing when our levels are low and then have the ability to reach for them again, should things get worse in the future. We at CDC will continue to follow the science and epidemiology to make public health recommendations and guidance based on the data. Our new framework was rigorously evaluated both with current data and retrospectively during the Alpha, Delta and Omicron waves and these new metrics have demonstrated predictive capacity for weeks into the future. We will continue to evaluate how well they perform in our communities. This new framework will best way for us to judge what level of preventive measures may be needed in our communities. If or when new variants emerge or the virus surges, we have more ways to control the virus and protect ourselves and our communities than ever before. Thank you. I'll now turn it back over to you, Benjamin.

Benjamin Haynes:

Thank you, Dr. Walensky and thank you, Dr. Massetti. Ted, we are ready to take questions.

Operator:

The phone lines are now open for questions. If you would like to ask a question over the phone, please press star one and record your name. We also ask that you just limit yourself to one follow up question. If you would like to remove your question, please press star two. One moment please. And the first question accused from Dr. Jon LaPook with CBS news, your line is not open.

Dr. Jon LaPook:

Hi, thank you. Thanks for this update and we've heard that, you know, the best mask is the one people will wear, but let's assume somebody's incentivized to wear the best mask they can and they're gonna try to get it well fitted. Can you be more granular about which mask provide the best protection is an N 95, KN-95, KF-94. surgical cloth. What should people who want to protect themselves the most, which of the masks they should be using? Thanks.

Dr. Walensky:

Maybe I'll start with that. Thank you, Dr. LaPook. Of course we've said in our prior masking guide that infiltration are key in those, the N-90-

Dr. Massetti:

It sounds like we might have lost Dr. Walensky. I think what she was noting was that we often have emphasized that fit and filtration are really critical and there are a variety of ways to achieve that.

One way is to use a respirator, um, like an N-95 or a KN 95. They provide good fit and filtration for people, and they provide high protection to the wearer. There are other options as well, including using a surgical mask or a surgical mask layered with a cloth mask. And also we have on our website resources to show people how to knot and tuck the ear loops on mask to improve fit and filtration as well.

Dr. Jon LaPook:

Right, no, of course, we all, thanks. We all see people with wearing just sort of a plain cloth and maybe it's underneath the nose, but I was just wondering if you wanted to emphasize what's the best case scenario for people since, since it just says, wear a mask.

Dr. Massetti:

So CDC recommends that that people should wear the mask that has the best protection and filtration for them and that they will wear consistently.

Dr. Jon LaPook:

Thanks.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Ron Lin with the Los Angeles Times, your line is now open.

Ron Lin:

Hey, I was wondering, can you go into how you came up with the details of the metrics for those three levels and what the science is based off of them in terms of numbers. And where would a place like LA county, which has tied its local mask mandate to CDCs old mask recommendations? Where would they lie? Would they no longer be required to no longer be recommended to wear masks? Thanks.

Dr. Walensky:

I'm back. So maybe I'll get started and pass it over to you, Dr. Massetti, thanks for filling in there. So, one of the things that was really important is we have more and more people and more and more immunity in the population. We wanted to make sure that we were focusing on severe disease because we do want to prevent severe disease. We want to prevent hospitalizations. We want to prevent our hospitals from becoming overwhelmed. So our metrics were really with that in mind, what are severe, how much severe disease is happening, and then to use those metrics to understand, can we find levels where we can predict outcomes in the future where we might be able to act on them now to avert those outcomes in the future. Bad outcomes, like ICU stays, high levels of death. So maybe I'll pass it over now back. So Dr. Massetti to give you more granular detail.

Dr. Massetti:

Great. Thanks so much, Dr. Walensky. So as Dr. Walensky noted, we were really focused on measures of healthcare strain and severe disease. And so we conducted an extensive review of all data systems that are reported to CDC and often available on our website on COVID data tracker.

We reviewed all data sources and really assess them against several criteria, including do they measure severe disease or healthcare strain? How well do they provide data that is available at the local level where it can really inform local decisions? And do we have national coverage for all counties in the United States? And are they reported frequently enough to be able to inform timely decisions? And based on that thorough review, we refined the list and came up with these indicators, including new hospital admissions and hospital beds utilized and complimented them with case incidents to really create a package of metrics to be able to understand happening at the local level.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Drew Armstrong with Bloomberg News, your line is now open.

Drew Armstrong:

Hi, Drew Armstrong from Bloomberg news. I'm wondering, thinking ahead, are there other COVID metrics or measures that CDC has using or collecting that should be overhauled or refined as we move into whatever this next phase of the pandemic is? And, if so, what are some potential examples of that?

Dr. Walensky:

So we have, we certainly look at comprehensive data and we get a whole stream of data, some that are different by jurisdiction. So for example, we just last week posted our wastewater data, and we anticipate that our wastewater data, while we have 400 sites posted, and that represents about 53 million Americans, that is still focal. And we really want are working to expand that. So we intend to double that over the next month or so. Syndromic surveillance would be another way that we could expand some of these metrics again. As Dr. Massetti said, it's really important as we come up with national metrics that we have coverage from every county, not every county is reporting syndromic surveillance, although we're working to scale that up as well. So we have on our eye on many different metrics, which is why we hope that these metrics that we're releasing today will be very helpful for policy makers, but we also hope that local jurisdictions will take into account all the information that's available to them.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Helen Branswell with STAT. Your line is now open.

Helen Branswell:

Hi, thank you very much for taking my question. I know, I think this is gonna be an irritating question, but when you talk about, you know, the metrics about, you know, the percentage of people in hospital beds who are, there because of COVID, is that for COVID or with, I mean, will the with COVID people also be part of those calculations?

Dr. Walenksy:

Helen, that's a great question. We have spent a lot of time thinking about this. And let me tell you sort of where we landed and why. First, we are considering anybody in a hospital bed with COVID, regardless of the reason for admission and that the reason that we landed there is multifold. First many jurisdictions can't differentiate. So that was important for us to recognize and realize. Second, whether or not a patient is admitted with COVID or for COVID, they increase the hospital capacity and they're resource intensive. They require an isolation bed. They require PPE. They probably require a higher staff ratio. And so they are more resource intensive and they do take a COVID bed potentially from someone else. Interestingly, as well, as we have less and less COVID in certain communities, the amount of people who are coming into the hospital with COVID will necessarily decrease.

Dr. Walensky:

We will not have as many people walking around asymptomatically because there will just be less disease out there. So increasingly as we have less disease in the community, we anticipate that more of the people who are coming into the hospital are going to be coming in because of COVID. And then finally, as we have even less disease in the community, we anticipate that not every hospital is going to screen every patient for COVID as they walk in the door, especially if we have less and less disease in the community. And when that happens, we won't actually be able to differentiate. In fact, people who are coming in, who are tested will necessarily be coming in for COVID. So for all of those reasons, comprehensively, we decided to say with anybody coming in with a COVID diagnosis.

Helen Branswell:

Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Cheyenne Haslett with ABC News, your line is now open.

Cheyenne Haslett:

Hi, thank you for taking my question. Dr. Walensky can you explain the decision to include schools in the loosening of the mask recommendations? And as a follow up, on public transportation, do you expect that recommendation for masks to expire on March 18th or be extended?

Dr. Walensky:

Um, so maybe I'll take the first, the second question first and then pass the school question to Dr. Massetti. The COVID 19 community levels are intended for communities, they're not intended for our travel quarters, as you note, those expire in the middle of March, and we will be revisiting that in the weeks ahead. And then maybe Dr. Massetti, do you want to take the school question?

Dr. Massetti:

Yes. Thank you, Dr. Walensky. So, we've been reviewing the data on COVID illness in children for two years of a pandemic. And we have seen that although children can get infected and can get sick with COVID, they're more likely to have asymptomatic or mild infections. So fortunately we know that

when schools implement layered prevention strategies, that they can prevent SARS COV-2 two transmission or transmission of the virus that causes COVID 19 in schools. And we know that also because children are relatively at lower risk from severe illness that schools can be safe places for children. And so for that reason, we're recommending that schools use the same guidance that we are recommending in general community settings, which is that we are recommending people wear a mask in high levels of COVID 19. But that, the medium level that the recommendation is primarily based on whether somebody wants to talk to their healthcare provider about whether they're high risk.

Cheyenne Haslett:

Thank you.

Benjamin Haynes:

Next question, please, Ted.

Operator:

Next question is from Allison Aubrey with NPR. Your allow is now open.

Allison Aubrey:

Hi, thanks for taking my question. I'm wondering if the updated page where you're sort of saying the map of this is low, medium or high community, is this being updated with new data all of the time? So it's always up to date? And will this be updated sort of in perpetuity? We know that COVID is not being eradicated. There's talk of, we could see outbreaks at any point in the future. Just talk about sort of those, how actively this is maintained and for how long.

Dr. Walensky:

Thank you, Allison. We intend to keep this updated. Of course, not every county reports every metric every day. So we intend to keep this updated on a weekly cadence. And we intend to do so for the foreseeable future. Of course, this virus has dealt us many a curve balls but for the foreseeable future is what we're looking at right now.

Allison Aubrey:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from John Woolfolk with San Jose Mercury News. Your line is now open.

John Woolfolk:

Hi. So, the new metrics that you all are talking about sound like they're based mostly on the strain on the health bureaucracy and not, I mean, our readers are mostly interested in your guidance for what it means for them to avoid getting COVID and spreading it. And based on the metrics and the rules that were in place as of this morning, before announcement, that would mean like pretty much all of California where we are, "you should wear a mask if you don't want COVID" recommendation. And it

sounds like I haven't seen what your new metric says for our area, but it sounds like it's now saying, well, that's not operative anymore. Go ahead and take the mask off. Is that are people safe going in and around in public indoors without masks in places where your metrics now say it's a high transmission situation?

Dr. Walensky:

Thank you, John. So first and foremost, I'd like to go back to what Dr. Massetti said, which is anybody is certainly welcome to wear a mask at any time, if they feel safer wearing a mask. So we are absolutely endorsing if you feel more comfortable wearing a mask, feel free to do so. And we should encourage people to have that liberty to be able to do so. The intent of these community guidance is to look at really severe disease – people who are coming into the hospital. We know that there's going to be transmission of COVID 19 out there. And what we wanna do is make sure that our hospitals are okay and that people are not coming in with severe disease, but of course, is important to note that the volume of severe disease in the hospital is likely representative of the volume of disease in general in the community. So they are very much linked. Certainly it's also linked to vaccination rate as well, but certainly if people are interested in wearing a mask to feel safer, they certainly can, and anyone can go to the CDC website, find out the volume of disease in their community, and then make that personal decision.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Meg Tirrel with CNBC, your line is now open.

Meg Tirrel:

Well, thank you. I'm just wondering how dependably counties are reporting all of these metrics, particularly with case numbers. Is there enough testing going on for that to be a reliable metric and you know, the same question for the hospitalizations reporting?

Dr. Walensky:

Dr. Massetti? Do you want to take that one?

Dr. Massetti:

Sure. Yeah. So to the question about the hospitalization metrics. So those are actually reported by healthcare facilities. There are 6,000 hospitals in the United States that are required to report those data every day – Monday through Friday. And usually there's better than 95% coverage on any given day. So hospitals are very consistently compliant with reporting those data. We do have very high completion of those data. So we're quite confident that those data are continuing to flow in and reflect what's happening in those hospital. The case data are also largely reported from public health laboratories and have really reflected that the the nucleic acid amplification test results. They do not reflect in many places do not reflect at home tests, which are not reported, but those are the laboratory test results are continuing to be reported fairly consistently.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Catherine Roberts with consumer reports. Your line is now open.

Catherine Roberts:

Thanks for taking my question. I'm wondering, um, to what extent, if at all, um, does this new metric account for people who may have been seriously, um, disabled or sort of long term sick due to like long COVID, but who've never actually been hospitalized with acute COVID, is that factored into this at all?

Dr. Walensky:

Um, it's a good question. We, you know, we're not looking historically about at prior hospitalizations. What we're looking at is, um, hospitalizations now and hospital capacity. Now.

Catherine Roberts:

Is there any way to sort of account for those folks who know the folks who may have gotten a, some kind of disability from COVID, but who aren't, you know, taking up capacity? Is that, is that in the, in the works basically?

Dr. Walensky:

Um, so CDC has many different cohort studies to examine long COVID. We know that this is critically important. The NIH two is examining long COVID, and we are doing this through collaborations with states on survey data, long-term, prospective cohort data, um, and, and, uh, um, hospitalization and, and, uh, data from hospitals as well. So we are looking into this for sure. And, and we know much work in what many studies need to be done for long COVID specifically, but in terms of hospital capacity today to forecast what would happen six weeks from now, um, in our, in our COVID 19 community levels, the, that is not accounted for.

Catherine Roberts:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Dave McKinley with w G R Z Buffalo, New York. Your line is not open.

Dave Mckinley:

Yeah. Hi there. I hope you can hear me. Um, you have these, uh, uh, metrics where you would establish whether community was high, uh, medium, uh, subs or high, substantial, moderate low, and there were specific numbers attached had, have those numbers changed in term in determining high or, or substantial or moderate, or are those numbers, you know, where it was fewer than 100, as opposed to fewer than 50, are, are those changing at all? And, and the second part of my question has to do with air airplanes and stuff like the in buses. I, I, you may have addressed that, uh, and I may have missed it.

Dr. Walensky:

Yeah. So first of all, just take the easy one, which is this addresses communities, but not our travel corridors. So nothing will change in our travel corridors. With regards to where we were in our prior community transmission, those were different metrics. They were based on only cases and percent positivity that led us to those, blue, yellow, orange, red. And so cases will still be a part of it, but we need to recognize that, you know, cases we're counting cases differently now than we did, you know, over a year ago when we established those prior metrics. So now our case thresholds is going to be over 200 per hundred thousand, rather than the 100 per hundred thousand

Dave Mckinley:

That's high.

Dr. Walensky:

Again, it's not, yeah, it's not just, well, it's not just cases. It is cases of well as hospitalizations as well as hospital burden. So it's the, it's the, intersection of all of those that leads you to a green, yellow, or orange color in these new metrics.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Erin Garcia with science news. Your line is open.

Erin Garcia:

Hi. Um, thanks for taking my question. I was kind of curious how the method that we're using that you guys are switching to for COVID -19 compares to how we're surveilling for influenza, for instance, did you pull on any of the expertise from how we look at flu or is this completely separate?

Dr. Walensky:

Dr. Masetti, do you wanna take that?

Dr. Massetti:

Sure. Thank you, Dr. Walensky, and thank you for the question. So we talked to a lot of experts in flu surveillance and flu measurement. We have a lot of, wonderful experts both within the, within CDC and outside CDC to really understand kind of what is the future of surveillance for COVID- 19 and what can we learn from and apply from the, um, from the flu model? The metrics that we specifically are relying on here for these COVID- 19 community levels, don't , reflect data that were stood up in summer of 2020, specifically for pandemic response data collection and through the unified hospital data system. So this is really a phenomenal data source that allows us to on a daily basis assess how many new hospitalizations that have been, in, in hospitals for people with confirmed COVID- 19 and the percent hospital capacity, and hospital beds been used by people with COVID- 19. And so that is, that's not a data, that that includes flus, that has not a, a data surveillance system that, that has been used for flu, but we're really interested in expanding and, and also collecting, seeing how this model can also apply to other respiratory illnesses in the future.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Julie Steenhuysen with Reuters. Your line is now open.

Julie Steenhuysen:

Thanks for taking my call. So I'm interested in knowing, like how does the CDC arrive at the conclusion that hospitalization and capacity were the key issues that, you know, we need to focus on now and preventing transmission is less important and, won't this be challenging, to get compliance if there's another variant that comes along, that is more virulent than the one we have now.

Dr. Walensky:

Certainly maybe I'll start with the first, the second question first, and just say, we recognize that we need to be, flexible and to be able to say, we need to be able to relax our, our, layer prevention measures when things are looking up when we have fewer cases in fewer hospitalizations, and then we need to be able to dial them up again, when we might have, should we have a new variant or a new surge? And I think that that's a really important message that we're trying to get across here. What we do know about the current moment, um, with we saw certainly a severity a decreased severity associated with, we had many, many more cases than we had hospitalizations, as we saw than we saw with alpha or Delta. And in that backdrop, we also had much more population immunity by vaccination boosting and, and prior infection. And so many, many of our infections did not result in severe disease. It did not result in, increased hospital capacity. And it was in that context that we made this pivot.

Julie Steenhuysen:

Thank you.

Operator:

Next question is from Meg winger with the Denver post. Your line is open.

Meg Wingerter:

Hello. Thanks for taking my question. I wanted to ask about, so it sounds like for the hospital capacity, you're specifically looking at people hospitalized, um, with COVID. Um, but what we're having in Colorado right now is very low, pretty low at any rate COVID hospitalizations, but are beds are still 90% full any given day. Is there any way you want communities to factor in that overall level of capacity where even a, a smaller surge could be a bigger problem because there's not much left. Thank you.

Dr. Walensky:

Maggie. You actually hit the nail exactly on the head. So not only are we looking at hospital admissions but also hospital capacity, those who are admitted with COVID-19, what fraction of their bed. So if you're at 90% in Colorado that, ou know, we would be taking that exact, uh, parameter into account.

Speaker 19:

Next

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Michael Imani with K O M U. Your line is now,

Micheal Imani:

Hi, how are you? This might be for both of you, but I actually wanted to hear from Dr. Walensky as well. But this is in relation to the new metrics or the new, excuse me, the new, holistic view of risk from coronavirus, to the community. And I was wondering how you guys are making that change. I know you kind of detailed it in your opening, but I was wondering if you can get into specifics with regards to that.

Dr. Walensky:

So thank you. So we are looking at, fraction of hospitalizations that are COVID, we're looking at number of admissions for a hundred thousand, that are COVID. And then we're also looking at cases. And so all three of those together, we have thresholds that we've measured. Then Dr. Massetti has a, has discussed, and we created those thresholds based on their ability to be predictive of, ICU safe hospitalizations and deaths in three to six weeks in the future, so that we could take action. So, all of that work together leads us into three different colors, green, yellow, and orange. Those colors will reflect low, medium, and high community levels, and then those levels get matched to our recommendations and our guidance.

Micheal Imani:

Thank you, doctor. I appreciate it.

Dr. Walensky:

Dr. Massetti, anything, anything to add there?

Dr. Massetti:

No, I think that's a, that covers it really well. Thank you, Dr. Walensky.

Operator:

Thank you. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Tom Howell with the Washington times, your line is not open.

Tom Howell:

Hey, thanks for doing the call. Can you give the immediate geographic impact of the guidance? Um, what percentage of counties are in the low category? What percentage are in medium and what percentage are in high? Thank you.

Dr. Walensky:

Dr.Massetti, you have those numbers.

Dr. Masetti:

I do, just right in front of me. So, these are as of, the latest data. 23% of counties are at low, 39.6% of counties are at medium, and 37.3% of counties are at high levels.

Tom Howell:

So all about 37.3 is high, your recommendation is that everyone wear masks in indoor public settings in those places? Is that correct?

Dr. Massetti:

Yes, that's correct.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Adriana Rodriguez with USA Today. Your line's now open.

Adriana Rodriguez:

Hi, thank you so much for taking my question. I was wondering why, vaccination rates weren't included in these metrics or in this equation to calculate, community COVID risk, and if maybe that will be included in the metrics sometime in the future.

Dr. Walensky:

So, you know, what we're really focused on is risk of severe disease and risk of, being admitted into the hospital risk of your hospitals, becoming full, truly vaccination rates do sort of fall on the causal pathway if you will, for risk of severe disease. So if someone is unvaccinated and has underlying health conditions, they certainly are at high risk of severe disease. And so, it, it is part of the equation. It's not sort of among the things that that's listed, but, certainly it is reflected in who will come into the hospital with severe disease. And, and of course we would always recommend that if you're unvaccinated, you and you're eligible for vaccination, you should get vaccinated. And if you're eligible for boosting, you should get boosted to remain up to date. And that of course would decrease is your risk of hospitalization. In fact, our most recent data have demonstrated that if you are boosted you're 97 times less likely to die of COVID than if you're unvaccinated.

Adriana Rodriguez:

So if, if a person is in one county and the hospitalization rates are the same as another person in another county, but vaccination rates are vastly different, mask guidance would be the same?

Dr. Walensky:

They would.

Adriana Rodriguez:

Thank you.

Benjamin Haynes:

Ted. We have time for two more questions.

Operator:

Okay. The next question is from Stephanie Innes with Arizona Republic, your line is open.

Stephanie Innes:

Uh, yes. Thanks for taking my question. I wanted to know if this framework takes into account people who work in high-risk jobs like grocery stores and restaurants, should they be considering if it's green, they don't need to wear a mask and should businesses think that way as well?

Dr. Walensky:

So certainly all of those all of our recommendations, are translated into policy at the local and jurisdictional level. And we would say any, any, local, business certainly has the, ability to make, recommendations based on or policy based on where they are, whether they have, they may have more information based on wastewater or high risk communities or, or equity for many different, for many different reasons. But, our guidance would say that if you are in a green community, that ,that community in general would not need to be wearing a mask. Certainly of course, anybody can wear a mask at any time if they choose to protect themselves that way.

Stephanie Innes:

Thank you.

Benjamin Haynes:

And the last question, please?

Operator:

Yes. The last question is from Dan Petro with the Chicago Tribune, your line is now open.

Dan Petro:

Can you address, the timing of this decision and perhaps the public perception that, CDC is being pulled along here by the, the governors in, in many states who didn't wait for these new recommendations before making changes to what was being done at the state level?

Dr. Walensky:

Yes, absolutely. First I will say that we at the CDC, and I think you've heard me talk publicly about this, have been thinking about, shifting our metrics to hospitalizations for some time. Now we've been talking about this for some time. Certainly we know that many governors made announcements several weeks ago, but many of those announcements actually were phased in. And in fact, didn't acutely say they were gonna take masks off, but they were going to take masks off at the end of February or in early March or in the middle of March. So ,I would say our guidance actually probably very much intersects exactly where many of those phase approaches are going to be in that many of those governors, when they're, when their, policies are at play, will coincide with exactly what we are recommending.

Benjamin Haynes:

Thank you, Dr. Walensky, and thank you Dr. Massetti. And thank you all for joining us today. If you

have further questions, please contact the media office at 4 0 4 6 3 9 3 2 8 6 or email media@cdc.gov. Thank you.

Operator:

This concludes today's call. Thank you for your participation. May disconnect at this time.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Exhibit 17

theepochtimes.com

Unruly Air Passenger Incidents Decline Significantly After Mask Mandate Suspension

By Lorenz Duchamps Lorenz Duchamps View profile Follow

3-4 minutes 5-6-22

The Federal Aviation Administration (FAA) on Wednesday reported a sharp decline in unruly air passenger incidents just one week after a federal transportation mask mandate was vacated by a federal judge.

According to data released by the FAA, there were 1.9 incidents per 10,000 flights for the week ending April 24, compared to 4.4 reported incidents per 10,000 flights in the prior week.

U.S. District Judge Kathryn Kimball Mizelle struck down the Centers for Disease Control and Prevention's (CDC's) mask mandate for airplanes and other forms of public transportation on April 18, saying the rule exceeded the agency's statutory authority because its implementation violated administrative law.

The FAA said the average rate in the last three months of 2020 was 2.45 incidents per 10,000 flights. Some airline officials had predicted the number of unruly passenger incidents would fall sharply when the mandate was lifted.

The decrease in incidents also comes as former FAA administrator Steve Dickson implemented a "zero-tolerance policy" against unruly passenger behavior in January 2021. The policy has led to numerous hefty fines instead of warning letters or counseling that were used in previous policies.

Last month, the FAA said that its zero-tolerance policy will become permanent even after the mask mandate was lifted. The policy has decreased the rate of unruly passenger incidents by nearly 60 percent, the agency said in a statement.

"The FAA will continue to work with its airline, labor, airport and security and law enforcement partners to continue driving down the number of incidents," it said.

Airlines had reported a high number of incidents since early 2021—more than 1,000 this year alone. About 70 percent of them involved passengers who refused to wear a mask.

Since January this year, the FAA has proposed approximately $2 million in fines, the agency said in mid-April. Among those civil penalties are its "largest-ever fines" against two passengers over alleged disorderly behavior on airliners.

About 80 unruly airplane passengers have been referred to the FBI for potential criminal prosecution.

In one latest case, a 23-year-old man who was restrained in his seat with tape after groping and assaulting flight attendants during a Frontier Airlines flight from Philadelphia to Miami last year was

sentenced on May 3 to 60 days in prison.

Maxwell Berry of Ohio had pleaded guilty to three counts of assault and initially faced up to 18 months in prison. The incident was captured in cellphone videos that went viral, bringing attention to the risks faced by flight attendants due to a growing number of unruly passenger incidents.

In an emailed statement, Berry's lawyer Jason Kreiss said the incident was "truly an aberration" in his client's life and "he's a really good kid from a great family who was punished for his worst day."

Reuters contributed to this report.

From NTD News

Follow

No. 21-11532-BB

United States Court of Appeals for the 11th Circuit

LUCAS WALL,
Appellant/Plaintiff

v.

CENTERS FOR DISEASE CONTROL & PREVENTION, DEPARTMENT OF HEALTH & HUMAN SERVICES, TRANSPORTATION SECURITY ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY, & DEPARTMENT OF TRANSPORTATION,
Appellees/Defendants

Appeal from the United States District Court
for the Middle District of Florida
No. 6:21-cv-975

BRIEF OF *AMICI CURIAE* 16 DISABLED PASSENGERS IN SUPPORT OF APPELLANT URGING REVERSAL

MICHAEL FARIS *et al.*
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I. CERTIFICATE OF INTERESTED PERSONS

Pursuant to 11th Cir. R. 26.1-2(b), we certify that the CIP contained in Appellant's Opening Brief (Brief at 1-32) is correct and complete except for the addition of those signing this brief:

- Aaron Abadi
- Angela Byrd
- Anthony Eades
- Avrohom Gordon
- Charity Anderson
- Cindy Russo
- Connie Rarrick
- Devorah Gordon
- Jared Rarrick
- Jennifer Rarrick
- Leonardo McDonnell
- Michael Clark
- Michael Faris
- Michael Seklecki
- Peter Menage
- Shannon Greer Cila

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IV. *AMICI'S* INTEREST IN THE CASE

Friends of the Court are 16 Americans whose disabling medical conditions precluding us from safely wearing a mask resulted in us being blocked from flying or using ground public transportation because of the Federal Transportation Mask Mandate ("FTMM" or "Mask Mandate") issued by Appellee Centers for Disease Control & Prevention ("CDC") and its parent agency, Appellee Department of Health & Human Services ("HHS"). The FTMM was enforced by Appellee Transportation Security Administration (TSA") and its parent agency, Appellee Department of Homeland Security ("DHS") via three "Security Directives"[1] and one Emergency Amendment. We have filed more than 100 disability discrimination complaints with Appellee Department of Transportation ("DOT") but the department has only investigated seven of them, in violation of the Air Carrier Access Act ("ACAA"). We speak to the Court on behalf of the millions of disabled passengers who were banned from using public transportation in America from February 2021 to April 2022 due to the FTMM – likely the greatest government-driven exclusion of the disabled from public services in this nation's history.

[1] We agree with appellant that TSA's Mask Mandate has zero to do with transportation security, therefore we adopt the term "Health Directives" throughout the remainder of this brief to more appropriately describe TSA's orders.

1. **MICHAEL FARIS** of Elizabethtown, Kentucky, lead *amicus curiae*, is a maintenance supervisor for helicopters based in Laverne, California, that are used in the western part of the United States to suppress wildfires and perform power-line construction. He must travel on commercial airlines every 12 days for work. He is medically exempt by a neurologist from wearing a mask due to Generalized Anxiety Disorder, but the airlines refused to grant him a mask exception because of the FTMM. American Airlines banned Mr. Faris in October 2021 for simply asking for a medical waiver at check-in. Forced masking on long flights causes Mr. Faris extreme anguish. While muzzled because of the Mask Mandate, he has fainted twice, once aboard a plane (smashing his face into a galley cart) and once in a jetway about to board an aircraft, causing injury to his elbows and knees. He is now enjoying mask-free flying thanks to the *vacatur* of the FTMM and prays this Court affirms that decision and applies it to TSA and DHS as well. Mr. Faris has filed 15 disability discrimination complaints with DOT, which has not investigated any of them.
2. **AARON ABADI** of New York City suffers from Sensory Processing Disorder, which means he can't wear a mask as it creates a sensory overload and can cause major discomfort. His multiple attempts to fly on planes,

ride on trains and buses, and use rideshare car services were almost completely unsuccessful since the Mask Mandate took effect Feb. 1, 2021. Mr. Abadi's employment for 30 years has been in waste management, requiring him to travel extensively both domestically and abroad. He became unemployed – and effectively unemployable – due to the Mask Mandate. Despite his medical records, he has been denied mask exemptions by numerous airlines and filed 50 discrimination complaints with DOT. The agency has not investigated 43 of them. In the seven it did, it found three airlines violated the law but did not fine them. In four other cases, DOT determined the airlines had not failed to comply with the Air Carrier Access Act.

