[redacted]

DECLARATION OF FACT IN SUPPORT OF SUSPENSION OF THE DEPARTMENT OF DEFENSE COVID-19 VACCINE MANDATE AND ASSOCIATED BOOSTERS

Affidavit presented to [redacted], a man [CAPT, USN].

I, [redacted], a man [SCPO, USN], depose and state as follows:

I make this affidavit, as a whistleblower under the Military Whistleblower Protection Act, Title 10 U.S.C. § 1034, in support of the above-referenced MOTION as expert testimony in support thereof.

The opinions expressed here are my own and arrived at from my persons, professional and educational experiences taken in context, where appropriate, by scientific data, publications, treatises, opinions, documents, reports, and other information relevant to the subject matter and are not necessarily those of the United States Navy, the United States Marine Corps or the Department of Defense.

EXPERIENCE & CREDENTIALS

1. I am an 18-year active-duty enlisted man in the U.S Navy and I currently serve at Marine Corps Base Camp Pendleton, California as a Special Operations Independent Duty Corpsman (SOIDC). My official duties as Senior Enlisted Medical Advisor include advisement to the commander of matters of operational medicine and the management of (22) SOIDCs in their care of (450) Reconnaissance Marines. Additionally, I am the Senior Enlisted Leader to approximately (130) Sailors, in such, I oversee their administrative process', provision of health care, and religious services to the (5) Marine units ((3700) Marines and Sailors) in which they serve.

2. I am a graduate of the Special Forces Medical Sergeant course from Fort Bragg, NC. My military training includes a combined four (4) years of military medical, CBRN, and advanced medical training with a focus on operational medicine in the deployed setting. Additionally, I obtained a Bachelor's degree in Clinical Health Sciences from the George Washington University of Health Sciences in 2019. My education has established a solid foundation that I leverage to better understand medicine, medical research, and bioethics application to my military environment. More importantly, I leverage this acumen with the refined skill of tactical observation to better draw conclusions and assessments from my operating environment.

3. Since January 2004, I have served on Active Duty in the Military and have been stationed primarily with Special Operations units or Special Operation Capable units. I have conducted (8) traditional deployments and (4) shorter operational taskings; my deployments include Iraq, South East Asia National Tasking #1, South East Asia National Tasking #2, Marine Expeditionary Unit #1, Marine Expeditionary Unit #2, Special Operations Task Force #1, Special Operations Task Force #2, Special

Operations Task Force #3, South East Asia Theater Tasking, POTUS Summit #1, POTUS Summit #2, and Joint Task Force North Customs and Border Patrol Operation.

4. My military career has been marked by accolades of high-performance marks, early promotions, and (9) personal awards; including (4) Navy and Marine Corps Achievement Medals, (3) Navy and Marine Corps Commendation Medals, and (2) Meritorious Service Medals. Throughout my career, I have served honorably and I have never accepted mediocracy, I have prided myself on accepting nothing but the most demanding assignments and schools.

5. Despite what can only be interpreted as a selfless career in support of our nation, I find myself unable to settle my conscience over the COVID-19 vaccine and associated mandates. Although coerce pressure from commanders and military policy seemed unbearable, I have not taken the COVID-19 shot and remain unvaccinated. My conviction, which can only be attributed to the Holy Spirit, has led me to see the unethical circumstances and harm surrounding these COVID-19 mandates. 03 September 2021 I sought a religious accommodation request (RAR) for an exemption to the COVID-19 vaccine, on 02 Nov 2021 I was notified of the denial of my RAR by the Deputy Commandant, Manpower, and Reserve Affairs (DC, M&RA). On 22 November 2021, I sent the Commandant of the Marine Corps an appeal of my RAR denial. 10 months later, as of 27 September 2022, I have not received a decision or message traffic regarding this appeal. I believe that COVID-19 mandates should never have occurred, and in light of available information should be halted immediately. This belief and conclusion are nuanced and multi-faceted, the following paragraphs depict points of what I believe are critical observations of the COVID-19 mandates.

SARS-COV-2

6. January 2020, during the initial outbreak of the pandemic, I had just deployed and was the Senior Medical Provider for several hundred active duty service members and contractors. During the initial weeks (towards the end of January 2020) I was informed of an exclusive meeting of senior medical advisors, infectious disease specialists, and CBRN subject matter experts, and it had been determined that the COVID-19 outbreak is not a biological weapon, but due to the anticipated 5-10% mortality rate we need to begin preparations to protect service members.

7. As the outbreak spread closer to our area of operations I sought support by requesting over$500,000 in equipment, supplies, and medications to expand our medical aid station into a (5) patient ICU capable of ventilating severely ill patients for (10) days. I leveraged our precarious position to request an emergency physician to assist in what could only be interpreted as an inevitable outbreak in our camp. Weeks and months dragged by, and we continued to train and improve our medical and decontamination protocols. We even worked with government and non-governmental organizations to provide guidance, laboratory direction, and purchase personal protective equipment to support the local hospitals. But the outbreak never happened, the impoverished city (over 1,000,000 persons) in which we operated, quarantined thousands in quarantine camps and quarantine islands but never seemed to need the ventilators that we anticipated. Sometimes the local hospitals were busy or full but the situation never seemed dire, just persistent. The local government officials and mayor (with whom I

was partnered) began to question if the lockdowns were worth the economic harm to a mostly poverty-stricken society. This decision to lockdown was made by the local department of public health with the recommendation and influence of the United States Government and WHO guidance.

8. I was “Dr. COVID”, I was the one to force social distancing and mask-wearing, I was the one that implemented full base spraying with bleach water, and I made the protocols that required full decontamination and washing of clothes after leaving the base, and during my 8-month tenure our camp never had a single case of COVID-19 infection. However, by the time I left our deployment, I was convinced that if I was not careful, I might catch COVID-19 and pass it on to loved ones or my pregnant wife. I was so extreme in my caution that I self-quarantined 14 days before redeployment and I wore an N95 for 3 days during my entire flight home, my face broke out in hives and sores where the masked touched . . . I was the epitome of "COVID" cautious.

9. Upon my return to my home unit, I was burnt out and conflicted about what was real regarding COVID-19 because the reality of the situation was beginning to set in, and the risk was not matching my caution, my observations did not match the narrative. I struggled to make sense of operational actions in the name of wellbeing and safety. Instead of establishing policy and mandates supporting COVID-19, I began to closely observe and analyze the information surrounding Sar-CoV-2 disease and the COVID-19 /vaccine/. To say the least, I ran from the responsibility of controlling COVID-19 protocols, and I never again accepted a position to regulate our service member's response to this “pandemic.”

RELIGIOUS BELIEFS

10. In my walk with Christ my ‘eyes have been opened to my transgressions and I have been doing my best to serve God in all that I do. Joshua 1:9 encourages me to “Be strong and courageous. Do not be afraid; do not be discouraged, for the Lord your God will be with you wherever you go.” The Bible also states “I will dwell in them and walk among them; And I will be their God, and they shall be My people.” 2 Corinthians 6:16. My ‘walk’ with God has encouraged me to turn from sin and seek growth through a personal relationship with him. Although I am not ‘sinless’ now nor through many past decisions, I now am seeking spiritual growth through every big decision in my life. Since my salvation in 2015, I have prayerfully recognized areas in my life that needed improvement and I strive to live a life that would be pleasing to God.

11. My awakening to vaccinations, including the COVID-19 /vaccine/, marks the first service-related conflict with my religious values. I believe that my God will supply me with every need (Philippians 4:19) and I have to have faith that God’s plan is greater than my own. As a Christian, I believe the Bible to be the inspired, inerrant, living Word of God. There are many places in the Bible that the ‘Holy Spirit’ has guided me to when making this decision. In 1 Corinthians 6:19, it states, “Do you not know that your bodies are temples of the Holy Spirit who is within you, whom you have received from God? You are not your own.” I am reminded that I am God’s child first and foremost. It goes on to say in 2 Corinthians 7:1, “Since we have these promises, dear friends, let us, therefore, purify ourselves of all that pollutes the body and mind, and perfect holiness out of awe of God.” Through my spiritual growth, I cannot knowingly continue to accept vaccines that contain neurotoxins, dangerous substances, weakened

viruses, animal parts, foreign DNA, albumin from human blood, and carcinogens that may prove harmful to the human body. My God has been established in my life as my highest authority over my morals, conscience, and character, and I must obey His will for my life first and foremost.

OPERATIONAL READINESS & NATURAL IMMUNITY

12. The Religious Freedom Restoration Act (RFRA) states that the "Government shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability." However, the "Government may substantially burden a person's exercise of religion only if it demonstrates that application of the burden to the person is in furtherance of a compelling governmental interest and it is the least restrictive means of furthering that compelling governmental interest" [Exhibit 1, https://mil.wa.gov/asset/5ba41fd4007a6 ;https://crsreports.congress.gov/product/pdf/IF/IF11490]. I do not believe that /vaccination/ against SARS-CoV-2 is the least restrictive means to accommodate individual religious beliefs meanwhile achieving the government's compelling interest in protection against SARS-CoV-2 disease.

13. I claim to have contracted SARS-CoV-2 in early August of 2021 before the COVID-19 vaccine mandates, Exhibit [2] and [3] indicate the documented presence of antibodies and T-cells I gained during infection. These naturally occurring God-given antibodies and T-cells are what have provided me the protection required to not contract the disease again and will provide the immunity to fight off future SARS-CoV-2 infections should I contract the disease again.

14. Following infection recovery, I have worked in a battalion aid station (medical), August 2021 to the present, I have been a first-hand witness to at least 4 "waves" of SARS-CoV-2 disease come through our command despite the greater than 95% COVID-19 vaccination rate at our command. To put it tactfully, our command has been less than compliant with mask-wearing, and I, along with my co-workers, have effectively not worn a mask since August 2021. Despite my certainty of repetitive exposure to SARS-CoV-2 over the last 2 years, I have still not been reinfected, but have observed many fully vaccinated Marines and Sailors become reinfected and experience breakthrough infections. Each of these infections is associated with a loss of man-hours and this loss is exactly what the DoD is claiming to prevent by mass COVID-19 /vaccination/. Moreover, force readiness is the claim and justification that is made against servicemembers who are forced out for not accepting the COVID-19 vaccination.

15. I recognize and understand the Department of Defense's desire to sustain force immunization readiness in the aftermath of a global SARS-CoV-2 pandemic. However, the DoD had not been able to provide the "burden of proof" or substantiation as to why serologic immunity is insufficient to pacify immunization requirements. I will provide an understanding of the "burden of proof" associated with the "least restrictive means" of the matter at hand. The research provided in compilations such as the Brown Stone Institute's Natural Immunity posting provide the secular science behind God-given natural immunity. At the time of the data collection, 19 Sep 2022, this research revealed that natural immunity is an acceptable, even superior, and longer-lasting, alternative means to COVID-19 /vaccination/. The over 150 research articles represent over 1,600 separate contributors (doctors, scientists, statisticians, and researchers) reflections on natural immunity and vaccine efficacy. In my review of over (2,300)

pages of research, I found evidence that overwhelmingly supports natural immunity, especially in light of the underperformance of the current COVID-19 /vaccines/ [https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/].

16. For example, Gatit et al. conducted “a retrospective observational study comparing three groups: (1) SARS-CoV-2-naïve individuals who received a two-dose regimen of the BioNTech/Pfizer mRNA BNT162b2 vaccine, (2) previously infected individuals who have not been vaccinated, and (3) previously infected and single-dose vaccinated individuals”. Findings revealed, “13 fold increased risk of breakthrough Delta infections in double vaccinated persons, and a 27 fold increased risk for symptomatic breakthrough infection in the double vaccinated relative to the natural immunity recovered persons…the risk of hospitalization was 8 times higher in the double vaccinated…this analysis demonstrated that natural immunity affords longer-lasting and stronger protection against infection, symptomatic disease, and hospitalization due to the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity.”

17. Furthermore, on 12 Nov 2021 the 5th Circuit court recognized natural immunity when the stated "naturally immune unvaccinated worker is presumably at less risk than an unvaccinated worker who has never had the virus”, exhibit [4]. In their response to a FOIA request, the CDC also reinforced natural immunity on 05 Nov 2021 when they failed to reveal any documents about cases where individuals infected with SARS-Cov-2, recovered, and then later became reinfected or infected others [Exhibit 5]. We now know that as variants progress break through infections can occur in the unvaccinated, however, the lack of data showing this is proof that the experts do not fully understand what was occurring and policymakers are making decisions that were not supportable by verifiable fact. In my professional opinion, ignoring naturally acquired serologic immunity to SARS-CoV-2 is the epitome of medical malfeasance and to involuntarily separate service members on grounds of being unvaccinated is having a much greater impact on operational readiness and national security than this disease ever could.