3. **ANGELA BYRD** of Batavia, Ohio, was unable to fly since the Mask Mandate took effect Feb. 1, 2021, because she can't wear a face mask. She objects to forced muzzling because moisture builds up inside a mask, which becomes a hotbed for bacteria and pathogens. Ms. Byrd has battled an anxiety disorder for most of her life. When she covers her nose and mouth, she feels like she can't breathe. This makes her extremely nervous, which produces a sweat response, which moistens the mask and hurts her health. She also suffers from Chronic Obstructive Pulmonary Disorder and has lost a third of her lung capacity. She easily gets short of breath

without a mask. When she dons a face covering, she doesn't get good air circulation and is forced to remove the mask to breathe. Ms. Byrd also has tachycardia. Her resting pulse will, at times, be greater than 100 beats per minute. When she gets anxious and feels as if she can't breathe, her pulse goes even higher. She is already nervous when flying. Because of the Mask Mandate, she would not put herself in a situation where she couldn't breathe freely as it would be dangerous to her health. Like so many millions of other disabled Americans, the Mask Mandate meant Ms. Byrd was excluded from using the nation's aviation and transit systems.

4. **ANTHONY EADES** of Warsaw, Missouri, has medical conditions making it impossible for him to tolerate covering his face. Being shot in 2003 in Iraq while serving in the U.S. military caused some of his disabling conditions. His upper-respiratory distress limits his ability to breathe. Even without an experimental medical device obstructing Mr. Eades' oxygen intake, he has asthma that flares up with no notice. He suffers from Traumatic Brain Injury and Post-Traumatic Stress Disorder, which cause Mr. Eades to suffer severe anxiety and claustrophobia. When something is on his face, his anxiety level kicks into high gear. Mr. Eades was denied the ability to fly by TSA and Southwest Airlines from Phoenix, Arizona, home to Kansas City, Missouri, on March 14, 2021, solely because he can't wear

a face covering. He was thrown off a flight before takeoff because he pulled his mask off his face so he could get some breaths. TSA revoked his Pre-Check membership for a year for needing to breathe, and then after Mr. Eades filed suit against the agency in the U.S. Court of Appeals for the Eighth Circuit, the agency retaliated by banning him from Pre-Check indefinitely. After this horrible harassment, Mr. Eades has yet to fly again. This has caused him to miss spending holidays with his 15-year-old from a prior marriage who lives in another state.

5. **AVROHOM GORDON** of New Richmond, Ohio, was not able to travel because of the FTMM and his inability to wear a mask due to breathing issues that he had surgery for in the past. He has missed a few important events such as a friend's wedding, children's competition celebrations, work conferences, etc. On Jan. 17, 2022, Mr. Gordon was booked on Allegiant Flight 4692 from Cincinnati (CVG) to Los Angeles (LAX). Allegiant denied Mr. Gordon's mask exemption. He was not able to travel because he has a medical disability that does not allow him to wear a mask, and masking would have been harmful to his health. Mr. Gordon was forced to cancel his trip. On Jan. 18, 2022, Mr. Gordon was booked to return home on Frontier Flight 2184 from Ontario (ONT) to Las Vegas (LAS) and then Frontier Flight 2022 from LAS to CVG. Frontier denied Mr. Gordon's

mask exemption. He was not able to travel because masking would have been harmful to his health. Mr. Gordon was forced to cancel his trip. Mr. Gordon filed discrimination charges against Allegiant and Frontier with DOT. The department has not investigated his complaints.

6. **CHARITY ANDERSON** of Toledo, Ohio, was illegally restrained, harassed, and denied access to public transportation even though she has a medical exemption from face coverings due to her permanent disabilities. She was forced to endure many obstacles in attempts to get medical exemptions. Many times her requests were denied by transportation providers, which are not licensed to practice medicine and have no capability of evaluating her conditions. The FTMM caused Ms. Anderson undue stress in her professional and personal life by greatly restricting her transportation options.
    a. She was denied access to mass transit twice last year in Memphis, Tennessee.
    b. Prohibited from flying because she can't wear a mask, she was forced to drive to every out-of-state event, resulting in additional costs and wasted time.
    c. If her car were to break down, she would have no means to move around her own city on buses because of the Mask Mandate. Being

permanently disabled, Ms. Anderson is unable to ride a bike or walk long distances.

d. A few months ago, when the FTMM was in effect, Ms. Anderson booked a flight for a business trip and was bombarded with numerous illegal obstacles and intrusive procedures she had to succumb to just to take an important work trip. Southwest Airlines then denied her medical waiver, with no opportunity to appeal to CDC, TSA, or any other federal agency. The Mask Mandate placed extreme burdens on her, restraining her freedom of movement.

7. **CINDY RUSSO** of Santa Clarita, California, was restricted from traveling due to the FTMM because she suffers from claustrophobia and Post-Traumatic Stress Disorder. She medically can't safely wear a face mask. She has missed important personal as well as work-related events as a result. When her mouth and nose are covered, it is both mentally and physically harmful to Ms. Russo. It reminds her of a traumatic situation wherein she was trapped and couldn't breathe. It is extremely harmful for her to cover her face because it produces massive anxiety. When Ms. Russo is forced by the appellees to cover her face, she feels anxious, trapped, and starts to profusely sweat. Her heart races and her head pounds. Her doctor provided her an exemption from wearing a mask, but

no airline would accept it. Ms. Russo flew eight times during the pandemic when the Mask Mandate was in effect and was harassed when she had to remove her face covering, causing even more anxiety in an already stressful medical situation. She filed charges against American Airlines and United Airlines for disability discrimination. DOT has not investigated either of her complaints.

8. **CONNIE RARRICK** of Saco, Maine, and her husband, Jared, have seven children. Five of them reside in Alabama, Indiana, Iowa, Missouri, and Tennessee. Because her family is so spread out, flying is essential for Mrs. Rarrick and her husband to visit their kids and 20 grandchildren. Being deprived of flying because of their inability to wear a mask was devastating because they lost so many opportunities to visit family.
    a. In 2021, when the FTMM was in effect, two of the Rarricks' daughters were pregnant and expecting in January 2022 (Iowa) and March 2022 (Alabama). Both had some health complications with their pregnancies. Being denied the ability to fly was upsetting and a hardship.
    b. Due to her heart condition, Mrs. Rarrick can’t tolerate wearing a face mask. Covering her nose and mouth causes her heart rate to drop, a lack of oxygen, and an increase in carbon dioxide. This all

makes her feel like she can't breathe or that she is suffocating.

c. She was illegally restricted from flying during the COVID-19 pandemic because of her inability to wear a mask. From July 2020 to February 2021, Appellee DOT refused to enforce the Air Carrier Access Act, allowing airlines to completely refuse to transport any disabled passenger who could not don a face covering. After the FTMM took effect, DOT issued a notice to airlines advising them to break the law in eight ways.

d. The Rarricks were denied the ability to fly by Southwest Airlines from Portland, Maine, to Birmingham, Alabama, solely because they can't wear masks. This trip was to visit their daughter Jacqueline and her family, as well as to attend a family reunion with numerous siblings and other relatives they had not seen in a long time. Mrs. Rarrick had recently been hospitalized and her doctor told her the only safe way for her to travel to Alabama was by air. She had to cancel the trip.

e. In December 2021, the Rarricks were not allowed to fly to visit their five out-of-state children and 20 grandchildren for Christmas. Instead, they drove about 3,000 miles in a two-week period. This lengthy time on the road caused her major complications due to

Mrs. Rarrick's heart issues. She was physically unable to enjoy the trip.

9. **DEVORAH GORDON** of New Richmond, Ohio, is the wife of Avrohom Gordon. She has a medical disability that does not allow her to wear a mask. She flew 10 times during the pandemic and was harassed about masking, causing even more anxiety to an already stressful medical situation. Her medial waivers were denied by Allegiant Air, American Airlines, and Frontier Airlines.

    a. On her most recent trip, Mrs. Gordon felt physically, emotionally, psychologically, and spiritually ill for the duration of travel Jan. 17-18, 2022, from Ohio to California and return. At both the security checkpoint and boarding gate on Jan. 17, Mrs. Gordon said she has a disability that prevents her from wearing a mask safely. TSA and Allegiant asked her if she had a medical certificate from a doctor. She responded that according to law, they may not ask her for details of her disability or require her to prove her disability with a medical certificate. TSA refused to allow her through the checkpoint without covering her face; likewise Allegiant would not let her on the plane maskless. Aboard the Allegiant aircraft, multiple threat-

ening announcements were made that according to the "law," passengers must mask or "be kicked off the plane and/or arrested, fined and/or put in jail." Mrs. Gordon went to the lavatory without a mask on. Upon exiting, an Allegiant flight attendant immediately reprimanded her strongly, stating that "You must wear the mask the whole time." While eating, an Allegiant flight attendant approached Mrs. Gordon and said "You have been told too many times to put the mask on." She complied with the orders of the flight crew and fully donned the mask for the rest of the flight, even though she had not yet finished eating and she medically can't tolerate having her breathing blocked. The Allegiant flight attendant nevertheless asked for Mrs. Gordon to surrender her ID. When she hesitated, the Allegiant employee threatened to have the police meet her at the arrival gate, where she "would be fined $10,000." When Mrs. Gordon did not comply with the request to present her identification, the Allegiant flight attendant told her she had a choice to surrender her ID or have the police meet her at the gate. Mrs. Gordon again chose not to surrender her ID because she had not violated any laws. The flight attendant replied in a nasty tone "fine, so the police will meet you at

the gate." The captain then announced on the aircraft's public-address system "There is one passenger that is not complying with the mask rules. We will give her one last chance and hope she will make the right choice, otherwise she will be met at the gate by the police." The flight attendant then came back and presented her with a written warning. When the Allegiant flight arrived at LAX, there were two police officers who met her at the gate. Mrs. Gordon agreed to speak with them. They asked her for her ID and warned that if she did not surrender it, the FBI could be called, she could go to jail, and could receive a big fine. (All of which are lies since the FTMM is not a criminal law enacted by Congress.) Mrs. Gordon eventually surrendered it, because they would not/could not give her clear information about the process when she asked and she could not think straight with the mask on. The officers gave her ID to Allegiant and then returned it to her. It soon become clear that no laws had been violated, and the airport police could not do anything further. Mrs. Gordon removed her mask and proceeded to exit the terminal without any further incident.

b. On the return trip Jan. 18 from ONT, Frontier told her at the gate to don a mask. Mrs. Gordon informed Frontier's agent that she has a

disability that does not permit her to wear a mask. Frontier informed her that this needs to be cleared in advance. Mrs. Gordon informed them that this constitutes discrimination. She demanded to speak with a supervisor. The Frontier supervisor was unable to cite any law that required her to wear a face mask. But the supervisor denied her boarding. Being coerced and under threat of being prevented from returning home, Mrs. Gordon harmed her health by donning a mask against her will. Then she was permitted to board the aircraft. On board, Frontier did not allow Mrs. Gordon to use her own mask and provided a disposable blue surgical mask to her. On the wrapper it came in, it was written: "CIVIL PROTECTION, NOT MEDICAL."

10. **JARED RARRICK** of Saco, Maine, is the husband of Connie Rarrick. Due to a brain bleed and age, he can't tolerate wearing a face mask. Covering his nose and mouth causes a lack of oxygen and an increase in carbon dioxide that causes Mr. Rarrick to feel like he can't breathe or that he is suffocating. His problems being denied the ability to fly because of the FTMM are detailed above in his wife's statement.

11. **JENNIFER RARRICK** of Saco, Maine, is the daughter of Connie and Jared Rarrick. Due to her migraines, Ms. Rarrick can't tolerate wearing a

face mask. Covering her nose and mouth not only causes a migraine within 15 minutes, but also causes a lack of oxygen and an increase in carbon dioxide that causes her to feel like she can't breathe or is suffocating. She currently lives with her parents. Due to her mother's poor health after their forced 3,000-mile road trip to visit family for the winter holidays, she missed various events due to caring for her mom. When the Rarricks arrived home, her mother was ill from January until May. Mrs. Rarrick is still dealing with complications from not having enough time to rest between driving days. Ms. Rarrick has not been able to work due to caring for her mother.

12. **LEONARDO McDONNELL** of Aventura, Florida, was banned from riding Space Coast Transit vehicles in Melbourne, Florida, because of his inability to mask due to several medical conditions. He also suffered harassment several times when flying Delta Air Lines without a mask, including one flight where the attendants constantly berated him for not muzzling even though he has a written mask exemption.

13. **MICHAEL CLARK** of Toledo, Ohio, fiancé of Charity Anderson, encountered harassment and intimidation as well as was denied access to public transportation due to the Mask Mandate even though he has a mask exemption from his doctor. He does not own a car and in the past

used public transportation regularly. The FTMM limited his ability to function on a day-to-day basis. Barred from the Toledo bus system, he was unable to do simple things such as going to the doctor or college in person. The Mask Mandate represents an attack on the disabled, especially working-class citizens such as Mr. Clark who do not have expendable income to travel privately in their own automobiles.

14. **MICHAEL SEKLECKI** of Austin, Texas, (formerly of Lake Mary, Florida), can't wear a mask because of his anxiety disorder. Covering his face makes it uncomfortable for him to breathe. He presents as an *amicus curiae* on behalf of himself and his 5-year-old son, M.S. His son also can't tolerate having his breathing blocked. M.S. struggles with behavioral and developmental delays due to Autism Spectrum Disorder. This disorder prevents M.S. from being able to wear a face mask or shield. M.S. received for several months in 2021 and 2022 specialized medical treatment at Boston Children's Hospital in Massachusetts for severe gastroenterology disorders that Florida physicians had been unable to diagnose and treat. Mr. Seklecki and M.S. had to fly from Orlando to Boston often for medical care. They were banned by Frontier Airlines solely because M.S. can't wear a mask. Other airlines harassed and demeaned the family. Being denied the right to fly because they can't wear masks nearly jeopardized

M.S.' life as it wasn't practical for them to make the lengthy drive to and from Boston every time he had a medical appointment. Mr. Seklecki has filed several DOT complaints, none of which the department has investigated.

15. **PETER MENAGE** of Wasilla, Alaska, lost his job as an equipment operator at the North Slope oilfields along the Arctic Ocean because Alaska Airlines banned him from flying for eating breakfast without a mask on. Alaska is the only airline flying from Anchorage to Deadhorse, where Mr. Menage reported for work on a three weeks on/three weeks off schedule. Due to respiratory issues, Mr. Menage can't tolerate wearing a face mask. Covering his nose and mouth prevents proper breathing including faintness, hyperventilation, anxiety, and more. He obtained a medical mask exemption from his doctor Dec. 18, 2020. Mr. Menage contacted Alaska Airlines on numerous occasions, including in person at the ticket counter and via e-mail, presenting his medical waiver. On each occasion, he was informed that it would not be accepted. Because he had to fly to maintain his employment, Mr. Menage had to suffer with a mask on during the trips from Anchorage to Deadhorse and back. On one occasion, upon presenting his exemption letter to TSA personnel at the security checkpoint, an Alaska Airlines representative intervened and threatened

to ban him from the Deadhorse airport. On another occasion, Alaska's staff forbade Mr. Menage from consuming food or drinks for the duration of the flight even though the FTMM contains exemptions for eating and drinking. He was harassed and threatened with being banned from the airline, a threat Alaska carried out on a subsequent flight when Mr. Menage was not wearing a mask while eating breakfast.

16. **SHANNON GREER CILA** of Louisville, Kentucky, has a qualifying disability that makes it medically harmful for her to wear a mask. She was discriminated against by Southwest, Alaska, Delta, Frontier, and Spirit airlines. Covering her nose and mouth impairs Mrs. Cila's ability to remain calm, breathe, see, smell, taste, hear, keep her face clean, protect her immune system from accumulated bacteria and other unknown toxins, and to express herself and communicate effectively with others. She suffered numerous travel hassles and deprivations because of the FTMM:

    a. Mrs. Cila's husband, Eric, and her wanted to attend their dear friends' wedding in Houston, Texas. Because airlines were banning the disabled, she had to choose either to not to go or to drive down from Louisville because of her disabilities that prevent her from safely wearing a mask. This was emotionally painful, embarrassing, humiliating, and distressing, amplifying her medical symptoms and

causing a serious rift in her marriage. For Mrs. Cila to attend the wedding with her husband, she was forced to travel by herself by car from Louisville to Houston in her personal vehicle, which is old. The car broke down several times on the way there and back. The trip to and from Houston was more than 17 hours each way – a grueling drive for anyone who is not accustomed to motoring often. She suffered many expenses. For example, Mr. Cila accidentally flew home with her car keys. He had to pay more than $100 to overnight them back to her. It caused a great deal of emotional distress, strain, and hardship because her plans were further delayed to get back home. That never would have happened had she been able to accompany her spouse on the flights to/from Houston.

b. After the wedding, Mrs. Cila's paternal uncle died. She was not able to attend his funeral in eastern Texas with the rest of her family because of the FTMM.

c. Mrs. Cila's disabled, elderly father fell in his home in July 2021 in Trinity, Texas, where he resides in a rural location. He could not get to the Department of Veterans Affairs hospital in Houston, a two-hour drive, on his own. He went without medical care for two weeks before he could be seen. She couldn't go look after him because of

the FTMM banning her from flying. This put his life in direct danger because it was a bad fall and he shattered his humerus bone. He suffers from nerve damage from Agent Orange exposure during his military service. He has trouble using his legs and arms. Mrs. Cila feared for his life and wellbeing, yet she could not fly to be there for him because of the Mask Mandate.

d. Mrs. Cila had to travel by car to New York due to the FTMM. Her nondisabled friends, who were able to fly to the same event in New York, did not have to contend with the road dangers she did. Mrs. Cila had to rent a car for the trip because her vehicle is not reliable.

e. In September 2021, an employee and friend of her husband's died in Michigan. Mrs. Cila needed to fly the next day to attend the funeral, but there would not have been time to attempt to jump through all the airlines' arbitrary mask exemption hoops and paperwork because the FTMM unlawfully permitted air carriers to require advance notice (of up to 10 days) before a disabled person needing a mask waiver flies. This illegally denied disabled people the ability nondisabled Americans have to travel last minute when emergencies such as deaths occur. Mrs. Cila could not attend the funeral.

f. Later in September 2021, Mrs. Cila wanted to fly to Chicago to celebrate her birthday with her twin but could not do so because again her medial exemptions were refused by airlines due to the FTMM.

We submit this brief pursuant to FRAP 29. We consulted with Appellant Lucas Wall and appellees' counsel Alisa Klein, who both consented to this filing.

No party's counsel authored this brief in whole or part. No party or their counsel contributed money that was intended to fund preparing or submitting the brief. No person other than those signing this brief contributed money that was intended to fund preparing or submitting this document.

V. ARGUMENT SUMMARY

We support Appellant Lucas Wall's arguments that the Mask Mandate is *ultra vires* and should remain vacated worldwide pursuant to the decision in the related case of *Health Freedom Def. Fund v. Biden,* No. 8:21-CV-1693, 2022 WL 1134138 (M.D. Fla. Apr. 18, 2022); appeal pending No. 22-11287 (11th Cir.) ("*HFDF*"). This Court needs to go beyond the three findings of Judge Mizelle in *HFDF*, however, and rule in Mr. Wall's favor on the additional claims he presented below that were not addressed in the related action. The Court must reverse Judge Byron's dismissal of claims against TSA, DHS, and DOT; declare the FTMM violates the ACAA; and hold that the FTMM also runs afoul of three constitutional provisions and two international treaties that Congress demands the Executive Branch enforce in the aviation sector. The result of these two appeals should be a permanent injunction prohibiting the government appellees from ever reissuing a Mask Mandate or International Traveler Testing Requirement ("ITTR") ever again.

Like our friends the 313 Airline Workers, we focus this brief on our opposition to the Mask Mandate due to the constraint of FRAP's 6,500-word argument limit, which does not provide us space to also address the ITTR. We adopt by reference the entire *amicus curiae* brief filed earlier today by our

friends the 3 Dual Citizens (Uri Marcus, Yvonne Marcus, and Kleanthis Andreadakis), who are also disabled passengers the government and airlines restricted from flying due to the FTMM.

The Mask Mandate caused us incredible harm, all because of our medical conditions that make it unsafe for us to wear a mask. CDC's FTMM Order and TSA's Health Directives and Emergency Amendment all proclaimed the disabled who can't safely cover their faces are exempt, but then DOT put out guidance to the airlines it regulates that they are free to break the law in at least eight ways. CDC and TSA also included numerous provisions in the Mask Mandate that violate the Air Carrier Access Act, which Congress passed in 1986 to protect the disabled from discrimination in the provision of air transportation.

Some of us were totally banned from flying for 14½ months because airlines refused repeatedly our medical waivers despite documentation from our physicians that we can't safely wear masks. Thankfully the FTMM is not currently in effect, but it's critical this Court ensure it can never be brought back.

VI. ARGUMENT

A. The Mask Mandate discriminates against the disabled in violation of the Air Carrier Access Act, Americans with Disabilities Act, and Rehabilitation Act.

Thanks to the FTMM, millions of Americans who can't wear face coverings because of medical conditions were essentially banned from using all modes of public transportation nationwide for 14½ months for no rational reason. This grossly violates three federal laws protecting the disabled from discrimination: the ACAA (49 USC § 41705), which applies to airlines; the ADA, which applies to ground transportation providers; and the Rehabilitation Act, which applies to all entities receiving federal financial assistance (which included airlines during the COVID-19 pandemic and most state/local transit authorities). We will focus our argument on the ACAA since that's what Mr. Wall addressed below.

Under CDC's FTMM Order, a person with a disability who can't safety wear a mask is supposed to be exempt. However, the CDC Order goes on to place numerous restrictions on obtaining a mask waiver that violate the ACAA:

> "Operators of conveyances or transportation hubs may impose requirements, or conditions for carriage, on persons requesting an exemption from the requirement to wear a mask, including **medical consultation by a third party, medical documentation by a licensed medical provider, and/or other information as determined by the operator, as well as**

> **require evidence that the person does not have COVID-19 such as a negative result from a SARS-CoV-2 viral test or documentation of recovery from COVID-19. … Operators may further require that persons seeking exemption from the requirement to wear a mask request an accommodation in advance**." App. 494 (emphasis marks provisions that violate the ACAA).

Here's an excerpt of TSA Health Directive SD 1544-21-02D with illegal sections highlighted in bold underline and corresponding DOT regulations placed in brackets:

> "Aircraft operators **may impose requirements, or conditions of carriage, on persons requesting an exemption from the requirement to wear a mask [1]**, including **medical consultation by a third party [2], medical documentation by a licensed medical provider [3], and/or other information as determined by the aircraft operator [4]**, as well as **require evidence that the person does not have COVID-19 such as a negative result from a SAR-CoV-2 viral test or documentation of recovery from COVID-19 [5].** … Aircraft operators may also impose additional protective measures that improve the ability of a person eligible for exemption to maintain social distance (separation from others by 6 feet), such as **scheduling travel at less crowded times or on less crowded conveyances [6], or seating or otherwise situating the individual in a less crowded section of the conveyance [7]** or airport. Aircraft operators may further require that persons seeking exemption from the requirement to wear a mask **request an accommodation in advance [8]**." App. 515.

Air Carrier Access Act regulations violated:

1. "[Y]ou must not refuse to provide transportation to a passenger with a disability on the basis of his or her disability…" 14 CFR § 382.19(a).

2. Since airlines may not require a medical certificate for a passenger unless he/she has a communicable disease (14 CFR § 382.23(a)), they may also not require a third-party medical consultation. 14 CFR § 382.23(d).
3. "[Y]ou must not require a passenger with a disability to have a medical certificate as a condition for being provided transportation…" 14 CFR § 382.23(a). "You may … require a medical certificate for a passenger if he or she ***has*** a communicable disease or condition that could pose a direct threat to the health or safety of others on the flight." 14 CFR § 382.23(c)(1) (emphasis added).
4. Airlines are prohibited from requiring that a passenger wear a face covering or refuse him/her transportation unless they determine that the passenger "has" a communicable disease and poses a "direct threat" to other passengers and the flight crew. 14 CFR § 382.21. "In determining whether an individual poses a direct threat, you must make an ***individualized assessment***." 14 CFR § 382.19(c)(1) (emphasis added).
5. No provision of the Air Carrier Access Act or its accompanying regulations permits TSA to allow airlines to require that passengers submit a negative test for any communicable disease. Mandating disabled flyers needing a mask exemption submit a COVID-19 test before checking in

but not requiring the same of nondisabled travelers is illegal discrimination. "[Y]ou must not subject passengers with a disability to restrictions that do not apply to other passengers…" 14 CFR § 382.33(a).

6. "[Y]ou must not limit the number of passengers with a disability who travel on a flight." 14 CFR § 382.17.
7. "[Y]ou must not exclude any passenger with a disability from any seat or require that a passenger with a disability sit in any particular seat, on the basis of disability…" 14 CFR § 382.87(a).
8. "[Y]ou must not require a passenger with a disability to provide advance notice of the fact that he or she is traveling on a flight." 14 CFR § 382.25.

CDC and TSA's Mask Mandate violates provisions of federal law enacted by Congress and regulations duly promulgated by DOT that protect the disabled from discrimination. These agencies do not have a license to allow airlines to violate the law. "[T]he meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand." *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132 (2000).

With the appellee agencies telling airlines and other transportation providers that they may ignore anti-discrimination laws, most chose to ban the

disabled from boarding. Our numerous attempts to gain exemptions proved futile, just as Navy personnel experienced in seeking waivers from a vaccine mandate.

> "The Navy provides a religious accommodation process, but by all accounts, it is theater. … It merely rubber stamps each denial. … Religious exemptions to the vaccine requirement are virtually non-existent. … the record indicates the denial of each request is predetermined. As a result, Plaintiffs need not wait for the Navy to engage in an empty formality. … The Court finds that exhaustion is futile and will not provide complete relief… In essence, the Plaintiffs' requests are denied the moment they begin. *U.S. Navy SEALs 1-26 v. Biden*, No. 4:21-cv-1236 (N.D. Tex. Jan. 3, 2022) (enjoining Navy's vaccine mandate).

Unlike with the Navy's vaccine dictate, the Mask Mandate doesn't even provide the disabled any process for seeking a medical waiver from a government agency. CDC and TSA instead give private companies the power to "consider" mask exemptions, virtually all of which are refused, making it a futile gesture to seek a nonexistent exemption.

> "The judiciary is the final authority on issues of statutory construction and must reject administrative constructions which are contrary to clear congressional intent. If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect." *Chevron v. Natural Resources Defense Council*, 467 U.S. 837 (1984).

It can't be disputed that Congress' intentions are to ensure the disabled, a disadvantaged minority class, are protected from discrimination. Yet DOT put out a Notice of Enforcement Policy advising airlines they may ignore the

ACAA. App. 500-507.

Information provided to passengers by DOT contradicts the Notice. In a document "New Horizons: Information for the Air Traveler with a Disability," DOT informs flyers, *inter alia*, that "Airlines may not require passengers with disabilities to provide advance notice of their intent to travel or of their disability…" App. 569.

> "If a person who seeks passage ***has*** an infection or disease that would be transmittable during the normal course of a flight, and that has been ***deemed so*** by a federal public health authority knowledgeable about the disease or infection, then the carrier may: … Impose on the person a condition or requirement not imposed on other passengers (e.g., wearing a mask)." App. 573. (emphases added).

DOT publishes a 190-page handbook "What Airline Employees, Airline Contractors, & Air Travelers with Disabilities Need to Know About Access to Air Travel for Persons with Disabilities: A Guide to the Air Carrier Access Act (ACAA) and Its Implementing Regulations…" Relevant excerpts of this handbook are at App. 574-604. "If, in your estimation, a passenger ***with a communicable disease or infection*** poses a direct threat to the health or safety of other passengers, you may … (iii) impose on that passenger a special condition or restriction (e.g., wearing a mask)." *Id*.

But the FTMM unlawfully permitted airlines to require everyone to wear a mask, regardless of whether they had tested positive for COVID-19 or not.

B. DOT must be held to account for telling airlines they may violate the law.

We have filed more than 100 complaints with DOT regarding the airlines' discrimination, but the department has only investigated seven of those. Outrageously it agreed with Mr. Abadi on three occasions that airlines broke the law, but imposed no penalty.

DOT's Notice of Enforcement Policy created immense confusion because on the one hand it recognizes that banning the disabled from flying is illegal:

> "The CDC and other medical authorities recognize that individuals with certain medical conditions may have trouble breathing or other difficulties such as being unable to remove the mask without assistance if required to wear a mask that fits closely over the nose and mouth. … It would be a violation of the ACAA to have an exemption for children under 2 on the basis that children that age cannot wear or safely wear a mask and not to have an exemption for … individuals with disabilities who similarly cannot wear or safely wear a mask when there is no evidence that these individuals with disabilities would pose a greater health risk to others." App. 502.

> "The ACAA prohibits U.S. and foreign air carriers from denying air transportation to or otherwise discriminating in the provision of air transportation against a person with a disability by reason of the disability. When a policy or practice adopted by a carrier has the effect of denying service to or otherwise discriminating against passengers because of their disabilities, the Department's disability regulations in Part 382 require the airline to modify the policy or practice as necessary to provide nondiscriminatory service to the passengers with disabilities …" App. 503.

Yet DOT went on to tell airlines they may violate its own ACAA regulations due to the FTMM Order issued by CDC/HHS and the Health Directives published by TSA/DHS. The district court erred in dismissing Mr. Wall's claims against DOT on jurisdictional grounds. Because DOT's Notice of Enforcement Policy is not an order of the secretary of transportation, the Court of Appeals does not have exclusive jurisdiction. The claims against DOT were properly filed in district court and should have been adjudicated there. DOT should be forced to obey its statutory duty to investigate all complaints of disability discrimination and a writ of mandamus should issue directing it to rescind the offensive Notice of Enforcement Policy.

C. The Mask Mandate failed to give us constitutionally required due process as CDC and TSA did not allow appeals when airlines and other transport providers refused to honor our medical exemptions.

CDC and TSA gave transportation operators sole authority to determine if a passenger with a medical disability qualified for the exemption. This is not constitutionally permissible. Anyone denied a waiver must have the opportunity to have a speedy pre-deprivation hearing before someone such as a CDC or TSA administative law judge before they are prohibited from traveling because the Constitution guarantees our right to interstate movement.

> "The right to travel, to go from place to place as the means of transportation permit, is a natural right… A restraint imposed by the Government of the United States upon this liberty, therefore, must conform with the provision of the Fifth Amendment that 'No person shall be … deprived of … liberty … without due process of law'. … What is involved at the present stage is a question of substantive due process – whether the refusal for the reason given, as alleged in the complaint and undisputed thus far by the Secretary, was arbitrary. If so, it is not a valid foundation for the denial, for the Government may not arbitrarily restrain the liberty of a citizen to travel…" *Shachtman v. Dulles*, 225 F.2d 938, 941 (D.C. Cir. 1955).

> "Undoubtedly the right of locomotion, the right to remove from one place to another according to inclination, is an attribute of personal liberty, and the right, ordinarily, of free transit from or through the territory of any state is a right secured by … the Constitution. … The liberty, of which the deprivation without due process of law is forbidden, 'means not only the right of the citizen to be free from the mere physical restraint of his person, as by incarceration, but the term is deemed to embrace the right of the citizen to be free in the enjoyment of all his faculties; to be free to use them in all lawful ways…" *Williams v. Fears*, 179 U.S. 270, 274 (1900).

Under the due-process clause of the Fifth Amendment, the government may not revoke a passport or deny renewal without a hearing. *Bauer v. Acheson*, 106 F. Supp. 445, 448 (D.D.C 1952). It follows that likewise, the government may not revoke a disabled passenger's right to fly or use other modes of public transportation without a hearing.

> "[F]reedom to travel … like other rights, is subject to reasonable regulation and control in the interest of the public welfare. However, the Constitution requires due process and equal protection of the laws in the exercise of that control. … This court is not willing to subscribe to the view that the executive power

> includes an absolute discretion which may encroach on the individual's constitutional rights." *Id.*

As a result of the *Bauer* decision, the State Department hired hearing examiners and created a Board of Passport Appeals. *Aptheker v. Sec'y of State*, 378 U.S. 500, 503 (1964). Here, if CDC and/or TSA ever are legally allowed to issue another Mask Mandate, the Court must order them to create an office for hearings when the disabled are denied the right to travel (because we can't wear masks) to review if a medical exemption applies.

> "Free movement by the citizen is of course as dangerous to a tyrant as free expression of ideas or the right of assembly and it is therefore controlled in most countries in the interests of security. ... Freedom of movement, at home and abroad, is important for job and business opportunities – for cultural, political, and social activities – for all the commingling which gregarious man enjoys. ... Freedom of movement is kin to the right of assembly and to the right of association. These rights may not be abridged..." *Aptheker* at 519.

"The right of interstate travel has repeatedly been recognized as a basic constitutional freedom. ... Less drastic means, which do not impinge on the right of interstate travel, are available... other mechanisms to serve that purpose are available which would have a less drastic impact on constitutionally protected interests" such as using Do Not Board and Lookout (App. 605-609) to block sick passengers from boarding rather than forcing every traveler to obstruct his breathing. *Mem'l Hosp. v. Maricopa Cnty.*, 415 U.S. 250 (1974). CDC and and TSA "have not met their heavy

burden of justification, or demonstrated that … in pursuing legitimate objectives, [they have] chosen means which do not unnecessarily impinge on constitutionally protected interests." *Id.* There's nothing in the administrative record showing that CDC and TSA even considered using the Do Not Board and Lookout databases rather than impose the FTMM.

> "The right to travel is an 'unconditional personal right,' a right whose exercise may not be conditioned. … [The government] cannot choose means that unnecessarily burden or restrict constitutionally protected activity. Statutes affecting constitutional rights must be drawn with 'precision,' … and must be 'tailored' to serve their legitimate objectives. And if there are other, reasonable ways to achieve those goals with a lesser burden on constitutionally protected activity, a State may not choose the way of greater interference. If it acts at all, it must choose 'less drastic means.'" *Dunn v. Blumstein*, 405 U.S. 330, 341 (1972).

Courts have found that a traveler placed on the government's terrorist No Fly List must be provided due process. The same applies here to travelers prohibited medical exemptions to the Mask Mandate.

> "The List significantly interferes with Mohamed's fundamental right to interstate travel and is therefore subject to strict scrutiny. … Although the List does not prevent designees from traveling domestically, it limits their practical ability to do so. … placement on the No Fly List does far more than 'significantly discourage' designees from traveling; it often absolutely bars them from so doing and effectively precludes them from engaging in a wide range of constitutionally protected activities." *Mohamed v. Holder*, 266 F. Supp. 3d 868, 879 (E.D. Va. 2017).

> "The Supreme Court has consistently held that the state cannot deprive a person of a liberty … interest protected by the Due Process Clause of the Fifth … Amendment without a hearing. 'As our decisions have emphasized time and again, the Due Process Clause grants the aggrieved party the opportunity to present his case and have its merits fairly judged.' '[S]ome kind of hearing is required at some time before a person is finally deprived of" property or liberty interests. 'A fundamental requirement of due process is 'the opportunity to be heard.' It is an opportunity which must be granted at a meaningful time and in a meaningful manner.'" *DeNieva v. Reyes*, 966 F.2d 480, 485 (9th Cir. 1992) (internal citations omitted).

D. The Mask Mandate and lack of appeals process violates our constitutional right to travel.

The FTMM compels the disabled to choose between protecting our health or exercising our right to travel. Such coercion is constitutionally impermissible. Also, the district court ignored that the disabled in particular have a statutory right that supplements our constitutional freedom of movement:

> "A citizen of the United States has a public ***right*** of transit through the navigable airspace. To further that right, the Secretary of Transportation shall consult with the Architectural and Transportation Barriers Compliance Board … before prescribing a regulation or issuing an order or procedure that will have a significant impact on the accessibility of commercial airports or commercial air transportation for handicapped individuals." 49 USC § 40103 (emphasis added).

Courts are "tasked with upholding the Constitution and redressing fundamental rights because – no matter how dire the crisis – constitutional protections remain commandments, not suggestions. … just because COVID-19

continues to linger, that is not an invitation to 'slacken … enforcement of constitutional liberties.'" *Air Force Officer v. Austin*, No. 5:22-cv-9, 2022 WL 468799 (M.D. Ga. Feb. 15, 2022).

> "It is a familiar and basic principle, recently reaffirmed in *NAACP v. Alabama*, 377 U.S. 288, 307 … that 'a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.'" *Aptheker* at 500.

Strict scrutiny applies to deprivations of the constitutional right to interstate travel since it is a fundamental right deeply rooted in our nation's history and traditions. "[T]he 'constitutional right to travel from one State to another' is firmly embedded in our jurisprudence. … the right is so important that it is 'assertable against private interference as well as governmental action … a virtually unconditional personal right, guaranteed by the Constitution to us all.'" *Saenz v. Roe*, 526 U.S. 489, 498 (1999). "History and tradition establish the importance of the right to international travel, importance which suggests heightened scrutiny of incursions on that right. Supreme Court precedent bolsters that suggestion." *Maehr v. Dep't of State*, 5 F.4th 1100, 1112 (10th Cir. 2021), *cert. denied* 142 S. Ct. 1123 (2022).

"Strict scrutiny is a searching examination, and it is the government that bears the burden" of proof. *Fisher v. University of Texas*, 570 U.S. 297, 310

(2013). Specifically, the government must establish that a mandate is "justified by a compelling governmental interest and … narrowly tailored to advance that interest." *Church of the Lukumi Babalu Aye v. Hialeah*, 508 U.S. 520, 531-532 (1993). The FTMM fails strict scrutiny because there are far less restrictive options available to advance the federal government's asserted interest in combatting the spread of COVID-19 such as using Do Not Board and Lookout to stop ill travelers from boarding. App. 605-609.

If there are other reasonable ways to achieve an agency's goal with a lesser burden on constitutionally protected activity, it may not choose the way of greater interference. If it acts at all, it must choose "less drastic means." *Shelton v. Tucker*, 364 U.S. 479, 488 (1960); *see also Dunn v. Blumstein*, 405 U.S. 330, 343 (1972).

"[T]he government has the burden to establish that the challenged law satisfies strict scrutiny. … [N]arrow tailoring requires the government to show that measures less restrictive of the [constitutionally protected] activity could not address its interest in reducing the spread of COVID." *Tandon v. Newsom*, 141 S.Ct. 1294 (2021).

The district court accepted the government's absurd argument that depriving a person of using airplanes and other modes of mass transit doesn't interfere with the constitutional right to interstate travel because we could

still drive ourselves. But several of us don't own cars, and those that do suffered through arduous roadtrips that took days instead of a flight that would have taken but a few hours.

> "As a practical matter, an affected person is restricted in his ability to visit family and friends located in relatively distant areas of the country or abroad, which through flight can be reached within a matter of hours but would otherwise take days, if not weeks, to access. An inability to travel by air also restricts one's ability to associate more generally, and effectively limits educational, employment, and professional opportunities. It is difficult to think of many job categories of any substance where an inability to fly would not affect the prospects for employment or advancement; one need only reflect on how an employer would view the desirability of an employee who could not travel by air. An inability to fly likewise affects the possibility of recreational and religious travel, given the time periods usually available to people, particularly those who are employed." *Mohamed v. Holder*, 995 F. Supp. 2d 520, 528 (E.D. Va. 2014) (internal citations omitted).

E. The Mask Mandate is not authorized by the Public Health Service Act.

Mr. Wall's opening brief explores in great detail why the Public Health Service Act ("PHSA") does not authorize CDC and HHS to mandate masking. We wish to add a few additional observations. Masks are definitely not a "sanitation" measure.

Federal law defines a "marine sanitation device" as "any equipment for installation on board a vessel which is designed to receive, retain, treat, or discharge sewage, and any process to treat such sewage." 33 USC §

1322(a)(5). Similarly, federal railroad regulations define "unsanitary" as "any condition in which any significant amount of filth, trash, or human waste is present in such a manner that a reasonable person would believe that the condition might constitute a health hazard." 49 CFR § 229.5.

"A court does not simply assume that a rule is permissible because it was purportedly adopted pursuant to an agency's rulemaking authority." *New York Stock Exch. v. SEC*, 962 F.3d 541, 546 (D.C. Cir. 2020) (citing *Michigan v. EPA*, 576 U.S. 743 (2015)). So too here. CDC's general authority in the PHSA "to make and enforce such regulations as in [its] judgment are necessary," 42 USC § 264(a), "does not afford the agency authority to adopt regulations as it sees fit with respect to all matters covered by the agency's authorizing statute." *Id.* at 554.

Post hoc rationalizations of agency action offered in litigation are insufficient. CDC's attempt to justify the FTMM as being a "sanitation" measure when the word was never used in the order is nothing more than after-the-event explanation of counsel. *See Clean Wis. v. EPA*, 964 F.3d 1145, 1163, 1167 (D.C. Cir. 2020) (holding EPA designations unlawful because "we cannot accept … counsel's *post hoc* rationalizations for agency action").

> "The Department's interpretation goes too far. The first sentence of § 264(a) is the starting point in assessing the scope of the Secretary's delegated authority. But it is not the ending point. While it is true that Congress granted the Secretary broad authority to

> protect the public health, it also prescribed clear means by which the Secretary could achieve that purpose. … An overly expansive reading of the statute that extends a nearly unlimited grant of legislative power to the Secretary would raise serious constitutional concerns, as other courts have found. … Congress did not express a clear intent to grant the Secretary such sweeping authority." *Alabama Ass'n of Realtors v. HHS*, No. 20-cv-3377 (D.D.C. May 5, 2021) (vacating CDC's Eviction Moratorium).
>
> "The lack of express terms within the statute is significant: even 'broad rulemaking power must be exercised within the bounds set by Congress,' *Merck & Co. v. HHS*, 385 F. Supp. 3d 81, 92, 94 (D.D.C. 2019), aff'd 962 F.3d 531 (D.C. Cir. 2020) (stating that 'agencies are 'bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes'); and the CDC 'does not [have the] power to revise clear statutory terms,' *Util. Air Reg. Grp. v. EPA*, 573 U.S. 302, 327 (2014)." *Huisha-Huisha v. Mayorkas*, No. 21-cv-100 (D.D.C. Sept. 16, 2021) (enjoining CDC's Migrant Expulsion Order due to COVID-19).

As the district court noted in this case, "the statutory context implies a narrow grant of authority to the CDC to issue public health measures related or incident to quarantine. Section 361 appears under Part G of the PHSA, titled "Quarantine and Inspection,"…" App. 464. Yet Judge Byron went on to ignore this narrow grant and find that the PHSA does authorize masking as a "sanitation" measure. That finding has to be overturned.

To avoid constitutional problems such as the Nondelegation Doctrine, the Court should reject CDC's interpretation of § 264(a) as unreasonable. *P.J.E.S. v. Wolf*, No. 1:20-cv-2245, 2020 WL 5793305 at *14 (D.D.C. Sept. 25, 2020) (rejecting the government's "breathtakingly broad" interpretation

of 42 USC § 265, because "it would raise serious constitutional issues").

> "The powers that Congress afforded the Agency Defendants within the statute above do not include, or imply, the power to impose vaccine and/or mask mandates. … the Head Start Mandate is a decision of vast economic and political significance. … Like the CDC, the statute upon which Agency Defendants base their authority has never been used to impose a mandatory specific medical treatment… If the Executive branch is allowed to usurp the power of the Legislative branch to make laws, then this country is no longer a democracy – it is a monarchy. This two-year pandemic has fatigued the entire country. However, this is not an excuse to forego the separation of powers. If the walls of separation fall, the system of checks and balances created by the founders of this country will be destroyed." *Louisiana v. Becerra*, No. 3:21-cv-4370 (W.D. La. Jan. 1, 2022) (enjoining HHS' mask-and-vaccine mandate for Head Start).

F. The Mask Mandate is not authorized by CDC's regulations.

CDC cited several regulations in attempt to justify the legality of the FTMM, which notably is an order, not a duly promulgated regulation. When "the measures taken by health authorities of any State … are insufficient to prevent the spread of any of the communicable diseases … [the CDC director] may take such measures to prevent such spread of the diseases … including … sanitation … of animals or articles believed to be sources of infection." 42 CFR § 70.2. But CDC's director never determined which states had "insufficient" public-health measures, instead issuing a blanket statement that any state that doesn't require masks is deficient, despite there being no scientific

evidence to support masking, as our friends the 3 Industrial Hygiene Experts note in the *amicus curiae* brief they filed earlier today.

42 CFR § 71.31(b) likewise provides no authority for the FTMM. This provision states the CDC director "may require detention of a carrier until the completion of the measures outlined in this part that are necessary to prevent the introduction or spread of a communicable disease." This applies *after* a plane or ship arrives in the United States from abroad. It does not authorize masking during the international trip nor on any domestic flight.

The government also points to 42 CFR § 71.32(b), which allows CDC's director, when he/she "has reason to believe that any ***arriving carrier or article or thing*** on board the carrier is or may be infected or contaminated with a communicable disease, he/she may require detention, disinfection, disinfestation, fumigation, or other related measures…" (emphasis added). A human being is not a transportation "carrier" nor an "article or thing." And the regulation only applies to an *arriving* transportation carrier from a foreign country. No authorization for masking can be found here.

The title of this subpart confirms our contentions: "42 CFR Subpart D – Health Measures at U.S. Ports: Communicable Diseases." The regulations apply only upon arrival at ***U.S. ports of entry***, not to in-transit masking.

Finally, the other three regs cited (42 CFR §§ 70.3, 70.6, and 70.12) only apply to "A person who has a communicable disease," not every single person traveling on any form of public transportation.

> "[I]f CDC promulgates regulations the director finds 'necessary to prevent' the interstate or international transmission of a disease, the enforcement measures must resemble or remain akin to 'inspection, fumigation, disinfection, sanitation, pest extermination, destruction of infected animals or articles.' … never has CDC implemented measures as extensive, disabling, and exclusive as those under review in this action. However, in this action CDC claims a startlingly magnified power. … CDC's assertion of a formidable and unprecedented authority warrants a healthy dose of skepticism. … Both text and history confirm that the conditional sailing order exceeds the authority granted to CDC by Section 264(a). And if Section 264 fails to confer the statutory authority for the conditional sailing order, the regulations implementing Section 264 can grant no additional authority." *Florida v. Becerra*, 544 F. Supp. 3d 1241 (M.D. Fla. 2021) (enjoining CDC's pandemic restrictions for cruiseships).

Congress never authorized a Mask Mandate. Even if it did, it's quite possible Congress lacks authority to enact one, let alone an executive agency.

> "[T]he Commerce Clause does not empower Congress 'to regulate individuals precisely because they are doing nothing.' … it suggests that a broad mandate (e.g., one that generally requires individuals to wear masks) may be particularly susceptible to challenge because such a mandate could be construed as compelling individuals who are 'doing nothing' to engage in an activity – mask wearing – that is not even a commercial activity," according to Congressional Research Service.

Even if FTMM does not exceed Congress' authority under the Commerce Clause, it at a minimum fails the statute's interstate requirement because

more than 90% of public-transportation trips every day are intrastate. *See United States v. Lopez*, 514 U.S. 549 (1995) (discussing a lack of congressional findings regarding the effect on interstate commerce).

G. The Mask Mandate is arbitrary and capricious.

An order is arbitrary and capricious if it fails to "comply with [the agency's] own regulations," *Nat'l Env't Dev. Ass'n Clean Air Project v. EPA*, 752 F.3d 999, 1009 (D.C. Cir. 2014). As addressed above in Section F, CDC ignored its own regulations in promulgating the FTMM, one of many problems with the mandate the district court failed to address.

It's disturbing Judge Byron ignored the thousands of pages of evidence Mr. Wall submitted clearly showing the Mask Mandate had no basis in science. He did not address a single page of documents filed by Mr. Wall to rebut CDC's administrative record.

> "[D]istrict courts are permitted to admit extra-record evidence: (1) if admission is necessary to determine 'whether the agency has considered all relevant factors and has explained its decision,' (2) if 'the agency has relied on documents not in the record,' (3) 'when supplementing the record is necessary to explain technical terms or complex subject matter,' or (4) 'when plaintiffs make a showing of agency bad faith.'" *Lands Council v. Powell*, 395 F.3d 1019, 1030 (9th Cir. 2005).

During December 2021 and January 2022, as the mild Omicron variant spread across the United States, masks did nothing to stop it – a topic the

district court ignored. This was evidenced by the tens of thousands of flights that were canceled during the winter holidays because airline crews – who are forced to mask due to the FTMM – became infected in enormous numbers. App. 1,033-1,057.

H. TSA lacks authority from Congress to issue Health Directives.

TSA may only deny boarding to "a passenger who does not consent to a search." 49 USC § 44902(a). It can't stop someone not wearing a mask from embarking. Like with his claims against DOT, the district court erred in dismissing Mr. Wall's charges against TSA and DHS. Because the Court of Appeals only has exclusive jurisdiction to review TSA directives related to transportation security, the district court should have exercised its jurisdiction to review the Health Directives.

OSHA's Vaccine or Mask/Test Mandate, like TSA's Mask Mandate,

> "involves broad medical considerations that lie outside of OSHA's core competencies, and purports to definitively resolve one of today's most hotly debated political issues. *Cf. MCI Telecomms. Corp. v. AT&T*, 512 U.S. 218, 231 (1994) … There is no clear expression of congressional intent in § 655(c) to convey OSHA such broad authority, and this court will not infer one." *BST Holdings v. OSHA,* 17 F.4th 604 (5th Cir. 2021).

Never did Congress imagine that TSA could fine passengers starting at $500 for refusing to obstruct their breathing. "It is incumbent on the courts to ensure decisions are made according to the rule of law, not hysteria … One

hopes that this great principle – essential to any free society, including ours – will not itself become yet another casualty of COVID-19." *Dept. of Health & Human Services v. Manke*, No. 20-4700-CZ (Mich. 2020) (Viviano, J., concurring).

None of the statutes or regulations the government cites authorize TSA to make or enforce regulations that amount to a blanket preventative measure against people who *might* be carrying an infectious disease. Such a broad reading of the statute would be "tantamount to creating a general federal police power." *Skyworks v. CDC*, 524 F. Supp. 3rd 745, 758 (N.D. Ohio March 10, 2021). The Constitution does not provide the federal government with such a power. *Bond v. United States*, 572 U.S. 844 (2014).

Like the CDC order, TSA's Mask Mandate must be also declared unlawful because it's arbitrary and capricious. TSA admits it did not conduct any independent research regarding the efficacy of face masks in slowing COVID-19 transmission, but relied solely on CDC's flawed findings. Since CDC didn't enunciate any explanation for why the Mask Mandate was necessary, and TSA relied wholly on the other agency to support its directives, TSA's reliance on CDC is arbitrary and capricious.

TSA's mission is to prevent "violence and piracy," not a disease. 49 USC § 44903. Allowing TSA to regulate public health distracts the agency from its

security mission. Face masks make it harder for TSA to identify dangerous people, harming transportation security. There's a reason Congress assigned TSA a narrow, specific mission: Veering off into spheres unrelated to security makes our nation's transportation system more vulnerable to attack.

"[H]ealth agencies do not make housing policy, and occupational safety administrations do not make health policy. … In seeking to do so here, OSHA runs afoul of the statute from which it draws its power and, likely, violates the constitutional structure that safeguards our collective liberty." *BST Holdings*.

At minimum, Judge Byron's dismissal of Mr. Wall's claims against TSA and DHS was an abuse of discretion. If he believed the district court did not have jurisdiction, the proper remedy was to transfer those causes of action to the 11th Circuit. "Whenever a civil action is filed in a court … and that court finds that there is a want of jurisdiction, the court shall, if it is in the interest of justice, transfer such action … to any other such court … in which the action or appeal could have been brought…" 18 USC § 1631. "Section 1631 permits the severance and transfer of less than an entire action." *Mohamed v. Holder*, No. 1:11-CV-50, 2011 WL 3820711 at *10 (E.D. Va. Aug. 26, 2011).

I. The FTMM violates America's commitments under international law.

The protection of the rights of the disabled is of international concern. "[I]n accordance with the Universal Declaration of Human Rights, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights…" International Covenant on Civil & Political Rights ("ICCPR"), 999 U.N.T.S. (adopted by the U.S. on Sept. 8, 1992); App. 650.

By banning the disabled who can't don masks from flying, CDC and TSA violate our rights under international law to liberty of movement, freedom to leave any country, and ability to enter our own country. Our friends the 3 Dual Citizens covered the ICCPR well in their brief.

We also want to draw the Court's attention to the Convention on International Civil Aviation ("CICA"),[2] which the United States ratified Aug. 9, 1946. Pursuant to CICA Art. 37, the International Civil Aviation Organization ("ICAO") has adopted, *inter alia*, Annex 9, which contains provisions on facilitation of air transport, including the transport of passengers requiring special assistance. The 15th Edition of CICA Annex 9 became applicable Feb.

[2] This treaty is also known as the "Chicago Convention"

23, 2018. App. 632-643. Annex 9 to CICA is binding in this country as part of the treaty. In carrying out all federal aviation laws, the Executive Branch "shall act consistently with obligations of the United States Government under an international agreement." 49 USC § 40105 (b)(1)(A).

"Contracting States shall take the necessary steps to ensure that persons with disabilities have equivalent access to air services." CICA Annex 9 § 8.34. "[P]ersons with disabilities should be permitted to travel ***without the requirement for a medical clearance***. Aircraft operators should only be permitted to require persons with disabilities to obtain a medical clearance in cases of a medical condition where it is not clear that they are fit to travel and could compromise their safety or well-being…" CICA Annex 9 § 8.39 (emphasis added).

But the Mask Mandate, in violation of CICA and 14 CFR § 382.23(a), allows airlines to require a medical clearance/certificate to request a mask exemption. This violates international standards set by the ICAO. App. 644-649.

VII. CONCLUSION

This Court should not allow the government appellees to reinstitute policies that exclude the disabled from flying and using all other forms of public transportation nationwide because we happen to have medical conditions that don't allow us to obstruct our breathing. Since Judge Mizelle vacated the FTMM in *HFDF* 2½ months ago, we have been able to resume traveling again – as have likely millions of other disabled Americans who were barred from traveling during the COVID-19 pandemic due to an *ultra vires* policy with no scientific rationale that demonstrably did nothing to slow the spread of coronavirus in the transportation sector.

Private companies such as airlines, taxis, rideshare cars, and ferries should never be given *carte blanche* power to deny medical exemptions signed by our doctors. They are not medical providers and do not possess a medical license to overturn decisions made by actual doctors.

The decision below did not take into account Mr. Wall's disability nor even acknowledge that millions of others were excluded from public transportation because of our health problems. This Court must correct that gross deficiency, reverse Judge Byron's decision, and affirm Judge Mizelle's ruling.

XIII. SIGNATURES

Respectfully submitted this 5th day of July 2022.

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IX. CERTIFICATE OF COMPLIANCE

We certify that this brief complies with FRAP 29(a)(5) & 32(a)(5)(A) because it has been prepared in 14-point Georgia, a proportionally spaced font, and this document complies with the 6,500-word limit because the Argument contains 6,489 words as measured by Microsoft Word.

X. CERTIFICATE OF SERVICE

I certify that on July 5, 2022, I e-mailed this brief to these Court clerks for uploading into the 11th Circuit's Case Management/Electronic Case Filing system:

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I also certify that I am mailing four paper copies to the Court as required.

I also certify that I e-mailed this brief July 5 to the parties:

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No. 21-11532-BB

United States Court of Appeals for the 11th Circuit

LUCAS WALL,
Appellant/Plaintiff

v.