18. Long before the military COVID-19 mandates and /vaccine/ rollout the DoD's medical intelligence community exhibited continuous optimism towards natural immunity from Sars-Cov-2 infection, including statements that " T cells found in COVID-19 patients 'bode well' for long-term immunity" and "A growing collection of evidence suggests that T cells (CD4 and CD8) may provide the longest-lasting immunity to COVID-19" [Exhibit 6]. Moreover, the Uniformed Services University (USU) even hosted the Epidemiology, Immunology and Clinical Characteristics of Emerging Infectious Disease with Pandemic Potential (EPICC) study where they are evaluating the serologic immunity of COVID-19 vaccinated versus COVID-19 unvaccinated individuals. Despite USU's best attempts to discourage unvaccinated servicemembers from participating in the study, unvaccinated service members still have participated. A 19 January 2022 (Not released until 02 May 2022) participant study update stated "We found evidence of post-infection immunity even at one year after infection, including both antibodies (infection-fighting proteins) and "T-cells" (specialized immune cells which capture and kill viruses)" [Exhibit 7]. Once the mandates began the narrative quickly shifted to "pro-COVID-19 /vaccine/" and discounted any optimism towards natural immunity as an acceptable alternative to /vaccination/ [Exhibit 6, 2021.SEP].

19. AR 40-562 (BUMEDINST 6230.15B) Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases instruction guides services on how to vaccinate and maintain immunization readiness. The AR 40-562 states that “serologic or other tests can be used to identify pre-existing immunity from prior infections or immunizations that may eliminate unnecessary immunizations” and provides guidance for exemption from immunization [Exhibit 8]. Regarding military accessions, the instruction states: at “minimum, conduct serologic testing for antibodies for measles, rubella, hepatitis A, hepatitis B, and varicella” [Exhibit 8]. However, this “minimum” requirement for “military accessions” does not preclude medical professionals from screening for other diseases in the fighting force as proof of serologic immunity. It is common practice to defer immunizations based on serologic proof, ie. hepatitis, tetanus, etc. SARS-CoV-2 is a new disease for which we do not yet appreciate the totality of the humoral response in association with the spike protein. However, at this time it is known that the COVID-19 /vaccine/ humoral response is underperforming in comparison to natural immunity gained from infection with SARS-CoV-2. The AR 40-562 allows for services to code personnel found to be serologically positive for SARS CoV-2 antibodies as Medical, assumed (MA) or Medical, immune (MI) within the Immunization Tracking System [Exhibit 8]. Recognizing serologic immunity will prevent “superfluous immunization” which the AR 40-562 instructs health care professionals to “avoid”, [Exhibit 8]. This “code can be reversed upon further review”, thus leaving breathing space to allow for religious freedoms and allow for medical policy to adapt to emerging information [Exhibit 8]. It is my opinion that documentation and recording of SARS-CoV-2 natural immunity under the AR 40-562 are the least restrictive means to accommodate deeply held religious beliefs meanwhile allowing personnel to continue service in support of the United States Marine Corps and Navy.

20. Before August of 2021 the military had over a year and a half to learn how to operate under the threat of SARS-CoV-2 without using COVID-19 /vaccines/. This shows that leaders are already well equipped to provide reasonable accommodation without undue harshness. I claim to date, that my immunization status has no impact on my ability to support the Navy or Marine Corps warfighting functions, nor my ability to continue to serve this nation in the same capacity that I currently am.

21. I claim that in March of 2022, I attached to Team 3, Bravo Company, 1st Reconnaissance Battalion, for (2) months to provide them direct medical support for their CONUS deployment to Joint Task Force North. From 21 April to 22 May 2022 as part of team 3, Bravo Company our team provided area reconnaissance in support of Customs Border Patrol Counter Narcotics and Drug Trafficking Operations on the US Border.

22. I claim that during this operation my team and I were in direct contact, less than (6) feet, with US service members, US Customs & Border Patrol Agents, and migrants. At no point during (or after) my time operating with Team 3 did I contract SAR-CoV-2 disease. During the duration of the operation we were never directed to wear a mask, social distance, or take medications to prevent disease, nor were any of these preventative measures reasonable to do considering the nature of the operation.

23. I claim that my replacement was sick when we conducted Relief In Place (RIP) of our duties as Special Operations Independent Duty Corpsman (SOIDC). My replacement, whom I will refer to as 'Medic #2', did not test for SARS-CoV-2 before reporting for duty in JTF-N, even though he was significantly ill. On 26

May 2022, approximately, five days after conducting two days of face-to-face turnover medic #2, reported to me via text, "I found out my wife and son have COVID. Which means I had it when we were turning over."

24. I claim that I never tested, exhibited symptoms, or had family members or close friends contract SARS-CoV-2 following my time supporting Team 3, despite the blatant exposure to Medic #2 it never impacted me. However, on 2 June 2022, leaders within Bravo Company reported that "Covid is spiking in the hotel. . . .So no more room service or housekeeping unless done by request." I believe that it is possible and likely that Medic #2 spread SARS-CoV-2 infection to the hotel staff despite being inoculated with the COVID-19 /vaccine/.

25. Now with the release of MARADMIN 275/22, I am no longer allowed to travel and support operations on behalf of the DoD. The reality is that both vaccinated and unvaccinated can catch and spread SARS-CoV-2, the DoD has illogically applied science to bench servicemembers from doing what they have enlisted to do. Despite having religious exemption pending, being highly qualified, and having exhibited my ability to travel safely, I am forced to stay local to the command and route special request chits to the command anytime I want to take personal liberty or leave outside the immediate vicinity of the command. It does not make logical sense to allow me to travel for leave, but not for work. I believe this is a tactic used to marginalize the religious servicemember, hamper promotions, discourage reenlistments and psychologically demoralize service members with religious accommodation requests [https://www.marines.mil/News/Messages/Messages-Display/Article/3046536/announcement-of-revised-guidance-for-personnel-traveling-during-the-coronavirus/].

26. My Commanding Officer understands my work environment and the mission requirements of the unit. On my initial Religious Accommodation request, dated 12 Oct 2021 my Commanding Officer “forwarded recommending approval” [Exhibit 9]. This indicates to me that he has considered the operational risk that my COVID-19 vaccine status has on the command’s mission and that he is willing to accept that risk. Risk-to-force management is commonly delegated to subordinate commanders in garrison and wartime, this allows for rapid staffing and decisions to be made on the individual unit level to not impede the military's warfighting agility. This willingness of my commanding officer to accept my vaccination status was exhibited when he approved my deployment to JTF-N to support Reconnaissance Company Bravo's mission supporting Customs and Border Patrol.

HIV DEPLOYABILITY

27. As of April 2022 Servicemenber are no longer prohibited from commissioning and deploying in the military when infected with human immunodeficiency virus (HIV); [https://www.military.com/daily-news/2022/04/07/judge-overturns-military-ban-hiv-positive-troops-getting-commissioned-officers.html]. HIV, an incurable disease can lead to potentially life-threatening infections and requires medication to manage the effects of the disease. It is accurate and reasonable to claim that SARS-CoV-2 infection, a completely recoverable disease, is less duty limiting than being permanently infected with HIV. This illogic disparity between the way the two diseases are viewed by policy should provide pause

and concern to all judges, officers, and federal leaders affecting the outcome on the matter of military COVID-19 mandates.

COVID-19 ADVERSE EVENTS

28. The affidavits and testimony of LTC Theresa Long, LTC Peter Chambers, Dr. Malone, Dr. Mccollough, Dr. Ryan Cole and countless other experts provide strong testaments to the harm that these /vaccines/ are causing to the human body [Exhibit 10; (Army LtCol Theresa Long MD - Full Testimony 09/17/22) https://rumble.com/v1lbl6l-army-ltcol-theresa-long-md-full-testimony.html].

29. Throughout the last (2) years of the COVID-19 /vaccine/ mandates I have personally known patients who have had significant adverse reactions (primarily, but not limited to, duty limiting myocarditis) following COVID-19 /vaccination/. In contrast, I had never been witness to any other significant adverse events in the (18) years of prior vaccine administrations to patients.

30. Further confounding this observation is that I have known providers that were pressured and told not to document the events in the Vaccine Adverse Events Reporting System (VAERS), thus the numbers reflected in VAERS do not reflect the actual total of events. Although, the VAERS system is not flawless, to disregard it is malpractice, considering that it at least represents a portion of the actual adverse events experienced with the COVID-19 /vaccination/. The VAERS database can be validated when compared with other adverse event reporting systems such as WHO's Vigi Access database and Defense Medical Epidemiology Database (DMED). For example in 2021 the Vigi Access database reports (4,026,733) Pfizer COVID-19 adverse reactions and (27,051) influenza adverse reactions, resulting in a 14,885% greater incidence of adverse events with the Pfizer COVID-19 vaccination than Influenza vaccination during the same period [Exhibit 11]. This same correlation is supported and revealed in over 1000 peer reviewed medical papers [https://community.covidvaccineinjuries.com/compilation-peer-reviewed-medical-papers-of-covid-vaccine-injuries/] and other databases, such as revealed in the testimony of LTC Teresa Long regarding the DMED database [Exhibit 11; https://vaers.hhs.gov/, https://www.vigiaccess.org/].

31. On December 13th, 2021, I received a call from a young marine who got testicular cancer within weeks following his COVID-19 /vaccination/. This young service member was certain that the causation was directly associated with the vaccine because of the rapid onset following vaccination. This member had to have his testicle surgically removed and military doctors have consistently refuted the COVID-19 /vaccine/ as potential causation despite the evidence emerging regarding Vaccine Associated Enhanced Diseases (VAED). Dr. Ryan Cole, an expert pathologist, has presented strong evidence that there is a direct correlation between cancer formation and the COVID-19 /vaccine/ administration.

32. Over the last (2) years I have had a close patient/provider relationship with a base ophthalmologist. This doctor disclosed to me that the information surrounding the vaccine is extremely confounding and the safety in his opinion was questionable at the very least. He proceeded to describe several adverse events that he had been witness to, several of his patients, and co-workers patients, spontaneously developed optic neuritis following /vaccination/, one of these patients had already lost the use of one eye so this /vaccine/ injury in the other eye resulted in complete blindness. Additionally, this provider

described a death that occurred within the hospital. The cause of death was cerebral thrombosis and occurred within the same day of vaccination, however, he claimed that the member's cause of death was being attributed to a previously existing condition of Guillain-Barré syndrome. This provider has been resistant to going public with this information for fear of reprisal.

33. On 12 July 2022, I spoke with an Active Duty Navy Diver who reported to me that he had significant adverse reactions following his vaccination with COVID-19. This member reported that within (5) days of vaccination he began experiencing tinnitus and mental fog that progressed into multiple seizure events. The servicemember claimed to be in phenomenal shape before this event and is now being forced to medically separate/retire because of his injury. This service member stated that despite rapid onset following /vaccination/, his primary care physicians refuse to associate injury to the vaccine.

34. Through direct communication with appointment specialists in January of 2022, I was informed that cardiology at NRMTC Camp Pendleton was at least 4 weeks backlogged in appointments due to the surge in cardiac patients. I found this concerning since this admission was the month following the /vaccine/ mandate deadlines for the military. At this point majority of military units had completed vaccination (greater than 90% in the unit I serve). Again in September of 2022, I was notified directly by cardiology staff at NRMTC Camp Pendleton that the clinic was 9 months backlogged in uploading cardiology reports to the system. Not only had the military had an increase in cardiac cases, but Navy medicine doesn't even have a full picture of the damage that has occurred at the primary medical center for the largest unit in the Marine Corps (approximately 40,000 personnel). This correlation of cardiac injury in the DoD warrants further investigation and full transparency.

35. Countless other individuals have quietly confided in me about their individual experiences with adverse events with the COVID-19 /vaccine/. Just in my very small patient set, I have been made aware of numerous incidences of optic neuritis, color blindness, peripheral vision loss, tinnitus, persistent mental fog, syncope, seizures, cardiovascular distress, serial shingles outbreaks, abnormal dysmenorrhea (in both the vaccinated and as a result of vaccine shedding to unvaccinated), unexplained weight gain, nose bleeds, lymphadenopathy and severe myopathies. If the incidence of myocarditis, and other injuries, is as significant as reported to me privately we must consider the effect on a patient population whose survivability is 99.99% or greater. We are doing more harm than good and the end does not justify the means.

36. In addition to my anecdotal findings of vaccine injury I have been a part of a support network for injured servicemembers. These additional anecdotal stories, currently totaling well over (80) cases, were collected through a grassroots effort of a pool of only (500) service members; most of whom are pilots and officers across all branches of the DoD. [Exhibit 12] is a supplemental summary to the Congressional Vaccine Injury Report previously provided to give credibility to all cases cited within. This support group of vaccine injured was formed through casual first-hand acquaintances, these vaccinated servicemembers took the vaccine trusting that what they accepted to be injected into them was "safe and effective". Unfortunately for them, this was not true and many of them are still suffering the consequences of that decision. Many of these servicemembers are willing to discuss their experiences

privately but fear reprisal if exposed publically or to leadership. Our culture, even within the military, is paralyzed by fear and needs to come to terms with the gravity of what is not being openly discussed.