CENTERS FOR DISEASE CONTROL & PREVENTION, DEPARTMENT OF HEALTH & HUMAN SERVICES, TRANSPORTATION SECURITY ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY, & DEPARTMENT OF TRANSPORTATION,
Appellees/Defendants

Appeal from the United States District Court
for the Middle District of Florida
No. 6:21-cv-975

BRIEF OF *AMICI CURIAE* 3 INDUSTRIAL HYGIENE EXPERTS IN SUPPORT OF APPELLANT URGING REVERSAL

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I. CERTIFICATE OF INTERESTED PERSONS

Pursuant to 11th Cir. R. 26.1-2(b), we certify that the CIP contained in Appellant's Opening Brief (Brief at 1-32) is correct and complete except for the additions of ourselves:

- David Howard, *Amicus Curiae*
- Stephen Petty, *Amicus Curiae*
- Tyson Gabriel, *Amicus Curiae*

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IV. *AMICI'S* INTEREST IN THE CASE

Friends of the Court are three experts in the fields of industrial hygiene as well as occupational safety and health. We write in support of Appellant Lucas Wall's arguments that the Federal Transportation Mask Mandate ("FTMM or "Mask Mandate") imposed by Appellees Centers for Disease Control & Prevention ("CDC"), Department of Health & Human Services ("HHS"), Transportation Security Administration ("TSA"), and Department of Homeland Security ("DHS") is arbitrary and capricious. Also, these government agencies did follow the Administrative Procedure Act ("APA") notice-and-comment requirements before adopting the CDC/HHS FTMM Order, and TSA/DHS' three "Security Directives"[1] and one Emergency Amendment that require all transportation passengers and workers nationwide to wear face masks.

Had notice and comment been provided, we and many others in our profession would have advised these agencies that masks do not stop the spread of respiratory viruses such as COVID-19 and that Occupational Safety &

[1] We agree with Mr. Wall that TSA's Mask Mandate has nothing to do with transportation security, therefore we adopt his use of the term "Health Directives" throughout the remainder of this brief to more appropriately describe TSA's orders.

Health Administration ("OSHA") regulations require any company mandating N95 respirators (masks) to follow strict protocols including medical examination and fit testing. Also, we are personally subject to the Mask Mandate (which the CDC conflates N95 respirators with) every time we fly or use other modes of public transportation.

We support Mr. Wall's arguments that all components of the FTMM are *ultra vires* and should be vacated worldwide, as a different judge did for the CDC/HHS portion in the case of *Health Freedom Defense Fund v. Biden*, No. 8:21-cv-1693 (M.D. Fla. April 18, 2022) ("*HFDF*"). Although CDC, HHS, TSA, and DHS have temporarily suspended all mask dictates due to the decision in *HFDF* (currently on appeal to this Court; No. 22-11287), it is critical that this Court enjoin all four agencies from ever reissuing any directives forcing passengers and transportation workers to don face masks.

We obtained consent of Appellant Lucas Wall and Brian Springer, counsel for the government appellees, to file this brief. FRAP 29(a)(2).

No party's counsel authored this brief in whole or part. No party or their counsel contributed money that was intended to fund preparing or submitting the brief. No person other than those signing this brief contributed money that was intended to fund preparing or submitting this document.

V. STATEMENT OF THE ISSUES

We participate in this case to ensure the Court has a true understanding of the science: Face masks do not stop the spread of a respiratory virus but harm human health in many ways, as Mr. Wall has corrected pointed out. We are proud that he introduced into evidence below our Feb. 22, 2022, letter to Dr. Rochelle Walensky, CDC director; Anthony Fauci, chief medical adviser to President Biden; Sen. Ronald Johnson; Douglas Parker, assistant secretary of labor for occupational health and safety; and Jeffrey Zients, White House COVID-19 Pandemic Response coordinator. App. 959-985. We authored that letter along with five other colleagues in the fields of industrial hygiene as well as occupational health and safety to bring these government officials' attention to the fact that they have been misleading the public about the efficacy of face coverings as a tool to reduce transmission of coronavirus.

As we will explore below, the federal government has constantly lied to the American public about masks being a critical tool to slow down COVID-19 infections. In this case, the administrative record is virtually nonexistent when it comes to being supported by science. CDC and HHS cited only seven deeply flawed studies to come to the conclusion that masking everyone in the transport sector would "slow the spread." TSA and DHS cited not a single scientific study to justify their FTMM Health Directives.

VI. ARGUMENT SUMMARY

There are only two lawsuits we are aware of in the nation where a judgment has been issued on a challenge to the FTMM Order issued by CDC and HHS, and both happen to be from the Middle District of Florida and currently on appeal to this Court. Judge Mizelle in *HFDF* correctly held that the Mask Mandate was issued beyond CDC's statutory authority and was also *ultra vires* because the agency failed to provide notice and allow comments, and the policy is arbitrary and capricious. We are disappointed Judge Mizelle's well-reasoned opinion did not discuss the government's false claims that masks are an effective tool to curtail transmission of a respiratory virus when used by an untrained general public such as transit passengers and employees.

In this case, Judge Byron came to the exact opposite legal conclusions of Judge Mizelle and brushed off many of Mr. Wall's solid arguments against the legality of the FTMM (as well as the International Traveler Testing Requirement, a part of the case we do not address). Mr. Wall introduced 228 scientific and medical studies, articles, and videos into evidence below (indexed at https://lucas.travel/masksarebad) totaling thousands of pages, not a single one of which Judge Byron considered in his misguided ruling that CDC and HHS have the legal authority to mandate masks, that "good cause"

excused the APA's notice-and-comment requirement, and that the FTMM isn't arbitrary and capricious because it was issued without any basis in science or medicine. Judge Byron should have considered all the evidence Mr. Wall presented to rebut the findings of CDC and HHS.

The administrative "record may be supplemented to provide, for example, background information or evidence of whether all relevant factors were examined by an agency." *AT&T Info. Sys. v. GSA*, 810 F.2d 1233, 1236 (D.C. Cir. 1987). Supplementation of the administrative record is appropriate when an agency has deliberately or negligently excluded certain documents from the record, such as in this case. Mr. Wall's evidence helps the Court determine that the agencies failed to consider most relevant factors.

We hope the arguments and evidence we offer the Court will help it come to the correct conclusion in this case and the related appeal: Judge Byron's decision must be reversed, Judge Mizelle's ruling shall be affirmed, and the Court must permanently enjoin CDC, HHS, TSA, and DHS from ever again issuing a Mask Mandate unless Congress passes a new law specifically allowing them to do so.

VII. ARGUMENT

A. The Mask Mandate must be vacated and enjoined from ever being reissued because it is arbitrary and capricious.

There have been two responses to the COVID-19 pandemic: a medical response and an exposure-mitigation response. Many have inacurately assumed that the medical industry has expertise in both areas but this is incorrect. The medical industry is unschooled in exposure science and is in fact a customer to the exposure-science industry known as "industrial hygiene." This is the area where we offer expertise to the Court. A transportation security agency certainly has no qualifications to regulate industrial hygiene. Doing so makes the Mask Mandate arbitrary and capricious. If CDC's part of the Mask Mandate qualifies as such, then clearly TSA's portion does too. *HFDF*. The district court was wrong to dismiss Mr. Wall's claims against TSA and its parent department, DHS, because their mask directives do not involve security matters, therefore the "exclusive jurisdiction" of the Court of Appeals does not apply.

The medical response consists of learning about the pathogen and how it travels, how it affects and enters the body, the pathogen's structure and weaknesses, and what treatments work after exposure to the pathogen has occurred. Exposure-mitigation sciences will initially take the medical science to specifically evaluate possible options for combating the virus. Then, each

occupied space will be evaluated to identify current hazards and ensure a customized approach to each exposure will be met to ensure the occupants have optimal safety and health results.

We work in concert to mitigate various exposures in every single industry. You will find us in construction, mining, manufacturing, law enforcement, the military, insurance, food service, government, consumer shopping, and yes we serve the medical industry too!

OSHA sums up industrial hygiene as the "science and art devoted to the anticipation, recognition, evaluation, and control of those environmental factors or stresses arising in or from the workplace, which may cause sickness, impaired health and well-being, or significant discomfort among workers or among the citizens of the community." The American Industrial Hygiene Association ("AIHA") defines an industrial hygienist as "scientists and engineers committed to protecting the health and safety of people in the workplace and the community."

The Department of Labor defines a "qualified" person as one who by possession of a recognized degree, certificate, or professional standing, or who by extensive knowledge, training, and experience, has successfully demonstrated the ability to solve or resolve problems relating to the subject matter, the work, or the project. While we recognize the obvious significance

that medical science is required for a competent pandemic response, we disagree with the assumption that medical specialists are the qualified people to recommend exposure-mitigation strategies.

History has shown this before but the public and media did not catch these past mistakes. An example of the inept training of control measures in the medical field occurred during the Ebola outbreak in 2014. A hospital in Dallas, Texas, took in Ebola patients and found itself completely unprepared. The medical professionals got on the Internet and unprofessionally used some Personal Protective Equipment ("PPE"). As a result, nurses were exposed and became infected. Moreover, it can be assumed that the nurses were not fit tested for respirator use and no training on their control plan was provided. Thankfully, the nurses survived but court proceedings revealed bungled measures taken.[2]

Even early in the current pandemic, we witnessed firsthand the lack of training in the medical field on PPE use. Petite nurses were wearing large disposable N95 respirators (clearly not fit tested). In some cases, they took the bottom strap off, while others had their disposable N95 respirator on upside down. In addition, doctors were wearing a surgical mask with a disposable N95 respirator on top of it. This is improper use because the face mask

[2] https://tinyurl.com/2uhpwrth

was preventing the respirator from capturing a seal to the face. If healthcare professionals made these terrible errors putting on face coverings, one can only image that many members of the traveling public did so too because of having to comply with the Mask Mandate.

Dr. Wenliang Li preventing his N95 respirator from gaining a seal by wearing a surgical mask underneath

The inadequacies in the medical industry's comprehension of exposure mitigation are further illustrated in that around 90% of the OSHA citations that involve the pandemic are in the medical industry. The administration's citations consistently revolve around violations of the regulatory standards in PPE (29 CFR § 1910.132) and Respiratory Protection (29 CFR § 1910.134). It is such a profound issue that OSHA is in the process of creating regulatory standards for the medical industry as it relates to COVID-19.

Some disagree with our position that travelers and transit workers fall under the Code of Federal Regulations' requirements for masks. This is inaccurate for two reasons. First, the N95 is at the forefront of the mask debate and the N95 is a respirator, not a traditional mask. The "95" means the filter has 95% efficiency, which means it can only achieve that by being used correctly *every single time*. Further, it seals to the face, which qualifies it as a respirator. As such, N95 manufacturers require that the wearer should adhere to the Respiratory Protection Standard for safe use. CDC and TSA did not even mention OSHA's respirator regulations when they hurriedly issued their FTMM Order and Health Directives.

Second, government agencies are forcing people to wear a mask because of purported safety and health concerns. So, the logical starting point should be to use established science related to the safety and health professions to build from. Therefore, it is important for professionals in our industry to be engaged in this debate to ensure the bar for safety and health sciences is not lowered by the unqualified. Dr. Mark Gendreau is among many aviation health specialists who said when the pandemic began that masks "won't work against contracting a virus in flight" and "they don't stop someone from breathing in a virus droplet."[3] The appellees didn't listen.

[3] https://tinyurl.com/yay6hxx2

And sadly neither did Judge Byron. His opinion is full of extremely misguided statements buying CDC's contention that masks are effective. "In fact, the CDC correctly pointed out that the FTMM helps prevent the imposition of economic burdens by stymying the spread of COVID-19 and, consequently, avoiding future lockdowns and resulting losses." App. 461. There is no evidence to support this conclusion.

Given the government's own data, how are we to believe that masks have been effective in its goal of reducing COVID-19 transmission when TSA itself admits that 22,812 of its employees (35% of its workforce) [4] – all of whom were forced to wear masks for more than a year – have tested positive for COVID-19?

Government lawyers like to defend the FTMM by claiming doctors have worn N95 or surgical masks during surgeries or patient interactions as part of their daily routines for many decades. But they fail to explain that medical professionals wear masks to stop bodily fluid sprays and splashes from entering their orifices, not to prevent the transmission of respiratory droplets.

---

[4] Because so many COVID-19 cases are mild, health authorities estimate only half of infections are confirmed by testing. This means it's quite likely an astounding **70%** of TSA's 65,000 employees have been infected with coronavirus. So how exactly do face coverings prevent the transmission of COVID-19?

The Food & Drug Administration ("FDA"), a unit of HHS, admits this:

> "While a surgical mask may be effective in blocking splashes and large-particle droplets, a face mask, by design, it does not filter or block very small particles in the air that may be transmitted by coughs, sneezes, or certain medical procedures. Surgical masks also do not provide complete protection from germs and other contaminants because of the loose fit between the surface of the mask and your face."[5]

Here we have CDC and TSA requiring masks in no sector of the nation except transportation, without showing a single scientific study identifying this sector as being more vulnerable to coronavirus spread.

> "[T]he government has the burden to establish that the challenged law satisfies strict scrutiny. … [N]arrow tailoring requires the government to show that measures less restrictive of the [constitutionally protected] activity could not address its interest in reducing the spread of COVID. Where the government permits other activities to proceed with precautions, it must show that the [constitutionally protected] exercise at issue is more dangerous than those activities even when the same precautions are applied. Otherwise, precautions that suffice for other activities suffice for [constitutionally protected] exercise too." *Tandon v. Newsom*, 141 S.Ct. 1294 (2021).

It's important for the Court to understand that there has ***never*** been scientific evidence that supports universal mask use. This has been concocted by the Biden Administration to support the president's political objectives. App. 1,020-1,032. When agencies ignore enormous scientific evidence and

[5] https://tinyurl.com/pab7k8cy

fail to even give the public the chance to comment on a proposed directive, the law demands it be set aside.

It's not just our judgment that masks are ineffective in reducing COVID-19 spread; it's the widespread view of tens of thousands of experts worldwide. And notably our judgment has been proven true in the past 2½ months with no reports of COVID-19 hotspots in America's transportation sector since Judge Mizelle vacated the FTMM in *HFDF*.

As Mr. Wall notes, air travel is already equipped to provide a safe experience (App. 1,091-1,115), the use of Personal Protective Equipment by untrained people creates more risk, and mask guidance continues to come from unqualified scientists talking outside their lane of expertise.

After initially supporting the FTMM, leaders across the airline and travel industries came to realize the Mask Mandate did nothing but cause numerous disruptions as angry customers fought for their right to breathe freely. Their views on the science evolved (App. 1,058-1,098) as they saw the Omicron variant sicken thousands of their employees despite everyone being masked. App. 1,033-1,057. But the government continues pushing masks today, 2½ years into the pandemic (which many consider to be over now as COVID-19 is a mild illness that will continue circulating until more effective

vaccines are developed), failing to admit the science was never there to support such a mandate and it did not reduce COVID-19 spread in the transportation sector, as we've seen with no evidence of new outbreaks since the *vacatur* occurred April 18, 2022, in *HFDF*.

Dr. Leana Wen, who had been one of the nation's most forceful and prominent mask advocates, conceded late last year that "Cloth masks are little more than facial decorations. There's no place for them in light of omicron." App 765. Many others who previously believed in mask efficacy, including a former FDA chief, have come to the same conclusion.

New studies, articles, and expert testimony come out each month adding to the large and growing body of scientific data illustrating that masks have not stopped the spread of COVID-19 but are harmful to human health. The Court need only read the labels on boxes of masks for sale that Mr. Wall offered as evidence below to see how truly worthless they are. App. 1,000.

Former presidential COVID-19 adviser Michael Osterholm admitted that most masks are ineffective: "We know today that many of the face cloth coverings that people wear are not very effective in reducing any of the virus movement in or out," said Osterholm, director of the University of Minnesota's Center for Infectious Disease Research & Policy. App. 744.

We're disturbed that the government presented no evidence below that

CDC and TSA are using the existing Do Not Board and Lookout systems to stop passengers who have tested positive for COVID-19 from embarking aircraft. App. 605-609. Targeting travelers who are a genuine threat to public health – those who are infected – can be done without infringing on the freedom to travel for everyone else.

> "Not only is there no evidence that the applicants have contributed to the spread of COVID-19 but there are many other less restrictive rules that could be adopted to minimize the risk to public interests. Finally, it has not been shown that granting the applications will harm the public. As noted, the State has not claimed that attendance at the applicants' services has resulted in the spread of the disease. And the State has not shown that public health would be imperiled if less restrictive measures were imposed." *Roman Catholic Diocese of Brooklyn v. Cuomo,* No. 20A87 (U.S. Nov. 25, 2020).

B. The COVID-19 mitigation strategy of supposed public-health officials and TSA has not been prioritized in accordance with the Hierarchy of Controls. Had notice been given and our industry had the opportunity to comment, we would have raised concerns.

CDC and TSA issued the challenged Mask Mandate without giving notice and considering public comments. Had the agency done so, industrial hygienists and workplace-safety experts such as ourselves would have objected and offered our knowledge. A tribunal must "hold unlawful and set aside agency action … found to be … without observance of procedure required by law." 5 USC § 706(2)(D). This Court should hold unlawful and set aside the

Mask Mandate because CDC and TSA violated the APA's notice-and-comment requirements. 5 USC § 553. *HFDF*.

TSA asserts that notice and comment are waived when it must respond to an urgent transportation security threat and issues what it calls a "Security Directive." But because the so-called "Security Directives" at issue here are actually Health Directives, this exception to the APA doesn't apply – and the district court had jurisdiction.

We have been in several conversations with doctors and school administrators on COVID-19 exposure-mitigation tactics and have been met with the strawman argument that nobody really knows which exposure-control measures are working and which ones work better than others.

As occupational safety and health professionals, we affirm that our profession consists of trained experts in evaluating an environment for risks and exposure with the ability to measure the determined exposures and devise a mitigation plan. We use a long-standing, proven scientific system called the Hierarchy of Controls (Figure 1-A) that was introduced by the National Safety Council ("NSC") in 1950 to layer our exposure-mitigation strategies. This system also enables us to prioritize the mitigating efforts to better educate our customers as to which strategies are going to work the best. The

record shows CDC and TSA did not engage in any Hierarchy of Controls analysis or explain why they had good cause not to. "Besides its brief reference to the pandemic, the Mandate makes no effort to explain its reasoning that there was an exceptional circumstance at the time it implemented the rule." *HFDF*.

A decision to vacate that "maintains the separation of powers and ensures that a major new policy undergoes notice and comment" is in the public interest. *Texas v. United States*, 787 F.3d 733, 768 (5th Cir. 2015).

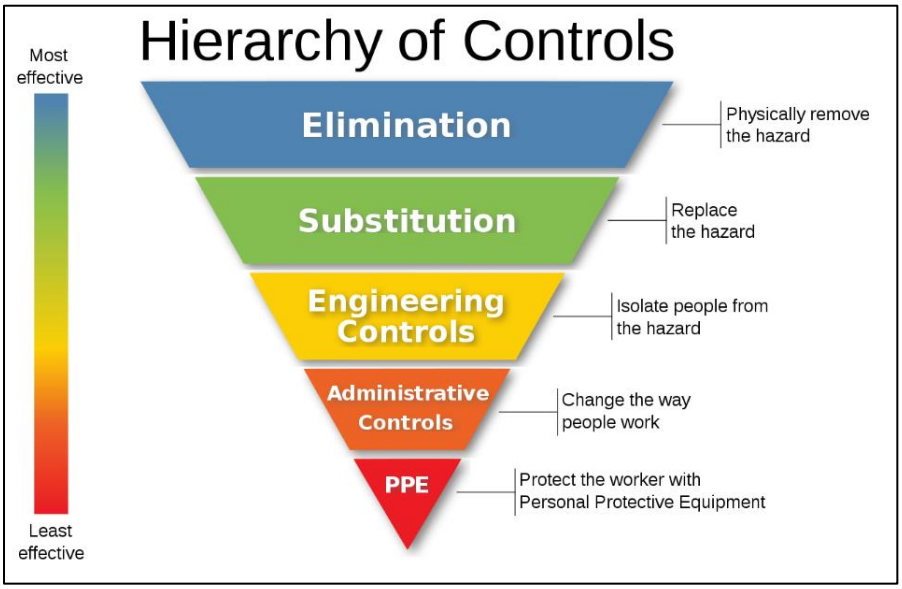


Figure 1-A: Hierarchy of Controls

The human interaction with a control, while it is engaged with the risk or contamination, is a primary difference between the class of controls on the high end of the hierarchy and those at the low end. In any compliance program, the most critical component of whether it will succeed or not is human

behavior. Human behavior as it relates to compliance with safety and health measures is such a juggernaut that we have entire education courses on Behavioral-Based Safety, which is why we always seek solutions that have a foundation in engineering controls.

If an agency order is based on scientific or other technical data, that data and the methodology used to obtain it should be included in the notice to allow meaningful comment. *Lloyd Noland Hosp. & Clinic v. Heckler*, 762 F.2d 1561 (11th Cir. 1985). But CDC provided no notice at all of the FTMM.

CDC (and TSA) should have received public comments that engineering controls isolate people from the hazard while the design and function of an administrative control is maintained by specific consistent proper execution of the procedural control. Any deviation from that then becomes contamination behavior and is deteriorating or downgrading its effectiveness.

At the bottom of the effectiveness chain is the Personal Protective Equipment category of controls. With PPE there is complete reliance on human use and interaction to maintain its designed scope of protection. In our careers, we have experienced personnel failing to use their PPE due to a lack of comfort, poor training, or myths they carried with them from a previous employer.

Masks *do not seal to the face and cannot offer protection*. They can reduce exposure to blood splatter for medical professionals at best, but they are not deemed a true protective piece. Therefore, a mask can in no way scientifically be considered a primary solution to an exposure issue as many doctors, government agencies, and politicians have claimed. A competent response would be focused on dilution, filtration, and destruction of the pathogen.

Airplanes provide state-of-the-art ventilation systems that provide fresh air to the cabin typically every few minutes and push the air in a laminar motion to reduce cross contamination. App. 1,091-1,115. This is important to understand because the American Industrial Hygiene Association conducted a study in 2020 (Figure 1-B) that found engineering controls (such as a ventilation system) provide the optimal solution for human protection. It produced a graph demonstrating a 95-99.9% risk reduction for exposure by simply having 6-12 air changes per hour.

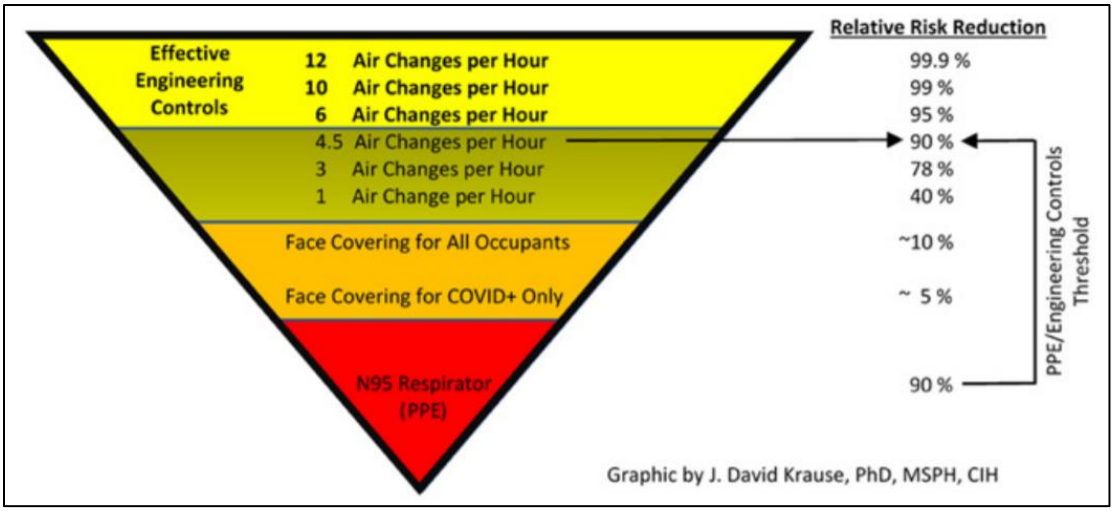


Figure 1-B: AIHA Reducing the Risk of COVID-19 Using Engineering Controls Graphic

CDC and TSA conducted no studies regarding mask efficacy. The N95's optimal performance is based on the user's adherence to the Respiratory Protection Standard as well as the manufacturer's requirements for discarding the N95 after 2-4 hours of use. But many flights, bus trips, and train rides are much longer than four hours.

"[A]n utter failure to comply with notice and comment cannot be considered harmless if there is any uncertainty at all as to the effect of that failure." *Sugar Cane Growers Coop. of Fla. v. Veneman*, 289 F.3d 89, 96 (D.C. Cir. 2002). The APA provides that people and organizations being regulated must be afforded the opportunity to participate and provide information and suggest alternatives so the agency is educated about the impact of the proposed rule and can make an informed decision. *NLRB v. Wyman-Gordon*,

394 U.S. 759 (1969). By giving affected parties an opportunity to comment and develop evidence in the record to support their view and objections, notice improves the quality of judicial review. *Small Refiner Lead Phase-Down Task Force v. EPA*, 705 F.2d 506 (D.C. Cir. 1983).

The "Absence of Apparent Transmission of SARS-CoV-2 from 2 Stylists after Exposure at a Hair Salon with a Universal Face Covering Policy in Springfield, Missouri, May 2020" study has been a foundational piece used by public-health officials to make the false claim that face masks are an added value when deployed in a community. We investigated this study, which CDC cites to justify the FTMM. Here is an overview of our findings:

- The study insinuates that 139 clients were not infected but the researchers in fact cannot make that claim. The sample size was 139, but the researchers were only able to collect factual evidence on 67 clients. Of the others, 37 clients refused to be tested and were self-reporting during a period when people had an incentive not to report themselves being sick due to quarantine and isolation policies. Another 35 clients were not contacted and did not receive a test, nor did they participate in self-reporting. Only 48% of the sample size was factually evaluated, while 52% had no data.
- The study admitted limitations in administrative controls of limiting

services, and stylists and clients not facing each other during services. By not facing one another, clients and hair stylists made their experience significantly safer by making the flow of potential virus transmission more difficult. This was a significantly missed opportunity by the research team to demonstrate multiple measures people can take to prevent transmission. This might be evidence of a bias of the research team in attempting to demonstrate the need for mask use. Regardless, by not properly evaluating all forms of controls in accordance with the well-established hierarchy demonstrates a significant lack of knowledge of this subject matter. Those involved in this defective study often cited by CDC are unable to properly evaluate such event.

- The study did not admit limitations by not evaluating sanitization efforts. The CDC falsely claims masks are a sanitation measure. Not true. *HFDF*. Sanitation of surfaces is a combination of administrative and engineering controls. These are administrative controls because of the consistent processes for surface cleaning efforts. They are also engineering controls because the cleaning agents utilized end the flow of contamination. These are higher forms of controls in mitigat-

ing the risk of exposure. By not properly evaluating all forms of controls in accordance with the well-established hierarchy demonstrates a significant lack of knowledge of this subject matter.

- The study did not admit the limitation of not evaluating the Heating, Ventilation, & Air Conditioning ("HVAC") system. By having an active HVAC system, airborne aerosols that carry infectious disease will be mitigated from the occupied space and prevent others from being exposed. Other than eliminating the hazard, the HVAC system is the first line of defense and the most critical exposure prevention method in a building. A focused emphasis should have been placed on evaluating this critical defense mechanism.

This study is not evidence-based science that should drive a public-health policy such as creating a Federal Transportation Mask Mandate. But despite its numerous flaws, it is still used by public-health officials around the world to push universal masking.

C. CDC and TSA continue to mislead the public on masks and droplets.

On Feb. 15, 2021, 13 scientists wrote a lengthy memo regarding the federal government's misleading language in these areas and requested that it be

corrected. They wrote: "To address and limit transmission via inhalation exposure and prevent COVID infections and deaths, we urge the Biden administration to take the following immediate actions:

- Update and strengthen CDC guidelines to fully address transmission via inhalation exposure to small inhalable particles from infectious sources at close, mid, and longer range. Updated guidelines should be informed by a risk assessment model that focuses on source and pathway (ventilation) controls first.
- Issue an OSHA emergency standard on COVID-19 that recognizes the importance of aerosol inhalation, includes requirements to assess risks of exposure, and requires implementation of control measures following a hierarchy of controls."

Edwards *et al.* demonstrated[6] that that the vast majority of COVID particles emitted during illness are aerosols, not droplets. Figure 2-A.

[6] https://www.pnas.org/content/118/8/e2021830118

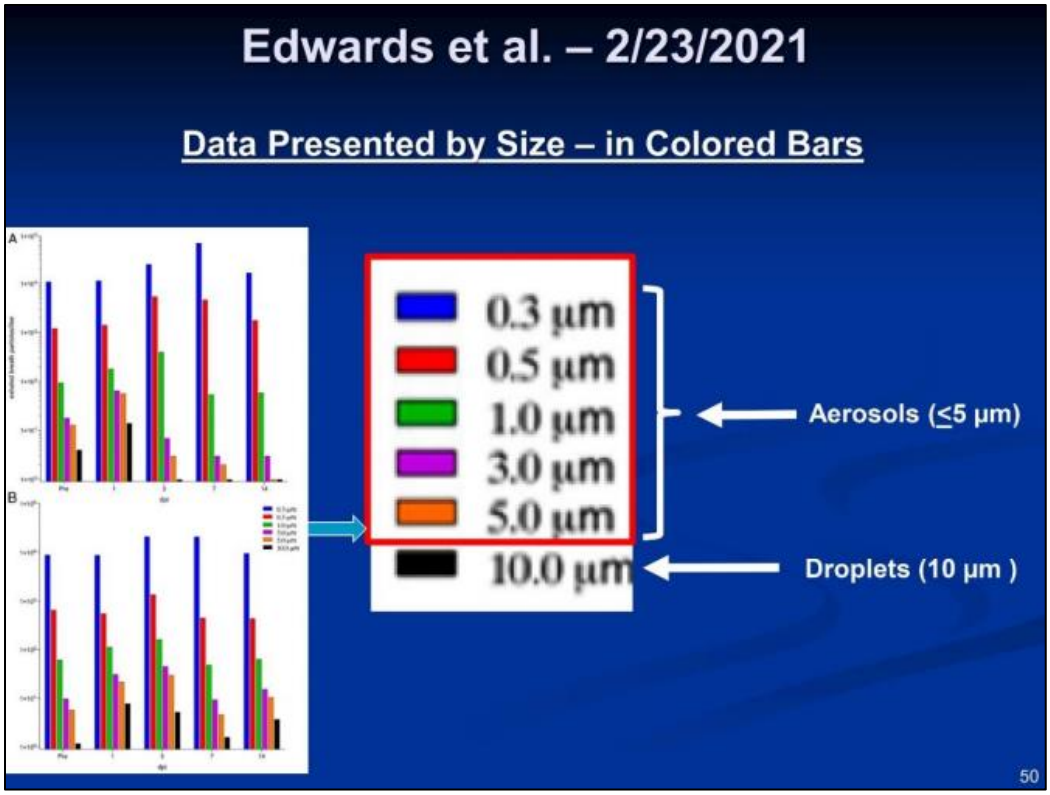


Figure 2-A: Edwards *et al.*, 2021 – Particle Size Emissions by Size & Time

While a mask might contain some droplets, it only does so for a period. As the mask is exposed to heat and moisture, it suffers from degradation within a few hours. Most importantly – a factor CDC and TSA did not consider – is that masks are not designed to stop aerosols.

Masks can't ever obtain a perfect fit to the face and efficiencies of masks are extremely low when worn in real-world scenarios (such as day-long usage by transportation workers or long-haul flyers). When the mask has more than a 3% gap, it effectively offers zero protection. Figure 2-B.

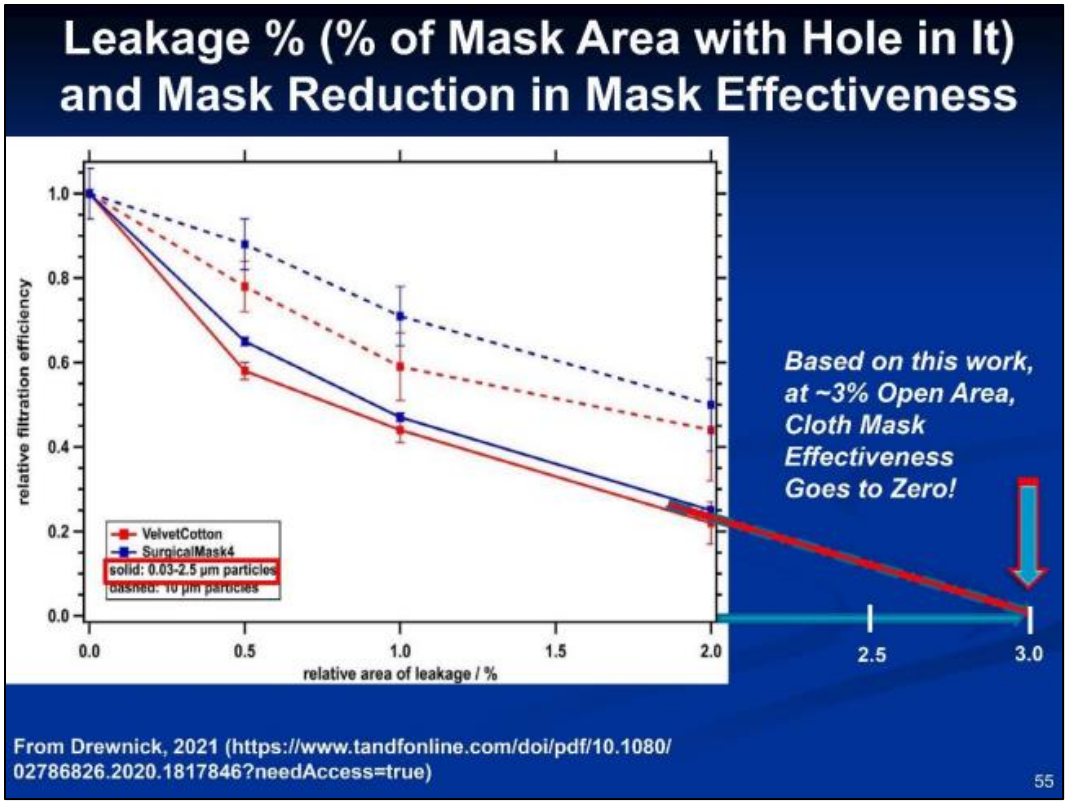


Figure 2-B: Loss of Mask Effectiveness in the Real World

The foundational debate around masks is their capability to protect the wearer and offer source control. Therefore, the critical issue to understand is how well does the mask seal to the face to offer such solutions? What's clear is small gap areas effectively render these devices ineffective.

The American Society for Testing & Materials ("ASTM") Standard Specification for Barrier Face Coverings F3502-21 states:

- "There are currently no established methods for measuring outward leakage from a barrier face covering, medical mask, or respirator.

Nothing in this standard addressed or implied a quantitative assessment of outward leakage and no claims can be made about the degree to which a barrier face covering reduces emission of human-generated particles." Note 2.

- "There are currently no specific accepted techniques that are available to measure outward leakage from a barrier face covering or other products. Thus, no claims may be made with respect to the degree of source control offered by the barrier face covering based on the leakage assessment." Note 5.

D. Universal mask policies such as the Federal Transportation Mask Mandate are adding risk.

Every mask experiment on CDC's website only shows how water droplets land in a mask. Then the experiments stop. There is no exploration of where the infectious material goes next. If a person has a mask on their face for several hours a day, that is significant time and opportunity for contamination build-up.

"CDC does not 'articulate a satisfactory explanation' – or any explanation at all – 'for its action' and fails to include a 'rational connection between the facts found and the choices made." *HFDF*, quoting *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

Every mask case study on CDC's website is predicated on the notion that masks are an engineering control – supposing that when placed on a face, they are then working at 100% efficiency, as though one is turning a light switch on. An important distinction between engineering controls and Personal Protective Equipment is that when a contamination is interacting with an engineering control, it is doing its work automatically and the human is rarely influencing the engineering control. With PPE, the human and the control are always in contact with the risk, thus the human can always influence the control, and always be exposed to the risk.

When PPE is used in the professional environment it was designed for, it is accompanied by strict behavioral processes for the purpose of reducing contamination. That's what it takes for a mask to succeed in its roll. This critical mechanism of mask functionality has been entirely removed in the public use of masks.

Why did the doctors who are prescribing public deployment of masks think masks would somehow magically work without compensating for contamination behavior? If we are going to be scientifically consistent, we must be able to reproduce this in all settings.

The message from doctors influencing public policy is clearly that behavior is not important to the protective function of a mask. That concept conflicts with our training and how we strive to execute strategies in the safety and industrial hygiene professions.

As mentioned before, a mask's ability to function properly is presumptive upon being worn properly, fit tightly, not touched, not adjusted, and cleaned. But TSA's Health Directives do not require any of this, rendering forced masking worthless – and therefore arbitrary and capricious. If a mask is not worn, fitted, cleaned, or touched properly, it is not working. If such concerns did not exist, why did the World Health Organization ("WHO") produce this list of "Don'ts"? Figure 3-A. And why did CDC and TSA ignore this list?

Figure 3-A: WHO Mask Safety Sheet – Don'ts

If there are no correlating safe behaviors with the deployment of masking (just as with any PPE policy), the mask cannot work and causes harm. App. 797, 808-852, & 958. Safety data for decades shows that at minimum 90% of the population will participate in the "Don'ts" list and nullify any possible benefit of mask use.

As safety and industrial hygiene professionals, we seek solutions that offer 90% or more protection for those we are tasked to protect. This simple data would quash the use of a mask in a typical professional setting, yet CDC and TSA continue to push universal masking as some kind of "silver bullet."

A Brownstone paper by Paul Alexander[7] published Dec. 21, 2021, shows the harms of masks, citing more than 150 studies. One of these authors testified in the Western District of Michigan court Sept. 28, 2021, that the small number of studies cited by CDC purportedly showing masks are effective did not support statements made by the agency, and most suffered from a lack of a control group (group similar to the mask study group not wearing masks) or cofounding factors (such as changes in HVAC systems, distancing, quarantining, and masks) wherein one can't determine the specific contribution of masking.

Now society has 2½ years of well-established data that significant harms of universal masking adds risk such as reduced learning and development as well as physical, emotional, and social harms (*see* Figures 3-B to 3-I). Yet Judge Byron's decision didn't mention a single harm of masking, when experts have identified more than 70. There is so scientific support whatsoever for Judge Byron's conclusion that:

> "In other words, masks have two functions: (1) they protect the wearer from breathing in harmful air particles … and (2) they prevent the wearer from breathing out harmful air particles … In this way, masks (to varying degrees) promote the public health by checking the transmission of airborne viruses, such as SARS-CoV-2, and thus fit within the definitions of 'sanitation.'" App. 470.

[7] https://tinyurl.com/mw2t6z6z

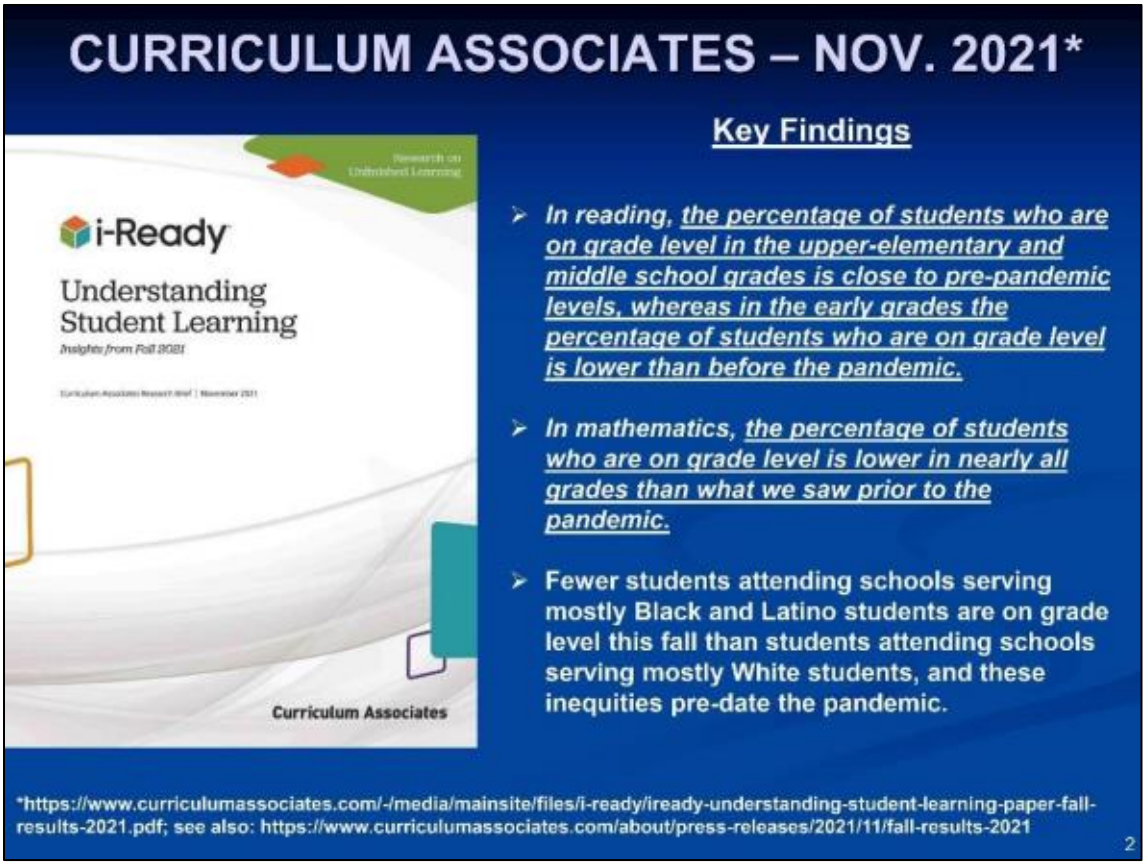


Figure 3-B: Curriculum Associates, Nov. 2021 – Title Page

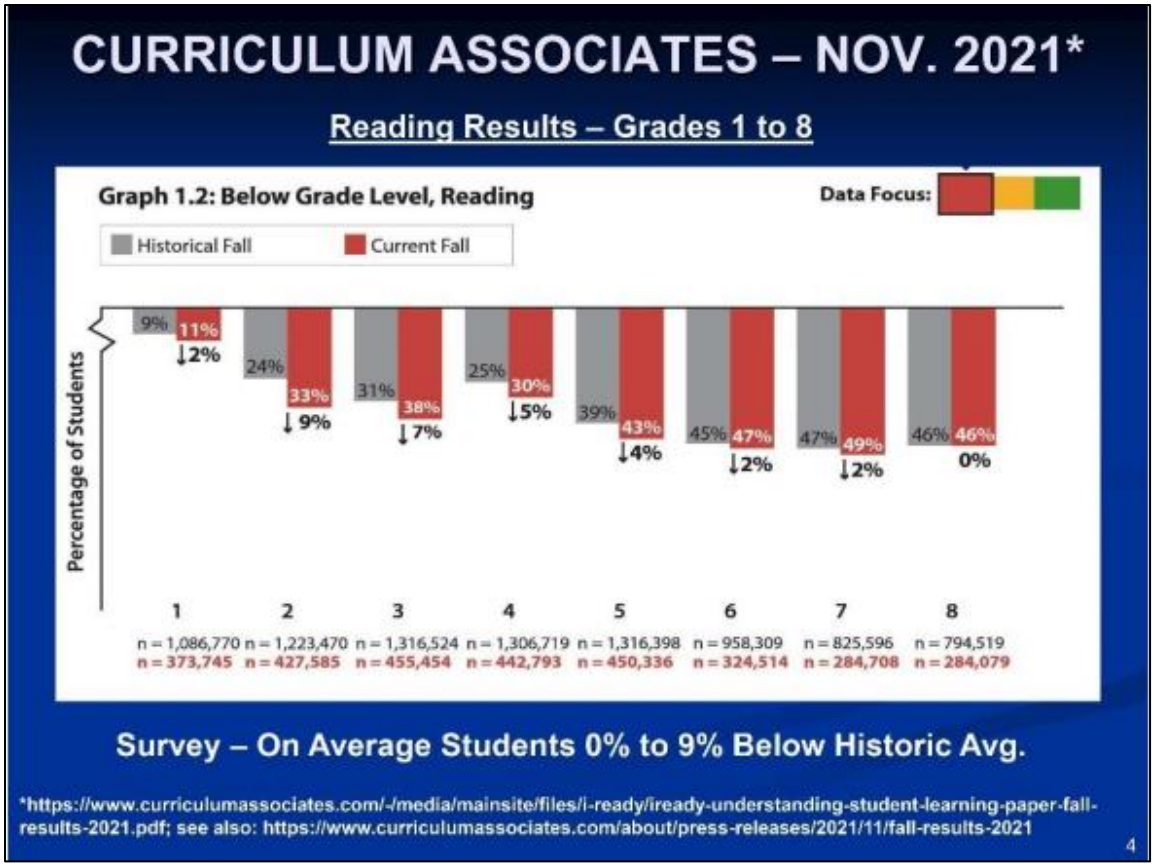


Figure 3-C: Curriculum Associates – Reading Deficits in 2021 vs. Prior Years

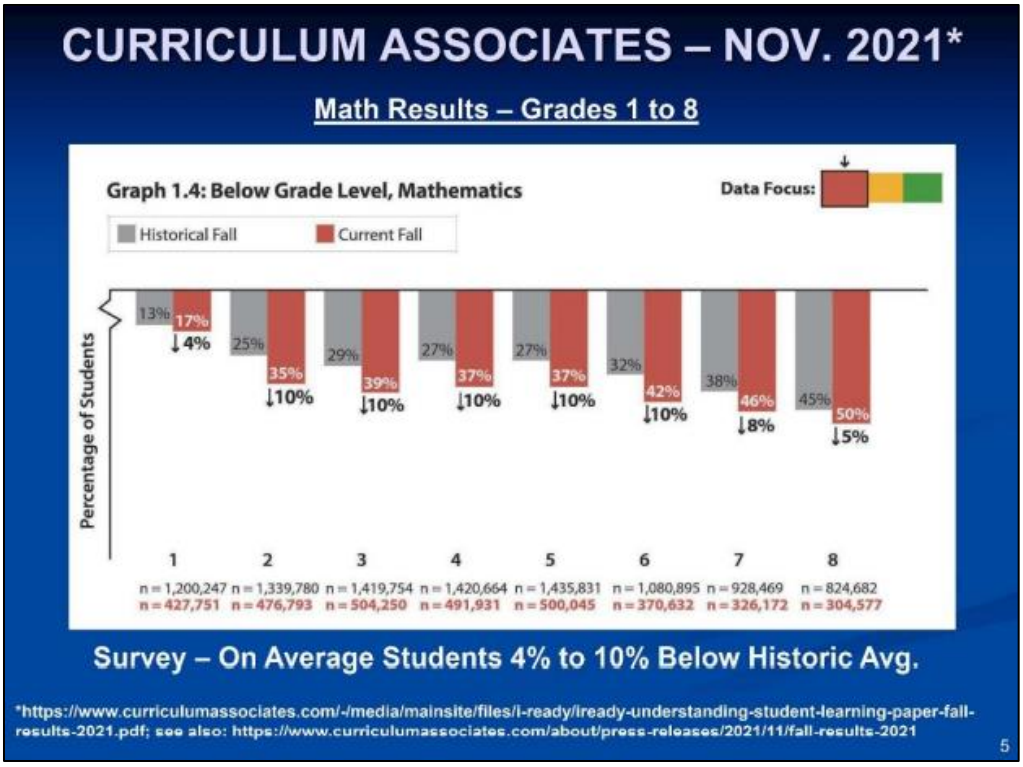


Figure 3-D: Curriculum Associates – Math Deficits in 2021 vs. Prior Years

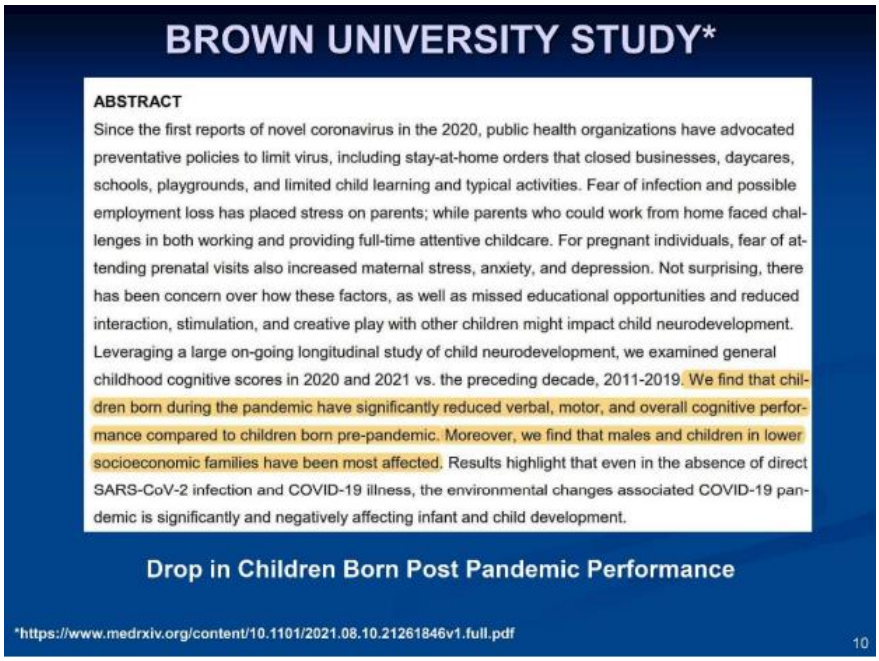


Figure 3-E: Brown University – Cognitive Deficits

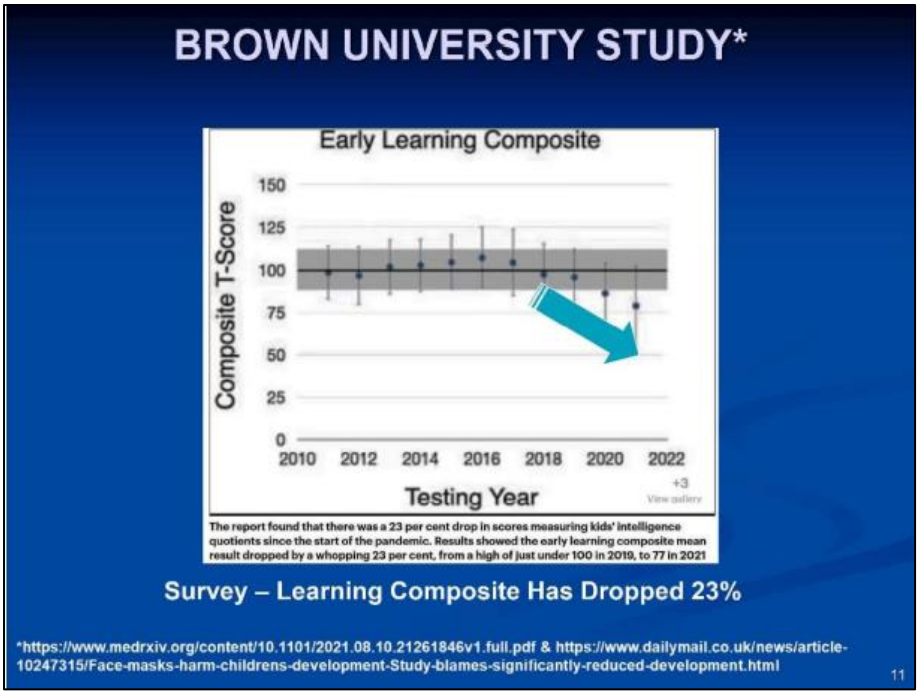


Figure 3-F: Brown University Study – Learning Loss of 23% for Children Born Since Pandemic

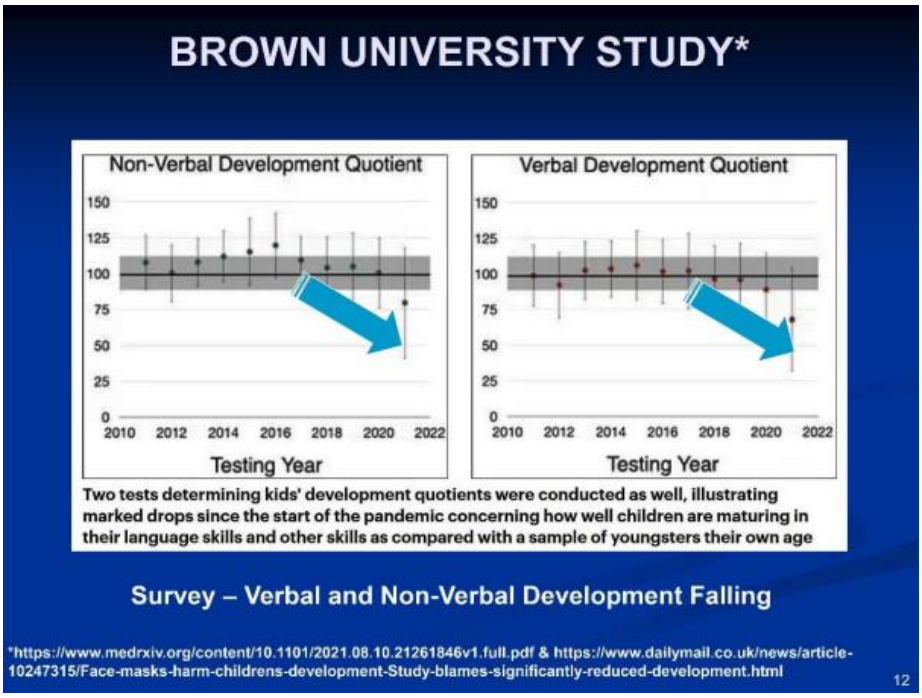


Figure 3-G: Brown University Study – Non-Verbal & Verbal Development Losses

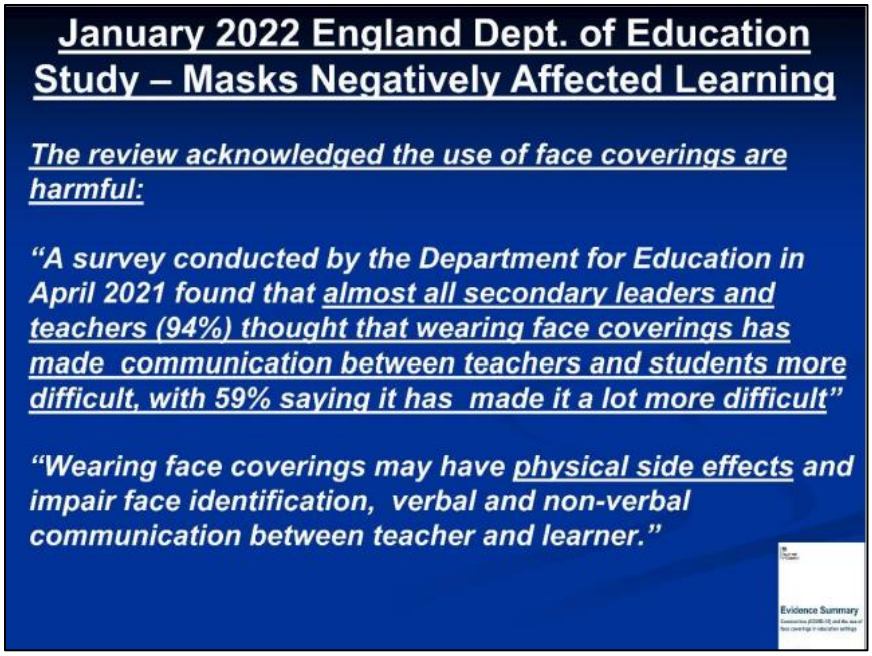


Figure 3-H: England Department of Education – Loss of Communication and Physical Effects

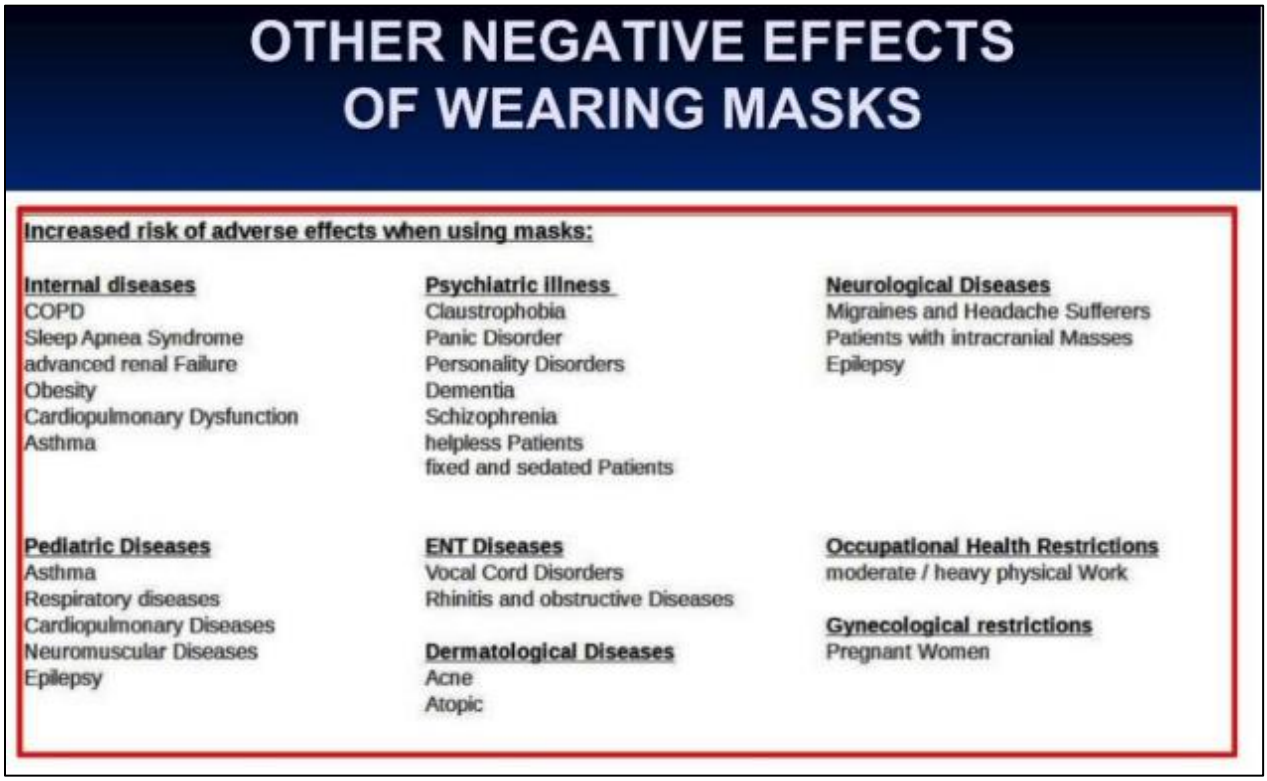


Figure 3-I: Kisielinski *et al.*, Areas of Quantitated Adverse Effects on Children & Adults

There has been a bombardment by policymakers such as those at CDC and TSA for the traveling public to "follow the science." However, the curious thing about that is even CDC's science does not actually say what we have been told it says. There is no research that offers a comparison to the real-life daily activities that both adults and children are engaged in such as flying or using public transit.