Sample excerpts from Exhibit [12].

a) Case 1_01: USAF A-10 Instructor Pilot. Major (O-4), mid 30s yr old male. Hospitalized 12 hours after vaccination. Diagnosed with pericarditis and anaphylaxis. Removed from flight status for six months; thus negatively impacting unit mission readiness. Lingering symptoms prevent the ability to attain FAA Class 1 medical without a waiver. VAERS case # 1797985.

"I have never felt so abandoned by the military. I have been forced to take something that brought me close to death. I was mocked, discredited, and unsupported. My family was burdened by my inability to be there for them for weeks while being burdenied by out-of-pocket medical expenses. My squadron was hurt by losing a full-time instructor for over six months with no end in sight. We have lost faithful brothers and sisters who refused to take these risks. Our squadron morale was ripped to shreds. All these things were completely unnecessary. We are truly less ready on multiple levels."

b) Case 1_02: USMC Infantry Officer, Captain (O-3), 28yr male. Diagnosed with pericarditis. He is currently seeking medical exemption at the recommendation of a civilian cardiologist after hospitalization. His command denied this request despite not being seen in person by military medical personnel but this Marine is appealing to the command and awaiting that decision. Months later, while performing warm-ups for PT, he is sent back to the ER with heart attack-like symptoms and shortness of breath. He was further diagnosed with costochondritis.

"I joined the Marine Corps out of deep pride and patriotism for my country…Unfortunately, it seems inevitable that I will be forced out of the Marine Corps with my name and character stigmatized with a general discharge. They will ensure I pay back tens of thousands of dollars of schooling, revoke my GI bill, take away my family's health insurance, and leave me with unresolved heart problems."

c) Case 1_03: USN, Captain (O-6) Unit Commander, mid-40s aged male. Developed autoimmune disorder and hospitalized 72 hours after vaccination. As a commander, it triggered an official SITREP of injury which was sent to Navy Command Headquarters highlighting his vaccine injury. The SITREP stated the command anticipated no media coverage. Under his command, he has "several" other fellow vaccine-injured service members including heart attacks. The Captain also relayed that there is one death of an otherwise healthy sailor in his command post-vaccination with the cause awaiting the coroner's report. The Captain wishes to remain anonymous for fear of reprisal and losing his command.

"When I was injured and hospitalized from the vaccine I was ordered to take, my leadership expressed concern I would be less effective at ordering and pressuring sailors under my command to take the vaccine."

d) Case 1_04: USN, Helo Pilot, CDR (O-5), 41yr male, cardiac and respiratory issues such as shortness of breath, chest pains, blurred vision, faintness, and heart palpitations. Diagnosis from the physician is likely myocarditis. Member was grounded by his flight doctor but despite his acute injury post-vaccination, the military medical personnel refused to put his adverse reaction into VAERS.

“The madness must stop. Please help us, I humbly implore the members of Congress to assist in taking a measured approach to looking at all the pros and cons of vaccination while not alienating service members who have otherwise devoted their lives to serving our great nation."

37. Whether it be pride, arrogance, or hubris, service men, women and doctors are failing to accurately report their experiences with the COVID-19 /vaccine/ injury within the DoD. This personal testimony of injury is supportable by the FDAs FOIA releases of the Pfizer COVID-19 /vaccine/ trial data, VAERS, emerging research (Over 1000 peer-reviewed research articles discussing vaccine injury) [https://community.covidvaccineinjuries.com/compilation-peer-reviewed-medical-papers-of-covid-vaccine-injuries/], and testimony from around the world. The current culture of the military is reflective of one that fears reprisal and has been placed in a box that they do not feel like they have a way out of without losing all that they have earned. I have been told numerous times by leaders and doctors that "I'm just following orders", "it's not my job to make policy, it's just to follow it", "I'm just trying to preserve my pension/retirement", "If my involvement in first-hand testimony is known I'm afraid they'll remove me immediately", and "I'm with you or I agree with you, but my hands are tied".

RESPONSE TO REAR ADMIRAL (LOWER HALF) HANCOCK'S DECLARATION IN SUPPORT OF BOARD OF INQUIRY / ADMINISTRATIVE SEPARATION DATED 22APR2022 [EXHIBIT 13]

38. Exhibit 13 is being utilized as a matter of fact in the administrative proceedings in support of separating servicemembers for not taking the COVID-19 /vaccination/. Reflections were made by analyzing data contained within the Navy Medical Intelligence Reports and Appendices from August 2021 to June 2022, these intel updates provide information to commanders for decision-making [https://esportal.med.navy.mil/bumed/rh/m2/NavyMedicineScientificPanel/COVID19%20Weekly%20Public%20Health%20Reports/Forms/Sorted%20Most%20Recent.aspx].

Response to [Note 5, Exhibit 13] of the Board of Inquiry/ Administrative Separation Declaration.

39. The claim the declaration fails to describe or recognize that the SARS-CoV-2 disease decreased in severity as time progressed. According to Navy Medical Intelligence Reports, there has not been a death in an unvaccinated service member since December 2021. These deaths occurred from August 2021 to December 2021 when the delta variant was in full effect. Moreover, one of these (10) deaths occurred in the partially vaccinated, greater than (14) days from the first dose, this death was subsequently added to the unvaccinated (or Not Fully Immunized) death count numbers in subsequent reporting.

40. Analysis of that case data from January 2022 forward in time describes the harm that boosters are doing to our otherwise healthy military [Exhibit 14]. It can be generalized that members unvaccinated in January 2022 remained so due to personal/religious convictions. Of concern, the complete data totals are no longer reported after April 2022. Totals of cases, hospitalizations, and deaths from January to April 2022 are as follows:

**See Note 1,2,3 & 4 below

a) 18Jan2022
Not fully immunized cases: 26,967 (See Note 1)
Not fully immunized Hospitalization: 173
Not fully immunized Death: 10
Fully immunized (Not Boosted) Case: 31,036
Fully immunized (Not Boosted) Hospitalization: 9
Fully immunized (Not Boosted) Deaths: 0
Boosted Case: 1,482
Boosted Hospitalization: 0
Boosted Death: 0

b) 22Feb2022
Not fully immunized cases: 27,577
Not fully immunized Hospitalization: 173
Not fully immunized Death: 10
Fully immunized (Not Boosted) Case: 45,269
Fully immunized (Not Boosted) Hospitalization: 13
Fully immunized (Not Boosted) Deaths: 0
Boosted Case: 2,709
Boosted Hospitalization: 0
Boosted Death: 0

c) 19Apr2022 (See Note 2)
Not fully immunized cases: 27,629
Not fully immunized Hospitalization: 176
Not fully immunized Death: 10
Fully immunized (Not Boosted) Case: 36,045 (See Note 3)
Fully immunized (Not Boosted) Hospitalization: 6
Fully immunized (Not Boosted) Deaths: 0
Boosted Case: 17,222
Boosted Hospitalization: 7
Boosted Death: 0

d) Changes in totals for each category during 4 months (See Notes 1,2,3 & 4):
Not fully immunized cases: +662 (+2.5%)
Not fully immunized Hospitalization: +3 (+1.73%)
Not fully immunized Death: +0 (+00%)
Fully immunized (Not Boosted) Case: + 14,233 (+45.86%, See Note 3)
Fully immunized (Not Boosted) Hospitalization: +4-10 (+44.44%-111.11%, See Note 3)
Fully immunized (Not Boosted) Deaths: +0 (+00%)
Boosted Case: +15,740 (+1062.08%, See Note 3)
Boosted Hospitalization: +7-13 (700-1300%, See Note 3)
Boosted Death: +0 (+00%)