Again Judge Byron bought the propaganda CDC sold the American public, failing to critically analyze false claims such as "CDC relied on an economic analysis of American data to support its prediction that the masking requirement could 'prevent the need for lockdowns and reduce associated losses of up to $1 trillion or about 5% of the gross domestic product.'" App. 472-473. The government hasn't ever provided any evidence to support this hypothesis.

These are keystone observations to make when critically examining CDC's health studies, which TSA relied on in issuing the Health Directives requiring mask use:

- The participants are typically in perfect health, whereas the public at large is typically unhealthy over a broad spectrum; and

- In each of CDC's mask-risk experiments, measurable clinical numbers always move or fluctuate. However, none of the studies bother to explore the continued rate of measurables beyond the chosen time limits of the study. This is a critically important omission as people in society are engaged in life activities for hours at a time, day after day, for weeks on end.

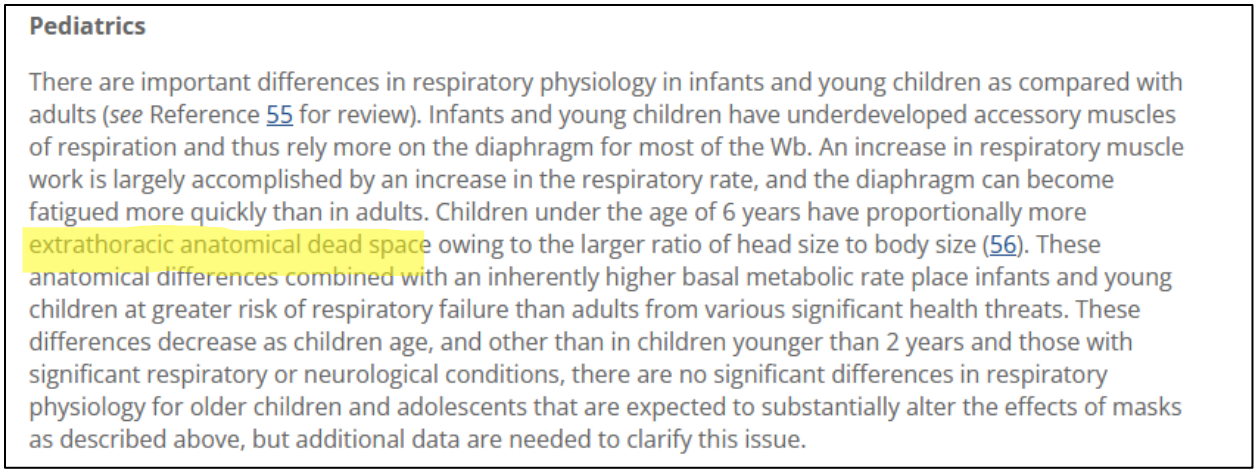
The following studies demonstrated some of these before-mentioned issues and negate the one-size-fits-all approach recommended by CDC and adopted by TSA in the Health Directives:

Beyond the larger sample size, advantages of our study include testing cloth facemasks that are actually being used by people in day-to-day life during the current pandemic, not excluding subjects with common co-morbidities like asthma [15], and measuring ventilation and not just oxygenation [12]. Our study has limitations that could be addressed in future work. First, our sample size is modest, though notably larger than many prior studies assessing gas exchange while wearing masks. Second, the duration of each study phase was 10 minutes, which was chosen to provide adequate time to observe physiologic changes but not require people to volunteer more than 90 minutes of their time. Though the substantial increase in heart rate with walking supports that the duration and intensity were sufficient, future studies may consider a longer duration and/or higher intensity of physical activity. Similarly, the rigor of the activity could be better controlled by using a treadmill. Third, the order of testing could be randomized to make sure that vitals obtained during the last phases (i.e. wearing the surgical mask) were not influenced by the subjects being tired from the prior phases. However, each subject had a 10 minute period of rest (sitting) before each walking phase during which their heart rate returned to baseline, so it is unlikely that the slight increase in heart rate observed with surgical masks was due to subject fatigue. Fourth, we used transcutaneous measurements of CO_2 tension rather than arterial blood sampling in order to minimize pain for the subjects, which may be a less accurate method of measurement. However, the SenTec monitor is validated as a surrogate for arterial blood sampling [16] and the measurements taken in triplicate in our study subjects were very consistent (almost always within 1–2 mmHg of each other).

Conclusion

In conclusion, facemasks did not impair oxygenation or ventilation among 50 adults at rest or during physical activity. No episodes of hypoxemia or hypercarbia occurred with either cloth or surgical masks, both at rest and while walking briskly. The risk of pathologic gas exchange impairment with cloth masks and surgical masks is near-zero in the general adult population.

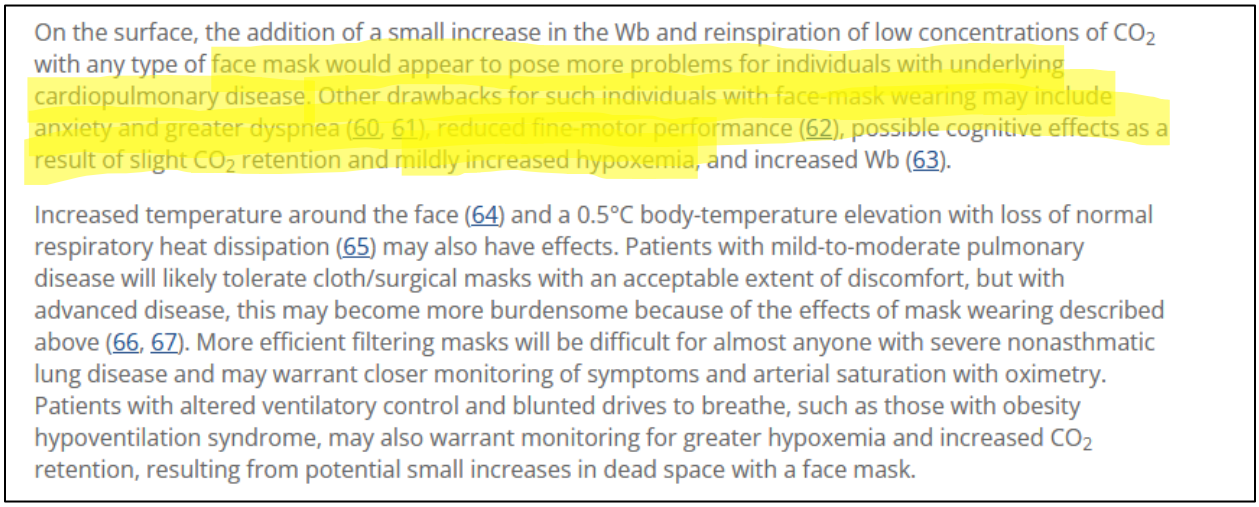
Figure 3-J: "The Effects of Wearing Facemasks on Oxygenation & Ventilation at Rest & During Physical Activity" Authors: Shein SL, Whitticar S, Mascho KK, Pace E, Speicher R, *et al.*



Pediatrics

There are important differences in respiratory physiology in infants and young children as compared with adults (*see* Reference 55 for review). Infants and young children have underdeveloped accessory muscles of respiration and thus rely more on the diaphragm for most of the Wb. An increase in respiratory muscle work is largely accomplished by an increase in the respiratory rate, and the diaphragm can become fatigued more quickly than in adults. Children under the age of 6 years have proportionally more extrathoracic anatomical dead space owing to the larger ratio of head size to body size (56). These anatomical differences combined with an inherently higher basal metabolic rate place infants and young children at greater risk of respiratory failure than adults from various significant health threats. These differences decrease as children age, and other than in children younger than 2 years and those with significant respiratory or neurological conditions, there are no significant differences in respiratory physiology for older children and adolescents that are expected to substantially alter the effects of masks as described above, but additional data are needed to clarify this issue.

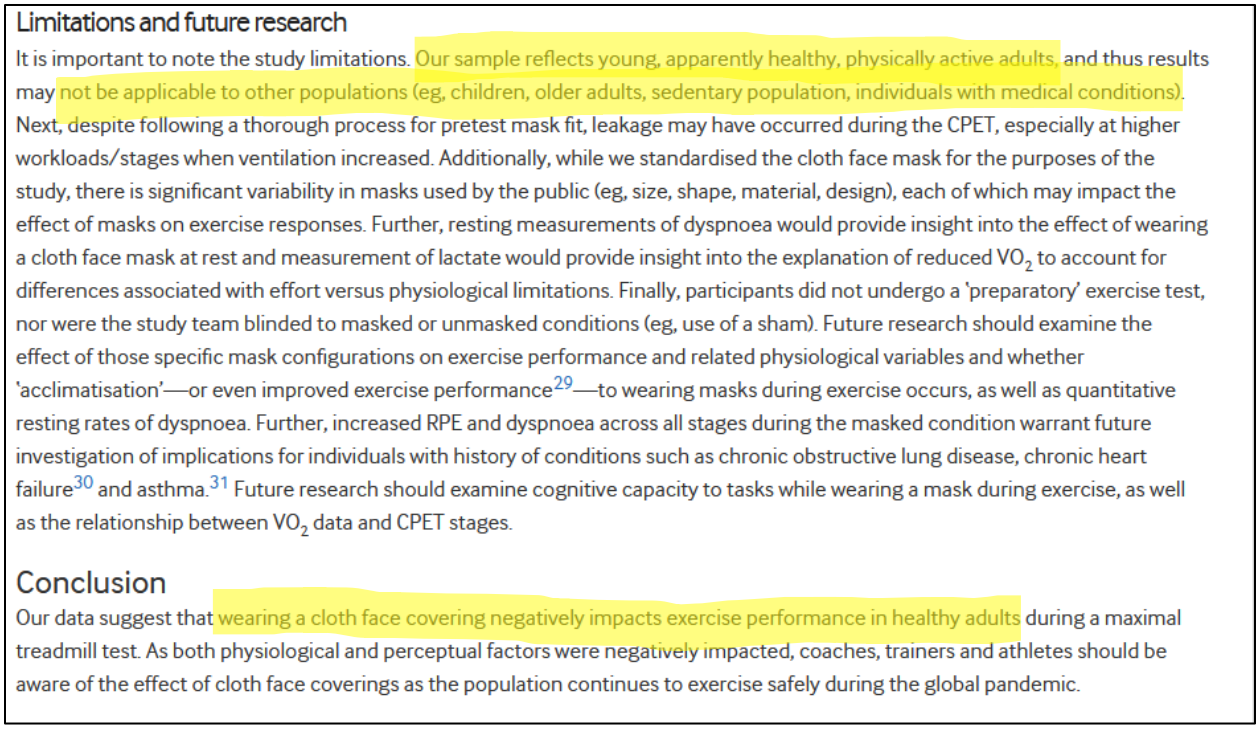
Figure 3-K: "Face Masks & the Cardiorespiratory Response to Physical Activity in Health & Disease" Authors: Hopkins SR, Dominelli PB, Davis CK, *et al*.



On the surface, the addition of a small increase in the Wb and reinspiration of low concentrations of CO_2 with any type of face mask would appear to pose more problems for individuals with underlying cardiopulmonary disease. Other drawbacks for such individuals with face-mask wearing may include anxiety and greater dyspnea (60, 61), reduced fine-motor performance (62), possible cognitive effects as a result of slight CO_2 retention and mildly increased hypoxemia, and increased Wb (63).

Increased temperature around the face (64) and a 0.5°C body-temperature elevation with loss of normal respiratory heat dissipation (65) may also have effects. Patients with mild-to-moderate pulmonary disease will likely tolerate cloth/surgical masks with an acceptable extent of discomfort, but with advanced disease, this may become more burdensome because of the effects of mask wearing described above (66, 67). More efficient filtering masks will be difficult for almost anyone with severe nonasthmatic lung disease and may warrant closer monitoring of symptoms and arterial saturation with oximetry. Patients with altered ventilatory control and blunted drives to breathe, such as those with obesity hypoventilation syndrome, may also warrant monitoring for greater hypoxemia and increased CO_2 retention, resulting from potential small increases in dead space with a face mask.

Figure 3-L: *Id*.



Limitations and future research

It is important to note the study limitations. Our sample reflects young, apparently healthy, physically active adults, and thus results may not be applicable to other populations (eg, children, older adults, sedentary population, individuals with medical conditions). Next, despite following a thorough process for pretest mask fit, leakage may have occurred during the CPET, especially at higher workloads/stages when ventilation increased. Additionally, while we standardised the cloth face mask for the purposes of the study, there is significant variability in masks used by the public (eg, size, shape, material, design), each of which may impact the effect of masks on exercise responses. Further, resting measurements of dyspnoea would provide insight into the effect of wearing a cloth face mask at rest and measurement of lactate would provide insight into the explanation of reduced VO_2 to account for differences associated with effort versus physiological limitations. Finally, participants did not undergo a 'preparatory' exercise test, nor were the study team blinded to masked or unmasked conditions (eg, use of a sham). Future research should examine the effect of those specific mask configurations on exercise performance and related physiological variables and whether 'acclimatisation'—or even improved exercise performance[29]—to wearing masks during exercise occurs, as well as quantitative resting rates of dyspnoea. Further, increased RPE and dyspnoea across all stages during the masked condition warrant future investigation of implications for individuals with history of conditions such as chronic obstructive lung disease, chronic heart failure[30] and asthma.[31] Future research should examine cognitive capacity to tasks while wearing a mask during exercise, as well as the relationship between VO_2 data and CPET stages.

Conclusion

Our data suggest that wearing a cloth face covering negatively impacts exercise performance in healthy adults during a maximal treadmill test. As both physiological and perceptual factors were negatively impacted, coaches, trainers and athletes should be aware of the effect of cloth face coverings as the population continues to exercise safely during the global pandemic.

Figure 3-N "Effects of Wearing a Cloth Face Mask on Performance, Physiological & Perceptual Responses During a Graded Treadmill Running Exercise Test" Authors: Driver S, Reynolds M, Brown K, *et al.*

E. Public-health agencies and those without any such expertise such as TSA continue to use unqualified scientists to provide masking guidance and continue to embarrass themselves by using scientific research that is not evidence-based. The Mask Mandate violates OSHA regulations for mask use.

In March 2020, Dr. Anthony Fauci went before the nation and professed that universal masking should not occur. Then in April 2020, he and other public-health officials reversed course, suddenly claiming there was scientific evidence to support their new guidance. Yet this went against decades of

tested science that has been utilized to protect U.S. workers. The "science" used to guide these new directives was flawed as mentioned *supra*.

Yet unqualified scientists continue to pose to the American public as "experts" or "qualified" individuals when in fact they are not. One of the most profound experiences in this buffoonery came on Sept. 16, 2020, when then-CDC Director Robert Redfield went before the Senate Appropriations Committee and testified, "These facemasks are the important, powerful public-health tool we have. … I might even go so far as to say that this facemask is more guaranteed to protect me against COVID that when I take a COVID vaccine."

Figure 4-A: Dr. Robert Redfield testifying about masks before the Senate Appropriations Committee

To illustrate the concerns the Court should have about government "scientists" providing these ridiculous and false statements about masking, we investigated the research they used to come to these conclusions. The study Dr. Redfield relied on to form his opinion was called "Quantitative Method for Comparative Assessment of Particle Removal Efficiency of Fabric Masks as Alternatives to Standard Surgical Masks for PPE."[8] Here are some of our findings:

- The Portacounts (equipment used for the study) were not calibrated before the study.
- The research team changed the original preprint title of this study. A significant difference in the original preprint and the preprint utilized by the research team (which became the official study name) was that the initial admission of the Portacounts being out of calibration was removed.
- To determine a fit, the mask is required to be tested against real-world scenarios of body movement. 29 CFR § 1910.134 App. A § 14. This study decided that because of social-distancing practices, this was not necessary, and they had their single test subject not move her head, not breathe out of her mouth, and only breathe from her nose. It falsely

[8] https://www.sciencedirect.com/science/article/pii/S2590238520303647

assumed that people in public, transportation workers, and those aboard transit conveyances would not move their heads and talk while wearing a mask.

- The masks had to be manipulated and a nylon layer was used to obtain a performance suitable to justify mask use. But "All personal protective equipment shall be of safe design and construction for the work to be performed." 29 CFR § 1910.132.
- Researchers made no mention of the need for people to have a medical evaluation before using respiratory devices that can achieve a high level of filter efficiency. But "Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee." 29 CFR § 1910.134(e).

It was astonishing when we made these discoveries. Professionally speaking, Dr. Redfield embarrassed himself that day and damaged his credibility. CDC used this fraudulent study to proclaim to the country that masks offer protection, when in fact, scientifically they do not.

Congress assigned statutory authority to OSHA, in the Department of Labor, to regulate workplace safety. All transportation hubs and conveyances covered by the Mask Mandate are workplaces. Therefore, this requires CDC

and TSA to adhere to the Code of Federal Regulations enforced by OSHA such as 29 CFR §§ 1910.132 & 1910.134.

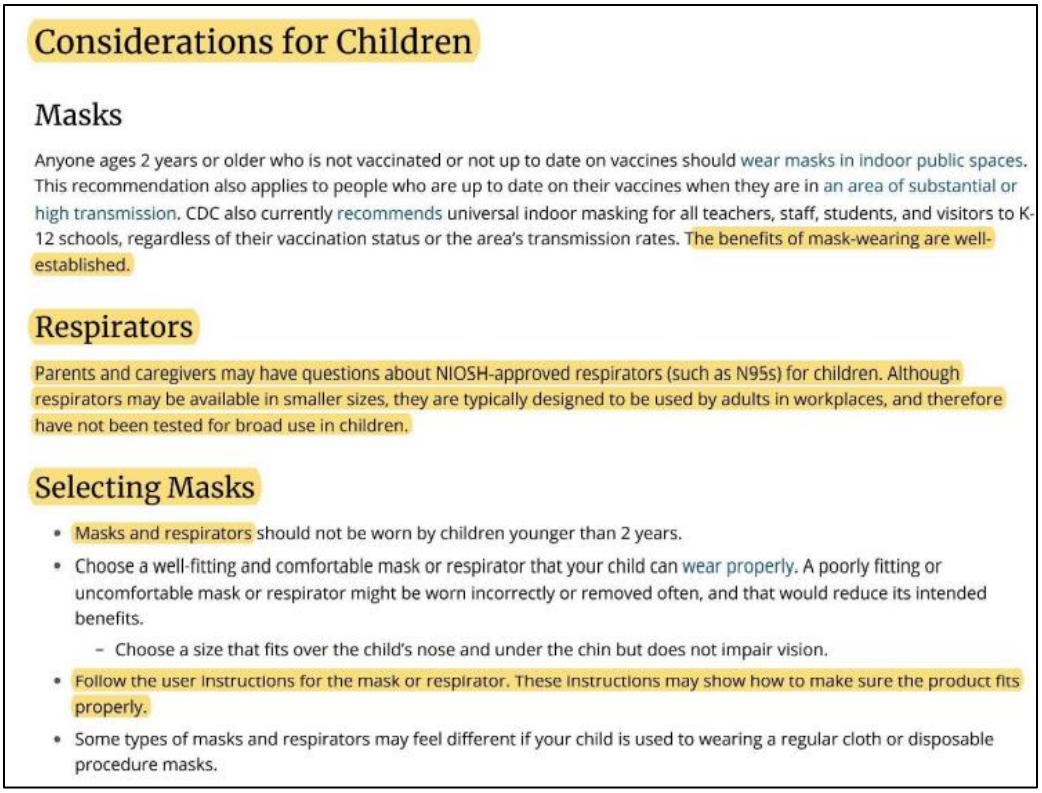
"The Mandate did not differentiate between kinds of masks based on their efficacy at blocking transmission." *HFDF*.

In July 2021, *amicus curiae* Tyson Gabriel published a video documentary showing many of the deficiencies in CDC's mask experiments.[9] We respectfully ask the Court to examine the evidence presented therein. We demonstrate where numerous studies manipulated results through adjusting mechanisms or ignoring their own data. In addition, the presentation helps clarify how the mask studies are unfinished low-level, starter studies, not the robust data that should be used to influence public policy.

On Jan. 28, 2022, CDC published new mask guidance called "Types of Masks and Respirators."[10] This was amazingly incoherent to established safety and health experts. In fact, this guidance significantly lowered the bar. An example can be found on Page 6. It insinuates that N95 respirators are safe for children. Figure 4-B. But in fact, most manufacturers such as 3M and Moldex clearly state that the N95s are not designed kids. Figure 4-C.

[9] https://www.tysciencegeuy.com/mask-documentary-series.html

[10] https://tinyurl.com/yck9syfd



Considerations for Children

Masks

Anyone ages 2 years or older who is not vaccinated or not up to date on vaccines should wear masks in indoor public spaces. This recommendation also applies to people who are up to date on their vaccines when they are in an area of substantial or high transmission. CDC also currently recommends universal indoor masking for all teachers, staff, students, and visitors to K-12 schools, regardless of their vaccination status or the area's transmission rates. The benefits of mask-wearing are well-established.

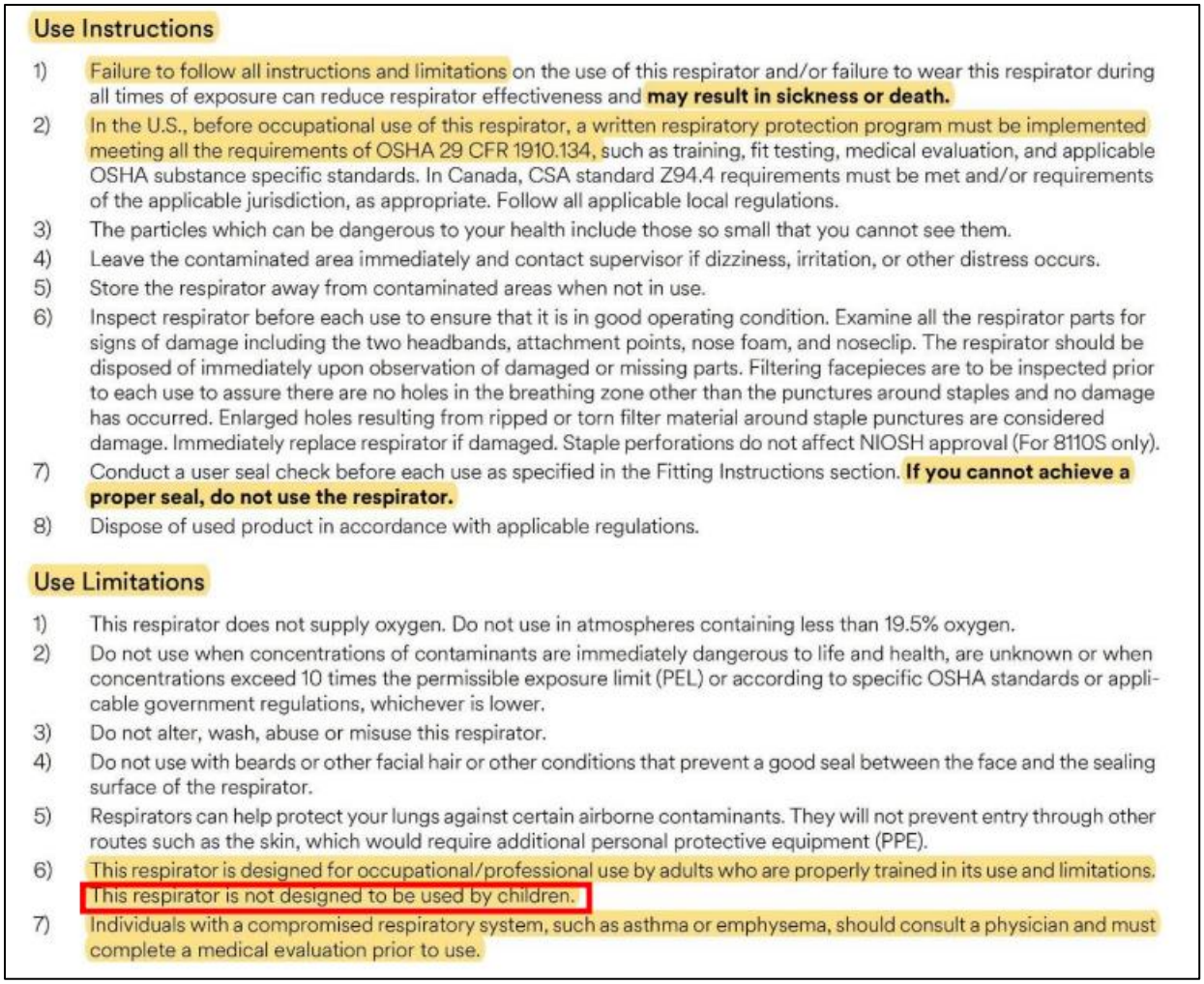
Respirators

Parents and caregivers may have questions about NIOSH-approved respirators (such as N95s) for children. Although respirators may be available in smaller sizes, they are typically designed to be used by adults in workplaces, and therefore have not been tested for broad use in children.

Selecting Masks

- Masks and respirators should not be worn by children younger than 2 years.
- Choose a well-fitting and comfortable mask or respirator that your child can wear properly. A poorly fitting or uncomfortable mask or respirator might be worn incorrectly or removed often, and that would reduce its intended benefits.
  - Choose a size that fits over the child's nose and under the chin but does not impair vision.
- Follow the user instructions for the mask or respirator. These instructions may show how to make sure the product fits properly.
- Some types of masks and respirators may feel different if your child is used to wearing a regular cloth or disposable procedure masks.

Figure 4-B: Misleading CDC Language Regarding Children Wearing Masks & Respirators



Use Instructions

1) Failure to follow all instructions and limitations on the use of this respirator and/or failure to wear this respirator during all times of exposure can reduce respirator effectiveness and **may result in sickness or death.**
2) In the U.S., before occupational use of this respirator, a written respiratory protection program must be implemented meeting all the requirements of OSHA 29 CFR 1910.134, such as training, fit testing, medical evaluation, and applicable OSHA substance specific standards. In Canada, CSA standard Z94.4 requirements must be met and/or requirements of the applicable jurisdiction, as appropriate. Follow all applicable local regulations.
3) The particles which can be dangerous to your health include those so small that you cannot see them.
4) Leave the contaminated area immediately and contact supervisor if dizziness, irritation, or other distress occurs.
5) Store the respirator away from contaminated areas when not in use.
6) Inspect respirator before each use to ensure that it is in good operating condition. Examine all the respirator parts for signs of damage including the two headbands, attachment points, nose foam, and noseclip. The respirator should be disposed of immediately upon observation of damaged or missing parts. Filtering facepieces are to be inspected prior to each use to assure there are no holes in the breathing zone other than the punctures around staples and no damage has occurred. Enlarged holes resulting from ripped or torn filter material around staple punctures are considered damage. Immediately replace respirator if damaged. Staple perforations do not affect NIOSH approval (For 8110S only).
7) Conduct a user seal check before each use as specified in the Fitting Instructions section. **If you cannot achieve a proper seal, do not use the respirator.**
8) Dispose of used product in accordance with applicable regulations.

Use Limitations

1) This respirator does not supply oxygen. Do not use in atmospheres containing less than 19.5% oxygen.
2) Do not use when concentrations of contaminants are immediately dangerous to life and health, are unknown or when concentrations exceed 10 times the permissible exposure limit (PEL) or according to specific OSHA standards or applicable government regulations, whichever is lower.
3) Do not alter, wash, abuse or misuse this respirator.
4) Do not use with beards or other facial hair or other conditions that prevent a good seal between the face and the sealing surface of the respirator.
5) Respirators can help protect your lungs against certain airborne contaminants. They will not prevent entry through other routes such as the skin, which would require additional personal protective equipment (PPE).
6) This respirator is designed for occupational/professional use by adults who are properly trained in its use and limitations. This respirator is not designed to be used by children.
7) Individuals with a compromised respiratory system, such as asthma or emphysema, should consult a physician and must complete a medical evaluation prior to use.

Figure 4-C: 3M Instructions for N95 Respirators – Not Designed for Children

We wrote our Feb. 22, 2022, letter to CDC Director Walensky to educate and assist her team in rescinding this publication and implementing strategies that are low risk and yield positive results. App. 959-985. In its response, CDC dodged the question of why the agency would recommend N95s for children when the manufacturers warn against it. CDC's position continues to be that masks work if they are used "properly" (i.e. glued to the face with no

gaps), which is never the case in the real world, especially with an untrained public. CDC and other agencies continue to cite "research" such as the fraudulent Bangladesh mask study (Ex. 1 and App. 892-900) and the erroneous "SARS-CoV-2 Incidence in K-12 School Districts with Mask-Required Versus Mask-Optional Policies – Arkansas, August-October 2021" study as continued validation for their "masks are great" policies.

Our same letter was sent to Mr. Zients at the White House. It appears he might have taken our guidance and pushed for engineering controls as the main solution. On March 23 (31 days after our letter was received), the White House posted the "Let's Clear the Air on COVID" brief[11] that communicates engineering control technologies as the best solution to mitigate exposure.

Yet CDC continues clinging to its false narrative that masks are effective and do not harm human health: "CDC recommends that everyone aged 2 and older – including passengers and workers – properly wear a well-fitting mask or respirator over the nose and mouth in indoor areas of public transportation (such as airplanes, trains, etc.) and transportation hubs (such as airports, stations, etc.)." CDC Statement of May 3, 2022; Ex. 2.

[11] https://tinyurl.com/2p8rha6x

VIII. CONCLUSION

It is astonishing to those of us who carry expertise in the safety and industrial hygiene fields that this universal masking nonsense has gone on for more than two years. Much of that has to do with courts not having the courage and integrity to listen and act upon information that is not carried in the media and in mainstream public-health circles. We're glad to see that is finally starting to change with Judge Mizelle's outstanding opinion in *HFDF* in April 2022. We hope this brief will help the Court understand how CDC's and TSA's Mask Mandate are arbitrary and capricious, not to mention all the other legal problems raised by Mr. Wall such as the agencies not having statutory authority to require face coverings, lack of notice and comment, violation of federal laws, and constitutional problems.

Because "our system does not permit agencies to act unlawfully even in pursuit of desirable ends," the Court must declare unlawful and vacate CDC's FTMM Order, TSA's three Health Directives, and TSA's Emergency Amendment. *Ala. Ass'n of Realtors v. HHS*, 141 S.Ct. 2485, 2490 (2021). We also ask the Court to award Mr. Wall his demanded relief of permanently enjoining CDC, HHS, TSA, and DHS from ever issuing any other orders requiring that transportation passengers and workers don face masks unless specific

authority is enacted into law by Congress (although even then the constitutional problems would remain).

"[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated – not that their application to the individual petitioners is proscribed." *Nat'l Mining Ass'n v. U.S. Army Corps of Eng'rs,* 145 F.3d 1399, 1409 (D.C. Cir. 1998). When "a provision is declared invalid," that provision "cannot be lawfully enforced against others" – not just against the one traveler before the Court in this case. *Barr v. Am. Ass'n of Pol. Consultants*, 140 S.Ct. 2335, 2351 (2020).

Respectfully submitted this 5th day of July 2022.

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IX. CERTIFICATE OF COMPLIANCE

We certify that this brief complies with FRAP 29(a)(5) & 32(a)(5)(A) because it has been prepared in 14-point Georgia, a proportionally spaced font, and this document complies with the 6,500-word limit because the Argument section contains 6,380 words as measured by Microsoft Word.

X. CERTIFICATE OF SERVICE

I certify that on July 5, 2022, I e-mailed this brief to these Court clerks for uploading into the 11th Circuit's Case Management/Electronic Case Filing system:

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I also certify that I am mailing four paper copies to the Court as required.

I also certify that I e-mailed this brief July 5 to the parties:

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Exhibit 1

stevekirsch.substack.com

We've asked Science to retract the Bangladesh mask study

Steve Kirsch

6-8 minutes

May 2, 2022

People think masks work, even though they don't

Even after the Federal transportation mask mandate was rescinded, judging by the behavior I observed in multiple airports, it appears that somewhere around half the public still thinks that masks work.

The mask study in Finland showed if there is an effect, it's negative

The best science shows that, if anything, the masks are more likely to be harmful than helpful; see this excellent video by UCSF Professor Vinay Prasad on the mask study done in Finland.

The Bangladesh study was widely hailed by experts as the definitive study that "proved" masks work

One of the key reasons that people think masks work is the Bangladesh study that was done by Stanford and Yale and was relied upon by both the CDC and IDSA. In fact, it's the only randomized study that we are aware of that claims masks work.

The other randomized trial, the one done in Denmark, was deliberately re-written to suggest masks

work because the medical journals wouldn't publish a negative study since it was counter-narrative. The BMJ courageously documented the scientific misconduct by the medical journals.

What if the Bangladesh study proved nothing?

So if we can show that the Bangladesh mask study actually shows that masks DO NOT WORK and we can get the paper retracted, then we've made an incredible difference. We can:

1. Force the medical community to admit that it has some very serious systemic issues that need to be addressed regarding scientific integrity.
2. Destroy the credibility of the CDC to give even the simplest medical advice. Drugs are very complex. Masks are simple. But the CDC can't even get something simple like masks right. It follows that it doesn't have a prayer to get something more complex like vaccines right.
3. Destroy the credibility of all the medical experts who relied on the study (pretty much everyone in the medical community). Not a single mainstream academic spoke out that the study showed nothing. They all screwed up.
4. Show that the medical community is utterly incapable of policing itself. This study wasn't rocket science. It's basic statistics. Why is a British mathematician easily destroying this study while nobody in the US medical community speaks out at all. And even when the "misinformation spreaders" were saying "masks don't work" the medical community still ignored looking at the issue. What does it take to get their attention?
5. Destroy the credibility of the press for not doing their homework in talking to us (we've said from the beginning that masks can't work)
6. Show the world that they should stop using masks, especially on kids and in schools.
7. Reduce pollution and trash from all the unnecessary masks that are being made
8. Show the entire world they were manipulated into adopting an intervention which at best did nothing and more than likely helped increase infection. Once they realize they were fooled on masks, it opens up the possibility that they might also have been fooled by the COVID vaccines. And once they realize they were misled by the COVID vaccines, they become open to the possibility that they were misled on other vaccines as well. They then start to realize that there was a reason for the liability protection request of the drug companies: it is because they knew their products were unsafe.
9. Demonstrate that, if we are given an opportunity to challenge the authorities, the "misinformation spreaders" always win.
10. Put an end to self-appointed "mask police" (these are people who come up to you and demand to know "where is your mask?")

The Bangladesh mask study actually didn't prove anything

We've shown that there is nothing shown by the Bangladesh study previously. We challenged the first author to defend his study and he failed. Badly.

But the nail in the coffin is this new analysis by UK Professor Norman Fenton.

Yale Professor of Economics Jason Abaluck, the first author of the Bangladesh study, reviewed Fenton's analysis. Abaluck self-determined that Fenton was incompetent so he could justify no longer talking to him.

Abaluck also noted that the reason they used cluster randomization in the trial is because they weren't testing whether masks worked on individuals, but whether community masking as a health policy would make a difference: would people comply and would it subsequently reduce the rate of infection. This subtle distinction is irrelevant. At the end of the day, Abaluck's cluster-randomization study showed that there wasn't any difference in infection rate between the groups.

In fact, Fenton showed that Abaluck's study was roughly equivalent to this experiment:

> To give a feel for just how 'insignificant' the 52% figure is - if you wanted to use it to conclude that the seropositivity rate is lower in people receiving the mask intervention than those who do not - then this would be much like flipping 201 coins, observing 101 'heads' and 100 'tails' and concluding that all coins are more likely to land on heads than tails.

Fenton asked Science to retract or correct the paper

On May 2, 2022, Fenton wrote to the journal that published the paper (Science) and requested that the Bangladesh mask study be either corrected or retracted since it incorrectly states that masks work.

Here is the conclusion of the paper:

> A randomized-trial of community-level mask promotion in rural Bangladesh during the COVID-19 pandemic shows that the intervention increased mask usage and reduced symptomatic SARS-CoV-2 infections, demonstrating that promoting community mask-wearing can improve public health.

The only thing that is true is that the intervention to ask people to wear masks did, in fact, increase mask wearing. The rest is wrong and needs to be retracted.

What happens next is the true test of character

Everyone makes mistakes. But what they do about the mistake after it is clearly pointed out is telling.

We will soon see how trustable the editors of Science are. If the journal does nothing, it will implicate the journal. Which means you shouldn't trust it in the future.

Secondly, the medical community (and mainstream media) should now quickly assess whether they made a mistake in promoting a false narrative. If they publicly fail to admit their mistake at this point, they are even more deplorable than I imagined.

What do you think will happen?

Exhibit 2

cdc.gov

Coronavirus Disease 2019

3-4 minutes 5-3-22

At this time, CDC recommends that everyone aged 2 and older – including passengers and workers – properly wear a well-fitting mask or respirator over the nose and mouth in indoor areas of public transportation (such as airplanes, trains, etc.) and transportation hubs (such as airports, stations, etc.). When people properly wear a well-fitting mask or respirator, they protect themselves and those around them, and help keep travel and public transportation safer for everyone. Wearing a well-fitting mask or respirator is most beneficial in crowded or poorly ventilated locations, such as airport jetways. We also encourage operators of public transportation and transportation hubs to support mask wearing by all people, including employees.

This public health recommendation is based on the currently available data, including an understanding of domestic and global epidemiology, circulating variants and their impact on disease severity and vaccine effectiveness, current trends in COVID-19 Community Levels within the United States, and projections of COVID-19 trends in the coming months.

Along with staying up to date with COVID-19 vaccines, avoiding crowds, wearing a well-fitting mask or respirator is one of multiple prevention steps that people can take to protect themselves and others in travel and transportation settings.

For more information about safer travel during the pandemic, see Domestic Travel During COVID-19 | CDC and International Travel | CDC.

The following can be attributed to CDC Director Rochelle P. Walensky, MD, MPH:

CDC continues to recommend that all people—passengers and workers, alike—properly wear a well-fitting mask or respirator in indoor public transportation conveyances and transportation hubs to provide protection for themselves and other travelers in these high volume, mixed population settings. We now have a range of tools we need to protect ourselves from the impact of COVID-19, including access to high-quality masks and respirators for all who need them.

Additionally, it is important for all of us to protect not only ourselves, but also to be considerate of others at increased risk for severe COVID-19 and those who are not yet able to be vaccinated. Wearing a mask in indoor public transportation settings will provide protection for the individual and the community.

###

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

No. 21-11532-BB

United States Court of Appeals for the 11th Circuit

LUCAS WALL,
Appellant/Plaintiff

v.

CENTERS FOR DISEASE CONTROL & PREVENTION, DEPARTMENT OF HEALTH & HUMAN SERVICES, TRANSPORTATION SECURITY ADMINISTRATION, DEPARTMENT OF HOMELAND SECURITY, & DEPARTMENT OF TRANSPORTATION,
Appellees/Defendants

Appeal from the United States District Court
for the Middle District of Florida
No. 6:21-cv-975

BRIEF OF *AMICI CURIAE* 3 DUAL CITIZENS IN SUPPORT OF APPELLANT URGING REVERSAL

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I. CERTIFICATE OF INTERESTED PERSONS

Pursuant to 11th Cir. R. 26.1-2(b), we certify that the CIP contained in Appellant's Opening Brief (Brief at 1-32) is correct and complete with only one addition:

- *Amicus Curiae* Yvonne Marcus, dual citizen of the United States and Israel

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IV. OUR INTEREST IN THE CASE

Friends of the Court are three dual citizens who are subject to Appellees Centers for Disease Control & Prevention ("CDC")'s and Department of Health & Human Services ("HHS")' International Traveler Testing Requirement ("ITTR" or "Testing Requirement") challenged by Appellant Lucas Wall: Uri and Yvonne Marcus, dual citizens of America and Israel; and Kleanthis Andreadakis, dual citizen of America and Greece.

We support Mr. Wall's arguments that the ITTR is *ultra vires* and should be enjoined worldwide, just as happened to the FTMM. *Health Freedom Defense Fund v. Biden*, No. 8:21-cv-1693 (M.D. Fla. April 18, 2022) ("*HFDF*"). The Court should reverse the judgment of the district court.

MR. & MRS. MARCUS: Uri and Yvonne Marcus, husband and wife, are U.S. citizens who reside most of the year at Shmu'el Lupo 6/18, Jerusalem, Israel 9355006. They maintain both a residential address and a business address in the United States. They are travelers subject to the ITTR.

Mr. Marcus was last in the United States from Nov. 20 to Dec. 9, 2020. He has not returned to his homeland since the initial ITTR version took effect Jan. 12, 2021, because he objects to having to undergo an invasive test as a condition of checking in for his flight, and is concerned about significant airline change fees if he can't find a test in time or receives a false positive result,

stranding him for several days in Israel and missing planned time with family and business associates in America. He is concerned that although CDC and HHS voluntarily withdrew the ITTR effective June 12, 2022 (App. 561-564), it could be reimposed at any time.

Mrs. Marcus was last in the United States from July 30 to Sept. 4, 2021. She was subjected to the ITTR upon her departure from Israel despite her lack of consent to use an Emergency Use Authorization ("EUA") or unauthorized medical device, which COVID-19 tests are classified as by the Food & Drug Administration ("FDA"). She has not returned to the USA since September 2021 due to the same concerns as her husband regarding the unlawful ITTR, even though Israel cancelled its testing requirement for all inbound travelers as of May 20, 2022.

Mr. and Mrs. Marcus are challenging CDC's ITTR and the Federal Transportation Mask Mandate ("FTMM") along with three other plaintiffs. *Marcus v. CDC*, No. 2:22-cv-2383 (C.D. Calif.). Along with one other petitioner, Mr. Marcus is also attacking the Transportation Security Administration ("TSA")'s enforcement of the FTMM. *Marcus v. TSA*, No. 21-1225 (D.C. Cir.)

MR. ANDREADAKIS: Kleanthis Andreadakis maintains a permanent residence in Tennessee but travels regularly to Greece to take care of required family business matters. His family also owns a home in Greece that

requires annual maintenance. He is a traveler subject to the ITTR.

For his Nov. 26, 2021, flight from Athens, Greece, to Newark, New Jersey, he was forced to submit a negative COVID-19 test due to the ITTR over his objections. This test cost him €60 ($67), which CDC and HHS won't reimburse. Like the Marcuses, he objects to forced use of emergency or unauthorized medical products and is concerned about being stranded in Greece during his next trip there, if the ITTR is reinstated, due to the possibility a rapid virus test is unavailable or he receives a false positive. He also objects to the cost of testing, which makes traveling to his ancestral homeland more expensive. Mr. Andreadakis is challenging CDC's ITTR and FTMM. *Andreadakis v. CDC*, No. 3:22-cv-52 (E.D. Va.). Along with one other petitioner, he is also attacking TSA's mask directives. *Andreadakis v. TSA*, No. 21-1237 (D.C. Cir.).

We obtained consent of Appellant Lucas Wall and Alisa Klein, counsel for the appellees, to file this brief. FRAP 29(a)(2).

Pursuant to FRAP 29(a)(4)(E), we certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than the three of us contributed money that was intended to fund preparing or submitting this brief.

V. STATEMENT OF THE ISSUES

1. Without providing public notice or soliciting comment, on Jan. 12, 2021, Appellees CDC and HHS announced an order (the ITTR) requiring all passengers flying to the United States from a foreign country to get tested no more than three days before their flight departs and to present the negative result (or documentation of having recovered from COVID-19) to the airline before boarding the plane.
2. The day after taking office (Jan. 21, 2021), President Biden issued "Executive Order Promoting COVID-19 Safety in Domestic & International Travel." E.O. 13998, 86 Fed. Reg. 7,205 (Jan. 26, 2021). This Executive Order directed the ITTR be continued.
3. The slightly revised ITTR (Biden Administration Version 1) took effect Jan. 26, 2021. 86 Fed. Reg. 7,387 (Jan. 28, 2021).
4. Version 2 of the ITTR took effect Nov. 8, 2021. It made a minor change: modifying the requirement for unvaccinated flyers to get tested within one day of departure (keeping the mandate at three days for fully vaccinated passengers).

5. CDC amended the ITTR order again, effective Dec. 6, 2021. This is Version 3[1] that was in effect until June 12, 2022: CDC Order "Requirements for Negative Pre-Departure COVID–19 Test Result or Documentation of Recovery from COVID–19 for All Airline or Other Aircraft Passengers Arriving into the United States from Any Foreign Country." 86 Fed. Reg. 69,256 (Dec. 7, 2021).
6. This latest edition made another slight change: requiring all passengers, regardless of vaccination status, to submit a negative COVID-19 test taken within one day of departure.
7. Before checking in for an international flight to the United States, the ITTR requires travelers to complete a "Passenger Disclosure & Attestation to the United States of America" form. All airlines must provide the disclosure to their passengers and collect the attestation prior to embarkation.
8. CDC prohibits airlines from boarding any passenger who does not submit the form with an accompanying negative COVID-19 test taken within one day of departure, which amounts to detaining and quarantining such a traveler in a foreign country.

[1] These three editions (January 2021, November 2021, and December 2021) apply worldwide. There were prior iterations of the ITTR that applied only to airline passengers departing certain foreign countries.

9. Congress has explicitly declined to require COVID-19 testing of international air travelers. There is no law authorizing the ITTR.

10. CDC and HHS made it clear in repealing the Testing Requirement effective June 12 that they will reimpose it any time they deem necessary, meaning this case is a live controversy for the Court's resolution.

VI. ARGUMENT SUMMARY

As dual citizens who frequently travel between the United States and our other nation of citizenship, we have an especially strong interest in ensuring the Testing Requirement is invalidated and can never come back. There is no statutory authority for CDC/HHS to require virus testing at foreign airports well outside U.S. jurisdiction. The agencies violated the Administrative Procedure Act ("APA") in issuing all versions of the ITTR without providing notice and allowing for public comments. The Testing Requirement is arbitrary and capricious; violates provisions of the Constitution and international law; runs afoul of the Food, Drug, & Cosmetic Act; and has no place in a free society that proudly governs itself by the rule of law – not by fiat of the CDC director.

The district court erred in ruling the ITTR is legal and constitutional. This Court should reverse that judgment, declare the ITTR *ultra vires*, and permanently enjoin CDC and HHS from ever reissuing it unless Congress enacts specific authorization.

VII. ARGUMENT

A. The International Traveler Testing Requirement is not authorized by the Public Health Service Act.

As part of their response to the COVID-19 pandemic, CDC and HHS issued a nationwide Eviction Moratorium ("EM") based on 42 USC § 264(a), which is part of the Public Health Service Act ("PHSA"). Likewise, as authority for the ITTR, the agencies invoked that same statute and two regulations implementing it (42 CFR §§ 71.20 & 71.31(b)).

Numerous federal courts struck down the EM, which the Supreme Court sustained, holding that Congress never gave CDC the staggering amount of power it claims to supposedly reduce the transmission of COVID-19. This Court also strongly signaled it disagrees with CDC's broad reading of § 264(a). Although not a merits decision, the dissenting judge on a 2-1 panel concluded CDC exceeded its authority by ordering the EM. And the two judges who denied a preliminary injunction wrote: "We have doubts about the district court's ruling on the first factor: whether the plaintiffs are likely to succeed on the merits. … the second sentence of § 264(a) appears to clarify any ambiguity about the scope of the CDC's power under the first." *Brown v.*

HHS, No. 20-14210 (11th Cir. July 14, 2021). The government did not prevail on the merits in any case challenging the EM.[2]

As Mr. Wall argues, the PHSA doesn't provide CDC or HHS the power to issue any orders, as the ITTR is labeled. App. 533. It may only issue ***regulations***. "The term 'regulations', except when otherwise specified, means rules and regulations made by [CDC] with the approval of the [HHS] Secretary." 42 USC § 201(d). Rules and regulations are codified in the Code of Federal Regulations. Orders are not. Since the ITTR is an order and is not published in the CFR, it's automatically *ultra vires*.

Should the Court continue its analysis, however, we further support Mr. Wall's assertion that virus testing does not comport to the statute's allowance for CDC to require the "inspection … of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings." 42 USC § 264(a).

The district court erred in determining that "Adding even more obscurity to the statutory text, Section 361 does not define those listed terms in subsection (a), including, as is pertinent here, the words 'sanitation' and

[2] *Tiger Lily v. HUD*, No. 2:20-cv-2692, 2021 WL 1171887 (W.D. Tenn. Mar. 15, 2021), aff'd 5 F.4th 666 (6th Cir. 2021); *Alabama Ass'n of Realtors v. HHS*, No. 20-cv-3377 (D.D.C. May 5, 2021), aff'd 141 S.Ct. 2485 (2021); *Skyworks v. CDC*, No. 5:20-cv-2407 (N.D. Ohio March 10, 2021); and *Terkel v. CDC*, No. 6:20-cv-564, 2021 WL 742877 (E.D. Tex. Feb. 25, 2021).

'inspection.' … Because both terms have multiple permissible meanings, they are inherently ambiguous." App. 465.

But there's nothing ambiguous about the language Congress used in this section. "Inspection" only applies to animals and articles. The use of the exact words "human beings" in the same sentence of § 264(a) conclusively shows Congress did not conceive the word "animals" as including humans.

The context of the word "inspection" also clearly shows it doesn't apply to people. The statute permits CDC to issue regulations (not orders) for "inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings…" 42 USC § 264(a). None of the other items listed in this sentence would ever apply to humans. So why would the district court believe that "inspection" would be the sole outlier and apply to airline passengers? "[T]he meaning of a word cannot be determined in isolation, but must be drawn from the context in which it is used." *Deal v. United States*, 508 U.S. 129, 132 (1993). *See also Hibbs v. Winn*, 542 U.S. 88, 101 (2004).

We also look to the other parts of § 264 for guidance on whether "inspection" may apply to humans. In other sections authorizing regulations CDC may promulgate to control disease spread among people, authority is given

for "*examination* … of individuals." 42 USC § 264(c) (emphasis added). The next part is titled "Apprehension and *examination* of persons reasonably believed to be infected." 42 USC § 264(d) (emphasis added). "*Regulations* prescribed under this section may provide for the apprehension and *examination* of any individual reasonably believed to be infected with a communicable disease… Such *regulations* may provide that if upon *examination* any such individual is found to be infected." 42 USC § 264(d)(1) (emphases added).

Moving down two sections, we again see the term "examination" used in connection with people, not the word "inspection," and once more CDC is only given power to promulgate regulations, not issue orders: CDC's director "is authorized to provide by *regulations* for the apprehension and *examination*, in time of war, of any individual… Such *regulations* may provide that if upon *examination* any such individual is found to be so infected, he may be detained…" 42 USC § 266 (emphasis added).

The district court examined in great detail 1940s dictionaries to ascertain the meaning of the word "inspection," ignorng the clear statuatory context that "inspection" is only permitted of anmials and articles whereas testing of human beings for viruses is an "examination" measure permitted only if a person is "reasonably believed to be infected with a communicable disease…"

42 USC § 264(d)(1). Regardless of whether the Court holds that testing qualifies as "inspection" or "examination," it's essentially a moot point because forcing every airline passenger flying to America to get a virus test fails the statute's clear requirement that CDC may only require this for someone "reasonably believed to be infected."

The district court went out of its way to find certain dictionaries that contain extremely long, multi-part definitions of "inspection" in a clear effort to find some justification for upholding the ITTR. App. 466-467. But it should have relied on more concise defintions that fail to include testing humans for a virus. Inspection is "the act of looking at some*thing* carefully, or an official visit to a building or organization to check that every*thing* is correct and legal." Cambridge Advanced Learner's Dictionary & Thesaurus (emphases added).[3] Three Cambridge dictionaries referenced on this webpage contain 17 examples of sentences using the word "inspection." These all refer to *things* such as buildings, hospitals, passports, luggage, aircraft, fields, engines, letters, elevators, etc. None a single example refers to people, and certainly not testing people for a virus.

Other sources also refer to objects, not people.

[3] https://dictionary.cambridge.org/us/dictionary/english/inspection (visited July 2, 2022)

> "An inspection involves checking some*thing*, i.e., examining and assessing some*thing*. We may inspect a building or organization to make sure that it meets specific standards. … inspection is the critical appraisal of materials, items, or systems… The inspectors determine whether the *item or material* is in proper condition and of the right quantity. They also determine whether it conforms to the company's, industry's, local, or national rules and regulations." Market Business News (emphases added).[4]

"[T]he act of looking at some*thing* closely in order to learn more about it, to find problems, etc.: the act of inspecting some*thing*." Britannica Dictionary (emphases added).[5] Inspection is "The act by a regulatory authority of conducting an official review of documents, facilities, records, and any other resources that the authority deems to be related to the clinical trial…" Segen's Medical Dictionary.[6] A legal dictionary defines "medical inspection" as "a complete inspection of a person by a doctor ***using only the naked eye***…" World Law Dictionary (emphasis added).[7] COVID-19, of course, can't be detected with the naked eye; it requires a test, which is not

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[4] https://marketbusinessnews.com/financial-glossary/inspection-definition-meaning (visited July 2, 2022)

[5] https://www.britannica.com/dictionary/inspection (visited July 2, 2022)

[6] https://medical-dictionary.thefreedictionary.com/inspection (visited July 2, 2022)

[7] https://dictionary.translegal.com/en/medical-inspection/noun (visited July 2, 2022)

an "inspection." "Inspection is an act ***limited to what one can observe visually***…" Yale School of Medicine (emphasis added).[8]

The Court should focus on how the terms are used in our society. A coroner, for example, is also called a "medical examiner," not a "medical inspector." We don't schedule an "annual inspection" with our doctor. We go for an "annual exam."