Note 1: Partially Vaccinated totals of data were absorbed into the "Not fully Vaccinated" category in January 2022. Unable to determine how many of the data points contributed to being partially vaccinated.

Note 2: Complete data totals not available after April 2022, unable to determine total picture effect on vaccinated vs. unvaccinated after April 2022.

Note 3: Category redefined, Fully immunized, and greater than 5 months since the last dose. Uncertain where the change (drop in value) in total was moved to for data analysis. For clarity, this category will only evaluate the 1-month change in data in the fully immunized numbers and a range in the boosted data numbers.

Note 4: Data-keeping categories changed names, ie. Unvaccinated became, Not Fully Immunized then became Unimmunized; each time redefining of vaccination the totals were rolled into the Unvaccinated category giving the appearance of relative efficacy in the vaccinated/boosted.

41. I believe ultimately data is obscured by the amount of vaccine uptake that occurred during this period of analysis and it is unclear if the vaccine is effective. It is, however, apparent that unvaccinated servicemembers' lives are not at risk of SARS-CoV-2 severe hospitalization or death when reviewing the available data from January 2022 to the present. The declaration's statement, "obviously the significance of (10) deaths needs no further explanation" [Exhibit 13] is misleading because there have been no deaths since December 2021, and the cases and hospitalizations of the boosted servicemembers exceed the unvaccinated servicemembers in the same period. As part of informed consent and complete transparency, I believe that servicemembers and dependents have the right to know the co-morbidities and findings of the autopsy reports associated with the (10) COVID-19 fatalities [Exhibit 14].

Response to [Note 6, Exhibit 13] of the Board of Inquiry/ Administrative Separation Declaration.

42. Declaration claims "Achieving 100% vaccination is the least restrictive means to maintain force readiness", however, the declaration fails to describe why serologic Immunity, per AR 40-562, cannot be utilized [Para. 19, Exhibit 8]. Moreover, the "burdensome non-pharmaceutical interventions (NPIs)" do not "far exceed the burden of having" temporary disability, permanent disability, and death that occurs as a result of taking the COVID-19 vaccine [Exhibit 12].

Response to [Note 7, Exhibit 13] of the Board of Inquiry/ Administrative Separation Declaration.

43. [Note 7, Exhibit 13] of the declaration claims "COVID-19 vaccination, however, has consistently demonstrated the greatest effectiveness of these measures", I refer to data evaluated [Para. 40] in response to [Note 5, Exhibit 13]. From January to April 2022 more boosted personnel caught SARS-CoV-2 and were hospitalized than unvaccinated in the same period. [Note 7, Exhibit 13] states "the ability to reduce the severity of disease in anyone who happens to become infected, for whatever reason, is of the utmost importance. That can only be accomplished by vaccinating our Marines and Sailors against COVID-19", yet the declaration fails to discuss why the numerous commercial treatments (both novel drugs and historic drugs) available to decrease the severity of the disease are inadequate.

Response to [Note 8, Exhibit 13] of the Board of Inquiry/ Administrative Separation Declaration.

44. Declaration states that "While natural infection provides some protection against subsequent infection and severe disease for some period of time, the level of protection/immunity cannot be accurately tested for at this point" [Exhibit 13]. The Uniformed Services University (USU) is hosting the Epidemiology, Immunology, and Clinical Characteristics of Emerging Infectious Disease with Pandemic Potential (EPICC) study where they are evaluating the serologic immunity of COVID-19 vaccinated versus COVID-19 unvaccinated individuals. 19 January 2022 the EPICC study claimed that "We found evidence of post-infection immunity even at one year after infection, including both antibodies (infection-fighting proteins) and "T-cells" (specialized immune cells which capture and kill viruses)" [Exhibit 7]. Again, the declaration fails to address the military's sutdy findings and the overwhelming amount of evidence and research emerging in support of Natural Immunity [https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/].

Response to [Note 10, Exhibit 13] of the Board of Inquiry/ Administrative Separation Declaration.

45. The declaration again reaffirms "Achieving 100% vaccination (or as close as possible) against COVID-19 is absolutely the least restrictive means of maintaining Marine Corps force readiness", refer to [Para. 12-19] for the counter. "Absolutes" do not leave much room for Commander's decision-making on what can only be described as a moving target, I would surmise that there are very few "absolutes" in the practice of medicine.

Response to [Note 11, Exhibit 13] of the Board of Inquiry / Administrative Separation Declaration.

46. The declaration briefly addresses the forced use of a U.S. Food and Drug Administration's (FDA) Emergency Use Authorization (EUA) products by saying that they "may be used interchangeably for purposes of administration". The declaration fails to address how these Investigative New Drugs Under EUA are "legally distinct products" that cannot be forced onto service members, and servicemembers are legally entitled to informed consent as governed by 45CFR and the Belmont Report [Exhibit 15]. This informed consent "as required by law, legally effective informed consent is obtained when authorities: 1) disclose quality information to the individual required to make an informed decision; 2) ensure the individual understands the risks and benefits of the experimental drug; 3) provides an opportunity for the individual to consider whether or not to participate; and 4) ensures the individual is not under "sanctions," "coercion," or "undue influence" by persons of authority when consenting to participate" [Exhibit 15].

DISCRIMINATION AND COERCIVE TACTICS

47. I claim that I obtained my Sub-Investigator Certification in 2017 from the FDA, so I could conduct informed consent of Experimental Use Authorization (EUA) Freeze-Dried Plasma (FDP) product, track its use and report back up the chain of command to the FDA. As part of this informed consent, I was required to conduct an hour-long briefing to all eligible personnel on the risks, benefits, and right to refusal of the EUA product. The program placed heavy emphasis on the impropriety of coercive tactics to obtain "consent." Impeccable documentation was required, all personnel had to be afforded consent, and all consents had to be legible, contain addresses, and contain witnessed signatures, with formatting and dates matching. Audits were regularly conducted so any improper documentation that failed to

meet this stringent standard was returned and required to be immediately resubmitted. Servicemembers are legally entitled to informed consent as governed by 45CFR and the Belmont Report [Exhibit 15]. In contrast, my experience with the COVID-19 vaccine has been completely the opposite, having observed coercion, public shaming, improper documentation, vaccine stacking, and an overall cavalier attitude towards a new vaccine that does not have any long-term data.