Importantly for the Court's analysis, as Mr. Wall correctly notes, the ITTR does not contain the word "inspection." App. 532-538. This justification for CDC's action was only raised by its lawyers during litigation. But "agencies are not entitled to deference for interpretations offered by their counsel in legal briefs." *Shea v. Clinton*, 850 F.Supp. 2d 153, 161 (D.D.C. 2012).

CDC's own definitions illustrate the farce of its belated claim that "inspection" applies to humans. Indeed, the agency itself uses the word "examination" to refer to people and specifically to virus testing:

> "*Medical examination* means the assessment of an individual by an authorized and licensed health worker to determine the individual's health status and potential public health risk to others and may include the taking of a medical history, a physical examination, and ***collection of human biological samples for laboratory testing*** as may be needed to diagnose or confirm the presence or extent of infection with a quarantinable communicable disease." 42 CFR § 71.1 (italics original; bold/italics emphasis added).

[8] https://www.jove.com/v/10119/observation-and-inspection (visited July 2, 2022)

Whereas CDC's definitions only use the term "inspection" to apply to vessels: "*Deratting Certificate* means a certificate issued under the instructions of the Director, in the form prescribed by the International Health Regulations, recording the inspection and deratting of the ship." *Id*. (italics original).

Congress has never enacted into law a requirement that airline travelers undergo virus testing before departing a foreign country. Executive agencies may not exercise their authority in a manner that is inconsistent with the administrative structure that Congress has created. Mandatory virus testing means CDC is imposing, for those unable to obtain a rapid COVID-19 negative test within a day of their flight – quarantine and detention of travelers in foreign nations, where it lacks jurisdiction. The statute CDC relies on to justify the requirement permits no such thing. Virus testing is not an enumerated measure in 42 USC § 264(a).

"[B]efore deferring to an administrative agency's statutory interpretation, courts 'must first exhaust the traditional tools of statutory interpretation and reject administrative constructions' that are contrary to the clear meaning of the statute." *Black v. Pension Benefit Guar. Corp.*, 983 F.3rd 858, 863 (6th Cir. 2020).

B. Regulations cited by CDC to justify the International Traveler Testing Requirement do so such thing.

Regulations cited in CDC's ITTR order don't help its case at all, a fact the district court did not address. Let's begin with 42 CFR § 71.20. It authorizes CDC's director to "conduct public health prevention measures, at U.S. ports of entry or other locations, through non-invasive procedures as defined in section 71.1 to detect the potential presence of communicable diseases." The government argued below that the phrase "or other locations" authorizes CDC to require virus testing in foreign countries. At first glance, that argument might seem plausible. But there are two problems. First, this regulation was promulgated by CDC citing its legal authority under 42 USC §§ 264 & 265. 82 Fed. Reg. 6,890 (Jan. 19, 2017). As discussed above, neither statutory provision allows for virus testing in foreign nations.

Second, "*Non-invasive* means procedures conducted by an authorized public health worker (i.e., an individual with education and training in the field of public health) or another individual with suitable public health training…" 42 CFR § 71.1 (italics original). But CDC has no way to control whether the tens of thousands of people around the globe conducting COVID-19 testing for passengers to comply with the ITTR are "authorized public health worker[s]" who have "education and training in the field of public health." Mr. Wall argued this point below, which CDC failed to rebut and the district

court did not address. In fact, the lower court didn't discuss the regulations CDC relied on at all in its judgment.

Now let's look at the second regulation cited: 42 CFR § 71.31(b). It provides that CDC's director "may require detention of a carrier until the completion of the measures outlined in this part that are necessary to prevent the introduction or spread of a communicable disease." Since virus testing in foreign nations isn't authorized by 42 USC §§ 264 & 265 nor any regulation under 42 CFR Part 71, this regulation doesn't justify the Testing Requirement. If it applied, it would only permit CDC to detain an airplane once it arrives in the United States and, perhaps, force all the passengers to undergo COVID-19 testing at the U.S. port of entry. This rule simply doesn't apply in foreign nations.

C. The International Traveler Testing Requirement is an improper delegation of legislative power.

If the Court upholds the lower court's decision that the Public Health Service Act does authorize the ITTR, then it must declare the PHSA unconstitutional as an improper delegation of legislative power by Congress to the Executive Branch. Under the Nondelegation Doctrine, Congress may not transfer legislative power to the Executive Branch. Acts of Congress must supply an intelligible principle to guide the executive's rulemaking authority.

If the Court finds it does authorize the ITTR, PHSA § 361 (42 USC § 264) violates Article I's Vesting Clause because Congress delegated legislative power to CDC and HHS with no intelligible principle to guide their discretion. That section authorizes CDC "to make and enforce such regulations as in [its] judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases … from one State or possession into any other State or possession." 42 USC § 264(a). The statute further provides that CDC may take certain specific measures as well as "other measures, as in [its] judgment may be necessary." *Id.*

The district court erred in permitting the expansiveness of § 264(a):

> "It follows that the second sentence does not *limit* the scope of the first; such a construction would not only conflict with the expansive grant of power in the first sentence, but it would also read restrictive language into the second. … That is, the second sentence is not an exhaustive list; it is merely a list of examples or suggestions." App. 463-464 (emphasis original).

It entirely failed to address Mr. Wall's nondelegation argument, and is at odds with how other courts interpret 42 USC § 264(a).

> "This kind of catchall provision at the end of a list of specific items warrants application of the *ejusdem generis* canon, which says that 'where general words follow specific words in a statutory enumeration, the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific words.' *Circuit City Stores, Inc. v. Adams*, 532 U.S. 105, 114-15 (2001) (citation omitted). The residual phrase in § 264(a) is 'controlled and defined by reference to the enumerated categories … before it,' *Id.* at 115, such that the 'other

> measures' envisioned in the statute are measures like 'inspection, fumigation, disinfection, sanitation, pest extermination' and so on, 42 U.S.C. § 264(a)." *Tiger Lily v. HUD*, 992 F.3d 518 (6th Cir. 2021).

If § 264 is so broad as to authorize the ITTR, then Congress provided no intelligible principle to guide CDC's discretion to take actions that "are" or "may be necessary" to "prevent the introduction, transmission, or spread of communicable diseases." Vesting CDC with such broad authority without an intelligible principle violates the Nondelegation Doctrine. The Sixth Circuit also noted the law doesn't give CDC the power to issue orders that aren't published in the Code of Federal Regulations.

> "[§ 264(a)] does not grant the CDC the power it claims. … [T]he first sentence grants the Secretary ***rulemaking authority***. But that authority is not as capacious as the government contends. When we interpret statutes, we must give effect to each clause and word. … Plainly, the second sentence narrows the scope of the first. … There is no clear expression of congressional intent in § 264 to convey such an expansive grant of agency power, and we will not infer one. … [CDC's] interpretation is both textually implausible and ***constitutionally dubious***." *Id.* (emphases added).

D. The International Traveler Testing Requirement violates the APA's requirements for notice and comment.

The ITTR affects our legal rights and obligations because it prevents us from flying into the USA without obtaining an expensive, time-consuming, and sometimes unreliable COVID-19 test. But we were not given notice nor

the opportunity to comment before the Testing Requirement's various versions went into effect.

> "CDC did not allow for public participation through notice and comment before issuing the Mask Mandate. Accordingly, promulgation of the Mandate violated the APA unless an exception to the ordinary rulemaking procedure applies. … Besides its brief reference to the pandemic, the Mandate makes no effort to explain its reasoning that there was an exceptional circumstance at the time it implemented the [order]. … Nor is the Mandate's invocation of good cause sufficient for the Court to find that the CDC engaged in reasoned decisionmaking when it found good cause." *HFDF*.

The district court in this case got it wrong in holding that "the good cause exception is not limited to emergencies; it applies when 'delay would do real harm.'" App. 479. But it cited no evidence that delaying the ITTR would have done any harm at all. The Testing Requirement never stopped new coronavirus variants from entering the United States, in large part since it only applied to airline passengers and not the (many more) people entering the USA by land and sea.

> "Furthermore, even for a good cause, including a cause that is intended to slow the spread of Covid-19, Defendants cannot go beyond the authority authorized by Congress. *See Ala. Ass'n of Realtors*, 141 S. Ct. at 2488-89; *see also Missouri v. Biden*, Case No. 4:21-cv-1329 at *3-4 (E.D. Mo. Nov. 29, 2021) (holding that Congress must provide clear authorization if delegating the exercise of powers of 'vast economic and political significance,' if the authority would 'significantly alter the balance between federal and state power,' or if the 'administrative interpretation of a statute invokes the outer limits of Congress' power'). Accordingly,

> the Court finds that the president exceeded his authority…" *Kentucky v. Biden*, No. 3:21-cv-55 (E.D. Ky. Nov. 30, 2021) (enjoining vaccine mandate for federal contractors). *See also Georgia v. Biden*, No. 1:21-cv-163 (S.D. Ga. Dec. 7, 2021) (same).

Had CDC permitted comments as required, thousands of dual citizens such as ourselves would have likely objected because the requirement is an unreasonable restriction on our constitutional right to travel and our right to enter and leave our countries of citizenship under international law.

We join Mr. Wall's contention that good cause did not excuse CDC's failure to comply with the notice-and-comment process for the ITTR because the agency had a full year to give notice, solicit comments, respond to those comments, and publish a regulation (not an order) in the Code of Federal Regulations from the date the secretary of health and human services declared COVID-19 a national emergency (Jan. 31, 2020) until the date the ITTR first took effect in January 2021. And Version 3 of the ITTR took effect in December 2021, nearly two years into the pandemic, again without any public comment.

"Notice and comment can only be avoided in truly exceptional emergency situations, which notably, cannot arise as a result of the agency's own delay." *Wash. All. of Tech. Workers v. DHS*, 202 F. Supp. 3d 20, 26 (D.D.C. 2016). An agency may not "show an emergency" when it "ha[s] been aware of the problem" but "nonetheless failed to take action." *Id.* "[I]t is too late for the

State to defend extreme measures with claims of temporary exigency, if it ever could." *South Bay United Pentecostal Church v. Newsom*, 141 S.Ct. 716 (2021) (Gorsuch, J.).

E. The ITTR is arbitrary and capricious because CDC and HHS fail to: explain why it doesn't apply to travelers entering by land and sea, acknowledge it imposes significant financial and time burdens on travelers for no discernable benefit, and consider that the policy can leave American citizens detained abroad indefinitely.

CDC and HHS failed to consider the burden of requiring all airline passengers to obtain a negative COVID-19 test within one day of departure. The district court ignored that the agencies never explained why the ITTR applies only to air travel, not to those entering the United States by land or sea. "CDC's failure to explain its reasoning is particular problematic here. At the time when the CDC issued the Mandate the COVID-19 pandemic had been ongoing for almost a year and COVID-19 case numbers were decreasing." *HFDF*.

CDC and HHS have not presented any evidence that air travelers pose a greater risk of bringing COVID-19 into the country than land and sea passengers. Numerous COVID-19 outbreaks among immigrants detained by the U.S. Border Patrol along the Mexican border as well as passengers and crew aboard cruiseships docking in the United States illustrate this point.

Agency action is arbitrary and capricious if it is not "reasonable and reasonably explained." *Ind. Boxcar Corp. v. R.R. Ret. Bd.*, 712 F.3d 590, 591 (D.C. Cir. 2013). CDC and HHS never tried to explain why the ITTR only applies to air travel when airplanes are much less likely to be a source of COVID-19 spread than travelers arriving by land and sea. App. 1,091-1,115.

Notably the Testing Requirement applies to all travelers, regardless of whether they are vaccinated, have naturally immunity, or are presently infected with coronavirus.

> "Congress directed the actions set forth in Section 361 to certain ***animals or articles***, those so infected as to be a dangerous source of infection to people. On the face of the statute, the agency must direct other measures to ***specific targets 'found' to be sources of infection – not to amorphous disease spread*** but, for example, to actually infected animals, or at least those likely to be…" *Skyworks*. (emphases added).

The ITTR imposes significant financial and time burdens on international air travelers. However, there is no benefit as the purported reason for the latest ITTR version – to stop the Omicron variant from entering the United States – was nonsense because it was already widely circulating domestically in December 2021 and would soon set record highs for daily positive COVID-19 tests in January 2022.

> "[T]his all assumes that COVID-19 poses any significant danger to workers to begin with; for the more than 78% of Americans aged 12 and older either fully or partially inoculated against it, the virus poses – the Administration assures us – little risk at

> all.) *See*, e.g., 86 Fed. Reg. 61,402, 61,402-03 ('COVID-19 vaccines authorized or approved by [FDA] effectively protect vaccinated individuals against severe illness and death from COVID-19.'). ... The Mandate is staggeringly overbroad. ... one constant remains – the Mandate fails almost completely to address, or even respond to, much of this reality and common sense." *BST Holdings v. OSHA*, 17 F.4th 604 (5th Cir. 2021).

If a passenger is in a country or region where rapid COVID-19 testing is not available and it's impossible to obtain a test result within a day of departure, the ITTR prohibits that person (including U.S. citizens) from flying to the United States indefinitely. When an American citizen visits a foreign country, he/she has no guarantee that he/she will ever be able to return home due to the ITTR's stringent one-day testing requirement.

Unavailability of rapid testing is hardly speculative. It has occurred in numerous countries during the pandemic including right here in the United States. Samples of news reports from January 2022: "[T]he U.S. finds itself in the midst of yet another coronavirus test shortage, with consumers facing limited sales at retailers and long lines at testing centers." "The confusion has frustrated some public health professionals who say there simply aren't enough kits to permit people who are sick, those exposed to someone who has been infected with the virus, and people who want to travel and attend gatherings to get tested." President Biden admitted finding rapid COVID-19

tests is a "real challenge" and "the need is great to do more in terms of the rapid tests and the availability of [them]."

CDC does not reimburse expenses as a result of canceled or delayed travel because of the Testing Requirement. CDC won't pay travelers the costs of new plane tickets, lodging, meals, and other expenses as a result of being detained in a foreign country if virus testing isn't available or a false positive is received. CDC also does not reimburse travelers for COVID-19 testing fees, which can cost as much as $200 depending on the location and type of test. If an airline passenger pays $200 for a coronavirus test and the results do not come back within a day, he/she must then pay $200 for another virus test while detained abroad – with no guarantee the results will come in time.

If a flight is canceled or delayed until the next day, an airline passenger is forced to obtain another expensive COVID-19 test. The ITTR makes no exceptions for situations like this wholly outside passengers' control.

Airlines, hotels, chambers of commerce, and many others have described the enormous problems with the ITTR: "Pre-departure testing is no longer an effective measure in protecting the United States from COVID-19. This requirement provides little health benefit, yet discourages travel by imposing an additional cost, as well as a fear of being stranded overseas." App. 1,088.

Another problem is that there is no evidence that PCR tests – a common COVID-19 testing method – are reliable.[9] An American airline passenger subject to the ITTR could receive a false positive and then be detained by CDC in a foreign nation, banned for no reason from returning to his/her country of citzenship.

CDC Director Dr. Rochelle Walensky admitted in December 2021 that "The newly updated CDC guidelines don't require testing at the end of isolation because PCR tests can stay positive for up to 12 weeks," well after a person is able to spread the virus to others.[10]

Finally, CDC and HHS did not explain that airplanes are among the safest places you can be during the pandemic due to high-efficiency filters that bring fresh air into the cabin every 3-4 minutes. App. 1,091-1,115. Aircraft cabins have more sterile air than many hospital operating rooms. Most importantly, there have not been any reported outbreaks of COVID-19 at airports or on board aircraft. Therefore, targeting only air travel with the ITTR is arbitrary and capricious.

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[9] https://www.brightworkresearch.com/understanding-the-pcr-test-and-how-there-was-never-a-reliable-test-for-covid (visited July 3, 2022)

[10] https://abc7ny.com/omicron-variant-covid-19-testing-pcr-test-corona-virus-isolation/11402303 (visited July 3, 2022)

F. The International Traveler Testing Requirement interferes with Americans' constitutional right to travel internationally.

The ITTR imposes impermissible government restrictions on our constitutional right to travel. This is especially a concern because we are dual citizens of the United States and another country. If we are abroad and can't obtain a rapid COVID-19 test, we are prohibited from flying home to the United States despite holding a U.S. passport. But

> "a United States citizen has a right to re-enter the United States. … a U.S. citizen's right to re-enter the United States entails more than simply the right to step over the border after having arrived there. *See, e.g., Newton v. INS*, 736 F.2d 336, 343 (6th Cir. 1984) (noting that citizens 'have the right to *return* to this country at any time of their liking' (emphasis added)). At some point, governmental actions taken to prevent or impede a citizen from reaching the border infringe upon the citizen's right to re-enter the United States." *Mohamed v. Holder*, 995 F. Supp. 2d 520, 536-537 (E.D. Va. 2014).

The right of international travel is constitutionally protected. When an order "impinges upon a constitutionally protected personal liberty, … the Government has the burden of demonstrating that [it] is a necessary … method of enforcement." *Maehr v. Dep't of State*, 5 F.4th 1100, 1108-09 (10th Cir. 2021), *cert. denied* 142 S.Ct. 1123 (2022). Here the ITTR fails the "necessary" test because CDC and HHS never demonstrated that virus testing only for airline passengers is a plausible way of keeping COVID-19 variants out of the United States.

"It might be suggested that a prospective airline passenger will not actually be deprived of his right to travel because there are alternative means of travel available. We do not find this argument persuasive 'since, in many situations, flying may be the only practical means of transportation.'" *United States v. Kroll*, 481 F.2d 884, 887 (8th Cir. 1973). There are no other reasonable modes of traveling between the United States, Greece, Israel, and most other foreign countries besides airplanes.

> "This freedom of movement is the very essence of our free society, setting us apart. Like the right of assembly and the right of association, it often makes all other rights meaningful – knowing, studying, arguing, exploring, conversing, observing, and even thinking. Once the right to travel is curtailed, all other rights suffer... Even though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved. ... We cannot exercise and enjoy citizenship in world perspective without the right to travel abroad; and I see no constitutional way to curb it..." *Aptheker v. Secretary of State*, 378 U.S. 500 (1964) (Douglas, J., concurring).

Strict scrutiny must apply in this case because CDC, through enforcement of the unlawful Testing Requirement, disparately impacts the freedom of movement compared to analogous activities that are not constitutionally protected.

> "In cases implicating this form of 'strict scrutiny,' courts nearly always face an individual's claim of constitutional right pitted against the government's claim of special expertise in a matter of high importance involving public health or safety. It has never been enough for the State to insist on deference or demand that

> individual rights give way to collective interests. Of course we are not scientists, but neither may we abandon the field when government officials with experts in tow seek to infringe a constitutionally protected liberty. The whole point of strict scrutiny is to test the government's assertions, and our precedents make plain that it has always been a demanding and rarely satisfied standard. ... Even in times of crisis – perhaps especially in times of crisis – we have a duty to hold governments to the Constitution." *South Bay* (Gorsuch, Thomas, and Alito, JJ., concurring).

The government doesn't control when citizens may travel, for what purpose, or using what mode. This right is reserved to the people by the Constitution.

> "That the right to international travel is deeply woven into our history and tradition is hard to deny. The Magna Carta established that it 'shall be lawful for any man to leave and return to our kingdom unharmed and without fear, by land or water, preserving his allegiance to us, except in time of war, for some short period, for the common benefit of the realm.' Similar notions appear in Blackstone: 'By the common law, every man may go out of the realm for whatever cause he pleaseth, without obtaining the king's leave ....' The colonists carried this tradition forward by citing British restraints on movement both between the colonies and beyond as causes for the Revolutionary War. ... To permit the government power to deny its citizens access to the outside world without a strong reason to do so seems inimical to the liberty that is every American's birthright. ... the right to international travel is implicit in the basic liberty protected by due process. ... In light of the 'history and tradition [that] guide and discipline' the inquiry, there is strong reason to conclude that the right of international travel cannot be substantially limited without passing muster under some form of heightened scrutiny." *Maehr* at 1110-12 (internal citations omitted).

"Freedom to leave a country or a hemisphere is as much a part of liberty as freedom to leave a State." *Shachtman v. Dulles*, 225 F.2d 938, 944 (D.C.

Cir. 1955) (Edgerton, J., concurring).

> "[I]t is difficult to see where, in principle, freedom to travel outside the United States is any less an attribute of personal liberty. Especially is this true today, when modern transportation has made all the world easily accessible and when the executive and legislative departments of our government have encouraged a welding together of nations and free intercourse of our citizens with those of other friendly countries. Personal liberty to go abroad is particularly important to an individual whose livelihood is dependent upon the right to travel..." *Bauer v. Acheson*, 106 F. Supp. 445, 451 (D.D.C 1952).
>
> "[A] citizen's right to be in the United States is obstructed if he or she cannot travel to the United States from an international destination. ... There is much to warrant extending the fundamental right to travel or movement to include international travel. As Plaintiff correctly observes, the right to international travel is recognized by international agreements to which the United States is a party, and in today's world, restricting a person's right to international travel can, in some circumstances, have as profound an adverse effect on a person's ability to exercise other liberty interests as a restriction on the right to interstate travel. As the Court has previously observed, interstate and international travel are increasingly seamless and we can no longer reasonably view interstate and international travel as discrete and separable activities." *Mohamed v. Holder*, 266 F. Supp. 3d 868, 878 (E.D. Va. 2017).
>
> "Although there are viable alternatives to flying for domestic travel within the continental United States such as traveling by car or train, the Court disagrees with Defendants' contention that international air travel is a mere convenience in light of the realities of our modern world. Such an argument ignores the numerous reasons that an individual may have for wanting or needing to travel overseas quickly such as the birth of a child, the death of a loved one, a business opportunity, or a religious obligation. ... The Court also disagrees with Defendants' assertion that *all* modes of transportation must be foreclosed before any infringement of an individual's due-process right to international travel

> is triggered. ... With perhaps the exception of travel to a small number of countries in North and Central America, a prohibition on flying turns routine international travel into an odyssey that imposes significant logistical, economic, and physical demands on travelers. ... the Court concludes on this record that Plaintiffs have constitutionally protected liberty interests in traveling internationally by air... The Court concludes international travel is not a mere convenience or luxury in this modern world. Indeed, for many international travel is a necessary aspect of liberties sacred to members of a free society." *Latif v. Holder*, 28 F. Supp. 3d 1134, 1148 (D. Or. 2014) (emphasis original).

G. The ITTR violates the International Covenant on Civil & Political Rights by interfering with several fundamental human rights established by treaty.

Like our Constitution, international human-rights law guarantees the right to liberty of movement:

> "1. Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement ... 2. Everyone shall be free to leave any country, including his own. 3. The above-mentioned rights shall not be subject to any restrictions except those which are provided by law... 4. ***No one shall be arbitrarily deprived of the right to enter his own country***." ICCPR Art. 12 (emphasis added); 999 U.N.T.S. (adopted by the U.S. on Sept. 8, 1992); App. 656-657.

As recognized in the ITTR, most – if not all – COVID-19 tests are experimental medical products authorized by FDA only for emergency use. The federal government provides rapid-test kits to U.S. citizens at no cost through the mail. However, these tests are issued by FDA under an EUA, making their use optional. They are also not accepted by airlines to comply

with the ITTR because they are self-administered, with no paperwork from a doctor's office, hospital, clinic, or testing center to confirm the specimen.

Not only does forced use of an emergency medical product without our consent violate the Food, Drug, & Cosmetic Act, it breaks America's commitment to basic human rights under international law: "[N]o one shall be subjected without his free consent to medical or scientific experimentation." ICCPR Art. 7; App. 654.

Congress has not passed a law requiring airline passengers be refused transportation unless they present a negative COVID-19 test. However, "No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law." ICCPR Art. 9; App. 655.

"[N]ot all international law obligations automatically constitute binding federal law enforceable in United States courts" and although treaties "may comprise international commitments" they "are not domestic law unless Congress has either ***enacted implementing statutes*** or the treaty itself conveys an intention that it be 'self-executing'…" *Medellin v. Texas*, 552 U.S. 491, 504 (2008) (emphasis added).

Some courts have held that the ICCPR is not "self-executing." However, Congress specifically provides that in carrying out all federal aviation laws, the Executive Branch "shall act consistently with obligations of the United

States Government under an international agreement." 49 USC § 40105 (b)(1)(A). This makes the ICCPR binding law when it concerns the aviation sector.

H. The International Traveler Testing Requirement violates the Food, Drug, & Cosmetic Act.

CDC and HHS acknowledge that rapid COVID-19 tests used by travelers to comply with the ITTR are authorized by FDA only for emergency use, or have no authorization whatsoever since they are obtained by passengers in foreign countries, where FDA has no control over the quality of the tests. "Viral Test means a viral detection test for current infection (i.e., a nucleic acid amplification test or a viral antigen test) cleared, approved, or ***issued an emergency use authorization (EUA)*** by the U.S. Food and Drug Administration…" App. 534 (emphasis added).

Since the ITTR only applies in foreign countries, there is no way for an airline passenger to determine if FDA, which lacks jurisdiction outside the United States, authorizes a testing procedure. CDC and HHS have no ability to verify the authenticity and reliability of COVID-19 tests manufactured abroad. An executive agency, no matter its own authority, may not issue edicts that are contrary to statutes enacted by Congress such as the FDCA.

The ITTR violates the FDCA by not giving passengers our right "to accept

or refuse administration of the [EUA] product…" 21 USC § 360bbb-3 (e)(1)(A)(ii)(III). "Nothing in this section provides the [HHS] Secretary any authority to require any person to carry out any activity that becomes lawful pursuant to an authorization under this section…" 21 USC § 360bbb-3(l).

CDC is not entitled to *Chevron* deference on the ITTR because it does not administer the FDCA, and therefore it has no authority to issue an order that overrides a statute enacted by Congress. *Chevron* deference "is not due unless a court, employing traditional tools of statutory construction, is left with an unresolved ambiguity." *Turner v. Bristol*, 2021 U.S. Dist. LEXIS 178062 at *21 (M.D. Fla. Sept. 20, 2021). The scope of CDC and HHS' authority is not ambiguous. The agency may not issue directives that violate laws codified in the U.S. Code.

There's good reason for these statutes prohibiting forced use of EUA medical devices. Requirements for emergency products are waived for, among other things, "current good manufacturing practice otherwise applicable to the manufacture, processing, packing … of products subject to regulation under this chapter…" 21 USC § 360bbb-3 (e)(3)(A). The FDCA is consistent with HHS regulations requiring that participants in trials of experimental medical devices must be informed that "participation is voluntary, refusal to participate ***will involve no penalty***…" 45 CFR § 46.116 (a)(8) (emphasis added).

VIII. CONCLUSION

This Court should not allow such a broad reading of 42 USC § 264(a) that would permit CDC to force all air travelers to endure virus testing in a foreign nation or be detained indefinitely. The ITTR also suffers from numerous other legal deficiencies.

> "Not only is there no evidence that the applicants have contributed to the spread of COVID-19 but there are many other less restrictive rules that could be adopted to minimize the risk to public interests. Finally, it has not been shown that granting the applications will harm the public. As noted, the State has not claimed that attendance at the applicants' services has resulted in the spread of the disease. And the State has not shown that public health would be imperiled if less restrictive measures were imposed." *Roman Cath. Diocese of Brooklyn v. Cuomo*, 141 S.Ct. 63 (2020).

Government "actors have been moving the goalposts on pandemic-related sacrifices for months, adopting new benchmarks that always seem to put restoration of liberty just around the corner." *South Bay* (Gorsuch, J.).

The district court improperly applied the Constitution, laws, and regulations in evaluating the legality of the Testing Requirement. As dual citizens who travel to/from the United States often, we join Mr. Wall in urging reversal and pray the Court permanently enjoins CDC and HHS from ever reimposing the ITTR.

Respectfully submitted this 5th day of July 2022.

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IX. CERTIFICATE OF COMPLIANCE

We certify that this *amicus curiae* brief complies with the requirements of FRAP 27(d) because it has been prepared in 14-point Georgia, a proportionally spaced font, and it conforms with the limit of 6,500 words because this document contains 6,499 words of Argument, according to Microsoft Word.

X. CERTIFICATE OF SERVICE

I certify that on July 5, 2022, I e-mailed this brief to these Court clerks for uploading into the 11th Circuit's Case Management/Electronic Case Filing system:

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I also certify that I am mailing four paper copies to the Court as required.

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