48. My immediate chain-of-command (CoC) has been relatively neutral regarding my position regarding the COVID-19 vaccine, I attribute this to my rank and medical background. However, I do have several anecdotes that may provide insight pressure service members have faced. The Military Times which has been considered a bi-partisan military publication is being used as a platform for members to discriminate and this undoubtedly leads to discrimination or the sentiment of biases. An example from the Military Times forum includes, “Those who are not vaccinated should be fired, and tagged as a potential threat to the country”. All social media forums tied to the military are ripe for this type of discriminatory discourse [Exhibit 16].

49. The Navy times has also been weaponized as a discriminatory mandate weapon. In November the Navy Times published an article that appears to use physiological operations tactics. The use of threatening verbiage in NAVADMINs, covered in the article, coupled with the picture of a needle being shoved through a tattoo inscription of “In God, We Trust” [Exhibit 17] is repulsive, discriminatory, and inflammatory towards personnel with religious accommodation requests. Actions like this within the military reek of social influence and lead to a massive swing in the baseline discrimination and marginalization of Christians within the military. The article included details of “consequences for failing to comply”, misrepresented and failed to properly characterize the “164 Navy family deaths” as a means to incite fear, and reinforced the NAVADMIN’s threats of adverse evaluations, and removal of qualifications, pay, and entitlements [Exhibit 17]. To date, there have been only (10) deaths associated with the Navy and Marine Corps, yet they used military retires, and prior service member fatalities to increase the statistics, and bolster the fear of injury. This article was a blatant coercive tactic that targeted service members with religious beliefs [Exhibit 17].

50. Numerous senior active & retired military leaders have repeatedly approached me attempting to get me to violate my beliefs. Statements such as “haven’t you considered the harm that you would be doing to your family”, “look at what you are giving up”, and “what premise are you doing this on” . . . “You don’t really believe that do you?”, and other statements such as “you would throw it all away for this? I mean, I understand that you think it violates your beliefs, but this isn’t the hill to die on”. The statement “not my the hill to die on” has been used numerous times, yet most, if not all, service members can agree that our service members' age group demographic are not at risk for severe disease, hospitalization, or death. Time and time again my conversations with service members have led me to the understanding that if military members had not been threatened with their jobs, positions, or deployments the overwhelming majority of them would not opt to receive gotten the COVID-19 /vaccine/, because most of them didn’t believe in it and felt they had no other choice.

51. My first conversation with my Senior Enlisted Leader on the topic was a deliberate weaponization of scripture to challenge me. Although the governing religious accommodation Department of Defense

instruction places the burden of determination of sincerity of belief on the chaplain corps, this enlisted leader felt the need to use his religious beliefs to influence my religious beliefs. He said things like “the Bible doesn’t tell you to not get vaccinated”, “think of yourself as Joseph and the military is your persecution”, and “its ok to accept that you were wrong and to have a change of heart” and “Bible doesn’t support your position”. I have since then established my position with him in scripture and medical fact, but this is just one anecdote and insight into the type of conversations that senior leadership was/are having with junior military members to convince them that mandate compliance was/is justified, despite one's religious beliefs. This instance was senior enlisted to senior enlisted, there is no doubt that the coercive pressure experienced by young service members to get the jab is significantly greater and would undoubtedly cross ethical boundaries.

52. Last year I attended a military ball with my wife and at our dinner table found our table centerpiece [Exhibit 18] a replica of a SAR-CoV-2 spore. On this spore bore an embossed chief petty officer anchor and an inscription. The inscription read: “YOU WILL BE FORCED TO ENDURE ADVERSITY FAR BEYOND WHAT HAS THUS FAR BEEN IMPOSED UPON YOU” [Exhibit 18]. Our military culture is selling our leaders on the lie that this sort of manipulation is acceptable. This centerpiece is repulsive and a sobering reminder that our military is vulnerable to the discriminatory narrative and if left unchecked this darkness will consume the world's greatest military force, a force that was once considered a beacon of freedom and democracy to the world will be relegated to whims of the societal narrative. This type of thought process is the same thought process that would encourage the careerist mentality, the same careerist mentality that would cause military leaders to celebrate their success at "implementing DoD vaccination mandate, by counseling (80) hesitant servicemembers into compliance and achieving a 99% vaccination rate", ... leaders celebrating their ability to convince servicemembers to violate their conscience is repugnant.

53. Service members have reported discrimination to me, examples include, “If you don’t get the vaccine I don’t trust your decision making”, fear inciting statements like “life or death” (said to a room of Staff Non-commissioned Officers in charge of combat training) and “you have no choice, go to medical and get it or face separation”. Additionally, reports of young Marines awaiting training are either deliberately not being informed of the religious accommodation process or being told that they cannot train while their religious accommodation request is being considered. A first-hand source reports “If someone wants a real lawsuit against the DoD, the young Marines uninformed and pressured is where to start”, he has personally witnessed “hundreds who were leaned into hard and strait misinformed of religious accommodation options”. The baseline narrative continues to foster a culture of discrimination. Terminology such as “unvaccinated” or “anti-vaxxer” are now household names synonymous with COVID-19 vaccine mandates. Despite your acceptance of previous or childhood vaccination, if you are not COVID-19 vaccinated you're an “anti-vaxxer” for better or worse you now carry that title. Personally, my professional capacity is now relegated to my COVID-19 vaccination status. Despite having religious exemption pending, natural immunity, and being highly qualified, I am no longer to travel and support operations on behalf of the DoD due to an illogical application of science.

CONTINUED MANDATES AND BOOSTERS

54. Despite the onslaught of emerging COVID-19 research, adverse media reports, whistleblower testimony, and vaccine injured claims exposing the COVID-19 fallacy the DoD is still pressing forward with mandates. Currently, the military requires vaccination of new accessions and requires boosters for personnel traveling abroad to specific Areas of Responsibility (AOR). The current III MEF Force Health Guidance claims members must be vaccinated and "fully up to date" against COVID-19, meaning that must have received their booster within 5 months [Exhibit 19]. Members who have or are planning on traveling to the III MEF AOR have been advised to receive boosters in order to facilitate "ease of travel" restrictions. "Booster hesitant" personnel have reported discrimination for not receiving additional shots, including the restriction of the personnel hesitant to receive boosters to the ship or base, forcing them to stand duties instead of being allowed to partake in periods of liberty, and complete removal from deployments altogether.

55. On 14 Sep 2022, I attended a senior medical leadership huddle, in order to discuss routine business and future priorities. Part of this meeting included a plan for EUA Bivalent COVID and Influenza /Vaccine/ rollout [Exhibit 20; https://www.aha.org/news/headline/2022-09-01-fda-issues-updated-eua-bivalent-booster-doses-fight-omicron-providers]. The Environmental Health Officer for my unit encouraged the group of senior medical leaders to "get creative" in how we get service members to accept this novel EUA bivalent /vaccine/, clearly foot stomping at the need for us to coerce members to accept it with our annual influenza shots. In an opinion, the military is setting the stage for the trial of the EUA booster (monovalent & bivalent) products to become FDA approved, it is my opinion the EUA boosting of servicemembers will be leveraged to set the stage for this emergency use 'authorized' booster to become fully FDA 'approved'. The boosted are at greater risk for hospitalization than the fully vaccinated or unvaccinated [Exhibit 14 & Para. 40-43] and in September 2022 pre-published research from Harvard & Johns Hopkins scientists found COVID-19 /vaccines/ to be worse than the virus [https://papers.ssrn.com/sol3/papers.cfm?abstract_id=4206070]. Moreover, the military's own Navy Medical Reports from May 2022 state there is little benefit to boosters [Exhibit 6, 2022.MAY]. How can senior leaders and the DoD morally proceed with this COVID-19 mandate and boosting campaign?

56. September 2021 I received email traffic that shows that the Surgeon General provides monthly or bi-monthly updates to the Secretary of Defense, Chief of Naval Operations, Commandant of the Marine Corps, and other senior leadership [Exhibit 21]. In this email, the Surgeon General provided the September 2022 COVID-19 Navy Medical Update [Exhibit 21]. This update is proof that last September, immediately following the order to mandate for the DoD, the leadership was briefed on many of the issues surrounding the vaccine. These briefed issues include but are not limited to /vaccine/ reactions among pregnant and lactating individuals, including miscarriages; unreliable levels of the passing of vaccine IgG into the breast milk of lactating mothers; safety of Pfizer vaccine, including a strong association with myocarditis, arrhythmia, deep-vein thrombosis, pulmonary embolism, myocardial infarction, intracranial hemorrhage, and thrombocytopenia. This injury risk was briefed as a moderate risk, meaning it warrants caution and some level of concern [Exhibit 21, page 12]. How does the DoD mitigate the risk of vaccine injury knowing it was a moderate risk? And how do we continue to mitigate this risk despite the available data showing the /vaccine/ is ineffective and harmful?

CLOSING REMARKS & CONCLUSIONS

57. I claim that I completed a religious accommodation package under duress and threat of punitive or adverse administrative action and the threat of the full range of administrative and disciplinary actions.

58. I rebut any presumption that completing a religious accommodation package waives any rights or implies any consent to or gives any legitimacy to the requirements that the religious accommodation addresses.

59. I have also followed the lead of LTC Long in her final injunction call, and have added her conclusions with which I fully concur and support her courses of action.

The subject matter of this Motion for legislative action and its devastating effects on members of the military compel us to conclude and conduct accordingly as follows:

a) None of the ordered Emergency Use COVID-19 vaccines can or will provide better immunity than an infection-recovered person;

b) All three of the EUA COVID-19 vaccines (Comirnaty is not available), in the age group and fitness level of my patients, are more risky, harmful, and dangerous than having no vaccine at all, whether a person is COVID-19 recovered or facing a COVID-19 infection;

c) Direct evidence exists and suggests that all persons who have received a COVID-19 Vaccine are damaged in their cardiovascular system in an irreparable and irrevocable manner;

d) Due to the Spike-protein production that is engineered into the user's genome, each such recipient of the COVID-19 Vaccines already has micro clots in their cardiovascular system that present a danger to their health and safety;

e) That such micro clots over time will become bigger clots by the very nature of the shape and composition of the Spike proteins being produced and said proteins are found throughout the user's body, including the brain;

f) That at the initial stage of this damage the micro clots can only be discovered by a biopsy or Magnetic Resonance Image ("MRI") scan;

g) That since there is no functional myocardial screening currently being conducted, it is my professional opinion that substantial foreseen risks currently exist, which require proper screening of all soldiers in this Task Force performing hazardous duties, including, but not limited to high altitude military free-fall (MFF) operations.

h) That, by virtue of their occupations, said MFF personnel present extraordinary risks to themselves and others. Microthrombotic changes could occur and pose a deleterious effect upon the normal physiology of vaccinated Soldiers, leading to catastrophic consequences at high altitudes.

j) That, based on the DOD's own protocols and studies, the only two valuable methodologies to adequately assess this risk are MRI imaging or cardio biopsy which must be carried out.

k) That, per the foregoing, I hereby recommend to the Secretary of Defense that all MFF personnel in the military service who required hospitalization from injection or received any COVID-19 EUA vaccination be grounded similarly for further dispositive assessment.

l) That this Court should grant an immediate injunction to stop the further harm to all military personnel to protect the health and safety of our active duty, reservists, and National Guard troops.

60. Pastor Matt Chandler proclaimed in a recent sermon that "the Holy Spirit does not illuminate and reveal what he will not empower you to step into and that conviction is a sweet gift from God." I love God and I want to obey His will for my life. I know that writing this affidavit is part of that obedience because I am listening to what He has put on my heart. It is with the deepest conviction that I ask anyone who reads this to please consider the magnitude of what I have described. If leaders do not act service members will continue to be injured and the systematic purge of the most religiously devout servicemembers from our military's ranks will continue, forever changing the moral baseline of our military. Religious freedom is a basic human right that servicemembers signed up to protect, service members did not surrender that right upon joining the military and now more than ever we need to show our solidarity to respect and honor this fundamental right. "Let us, therefore, make every effort to do what leads to peace and mutual edification" Romans 14:19.

61. Given my personal analysis of the COVID-19 vaccine mandates, personal experiences, and associated information available it is my wholehearted belief that the COVID-19 vaccine mandates are unethical, harmful, unlawful, and a violation of basic human rights.

I declare under penalty of perjury under the laws of the United States of America, pursuant to 28 U.S.C. § 1746, that the foregoing is true and correct to the best of my knowledge, information, and belief.

Dated: September 28, 2022

Respectfully submitted,

_____/S/_____ [redacted], [SCPO, USN]