August 31, 2021

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Dear _____,

I write regarding the requirement that I take the COVID vaccine by [date]. I have served in the [branch and whatever appropriate] with honor for [X] years and [Y] months with pride. I have the following challenges with regard to taking the COVID-19 vaccine.

I have already been infected with COVID-19, and as such I qualify under the medical exemption found at AR 40-562, ¶2-6a(1)(B), which provides medical exemptions for vaccinations, including "evidence of immunity based on documented infection." See also AFI-48-110, BUMEDINST 6230.15B, COMDETINST, M6230.4G regarding prior infection.

I attach my documentation of prior infection to this letter.

Multiple recent research reports show natural immunity provides greater resistance to COVID-19 than the vaccines; hence, support the exemption for those that have documented infection.

The Largest Statistical Study Contrasting Natural Immunity to Vaccines during the Presence of the Delta Mutation

See this statistical study of a very large sample of the Israeli population, *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections*[1]. ("Israeli Study"). The data source for the multi-variate regression analysis was a 2.5-million-member, state-mandated and second largest health fund in Israel covering 26% of the population and providing a representative sample of the Israeli population. [2]

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[1] *Comparing SARS-CoV-2 natural immunity to vaccine-induced immunity: reinfections versus breakthrough infections,* Sivan Gazit, MD MA; Roei Shlezinger, BA ; Galit Perez, MN MA ; Roni Lotan, PhD; Asaf Peretz, MD; Amir Ben-Tov, MD; Dani Cohen, PhD; Khitam Muhsen, PhD; Gabriel Chodick, PhD MHA; Tal Patalon, MD. https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1.full.pdf

[2] Overall, 673,676 MHS members 16 years and older were eligible for the study group of fully vaccinated SARS-CoV-2-naïve individuals; 62,883 were eligible for the study group of unvaccinated previously infected individuals and 42,099 individuals were eligible for the study group of previously infected and single-dose vaccinees.

The study in finding that those with natural immunity were significantly less likely to get reinfected by Covid-19 than the vaccinated, compared natural immunity to vaccine-based immunity using regression analysis. The study found with clear statistical significance and a very large sample size that when comparing previously infected vs. vaccinated individuals, with matching for time of the previous infection and the vaccination, the vaccinated were 13 times more likely, relative to the previously infected, to suffer a virus that broke through their immune protections:

> In model 1, we matched 16,215 persons in each group. Overall, demographic characteristics were similar between the groups, with some differences in their comorbidity profile (Table 1a). During the follow-up period, 257 cases of SARS-CoV-2 infection were recorded, of which 238 occurred in the vaccinated group (breakthrough infections) and 19 in the previously infected group (reinfections). ***After adjusting for comorbidities, we found a statistically significant 13.06-fold (95% CI, 8.08 to 21.11) increased risk for breakthrough infection as opposed to reinfection (P<0.001).***

This Israeli study concluded natural immunity is superior on duration, strength and preventing severity:

> This study demonstrated that **natural immunity confers longer lasting and stronger protection against infection,** symptomatic disease and hospitalization caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 two-dose vaccine-induced immunity. *Id.*

Given the clear superiority of natural immunities over vaccination post-Delta, let us next consider the relative performance pre-Delta.

A Review of a Cleveland Clinic Statistical Study Contrasting Natural Immunity to Vaccines Prior to the Presence of the Delta Mutation

An earlier study by doctors and researchers from the renowned Cleveland Clinic, *Necessity of COVID-19 vaccination in previously infected individuals*, ("Cleveland Clinic Study") that used data from 2020, before reports of the Delta variant, found that among 1,359 previously naturally infected subjects that remained unvaccinated throughout the study, zero were infected by COVID-19, while of the previously uninfected but vaccinated group, 15, or 0.7% became infected.[3]

[3] *Necessity of COVID-19 vaccination in previously infected individuals* - DocumentCloud, Nabin Shrestha, Patrick Burke, Amy Nowacki, Paul Terpeluk, Steven Gordon from the Departments of Infectious Diseases, Infection Prevention, Quantitative Health Sciences and Occupational Health, Cleveland Clinic, Cleveland, Ohio (posted June 1, 2021).

Methods. Employees of the Cleveland Clinic Health System working in Ohio on December 16, 2020, the day COVID-19 vaccination was started, were included. Any subject who tested positive for SARS-CoV-2 at least 42 days earlier was considered previously infected. One was considered vaccinated 14 days after receipt of the second dose of a SARS-CoV-2 mRNA vaccine. The cumulative incidence of SARS-CoV-2 infection over the next five months, among previously infected subjects who received the vaccine, was compared with those of previously infected subjects who remained unvaccinated, previously uninfected subjects who received the vaccine, and previously uninfected subjects who remain unvaccinated.

Results. Among the 52,238 included employees, 1,339 (53%) of 2,579 previously infected subjects remained unvaccinated, compared with 22,777 (41%) of 49,659 not previously infected. The cumulative incidence of SARS-CoV-2 infection remained almost zero among previously infected unvaccinated, previously infected subjects who were vaccinated, and previously uninfected subjects who were vaccinated, compared to a steady stream increase in cumulative incidence among previously uninfected subjects who remained unvaccinated. Not one of the 1,359 previously infected subjects who remained unvaccinated had a SARS-CoV-2 infection over the duration of the study. In a Cox proportional hazards regression model, after adjusting for the phase of the epidemic, vaccination was associated with a significantly lower risk of SARS-CoV-2 infection among those not previously infected (HR 0.031, 95% CI 0.015 to 0.061) but not among those previously infected (HR 0.031, 95% CI 0 to Infinity).

Conclusions. Individuals who have had SARS-CoV-2 infection are unlikely to benefit from COVID-19 vaccination, and vaccines can safely be prioritized to those who have not been infected before.

Further evidence in support of the above:

> Months after recovering from mild cases of COVID-19, people still have immune cells in their body pumping out antibodies against the virus that causes COVID-19, according to a study from researchers at Washington University School of Medicine in St. Louis. Such cells could persist for a lifetime, churning out antibodies all the while."[4] Senior author Ali Ellebedy, PhD explained that

[4] Washington University School of Medicine, at St. Louis, by Tamara Bhandari, May 24, 2021, Good news: Mild COVID-19 induces lasting antibody protection – Washington University School of Medicine in St. Louis (wustl.edu)

> "Last fall, there were reports that antibodies wane quickly after infection with the virus that causes COVID-19, and mainstream media interpreted that to mean that immunity was not long-lived," said senior author Ali Ellebedy, PhD, an associate professor of pathology & immunology, of medicine and of molecular microbiology.
>
> But that's a misinterpretation of the data. It's normal for antibody levels to go down after acute infection, but they don't go down to zero; they plateau. Here, we found antibody-producing cells in people 11 months after first symptoms. These cells will live and produce antibodies for the rest of people's lives. That's strong evidence for long-lasting immunity. *Id.*

While natural immunity has a perfect record in this study that predates the variant studies, a few infections did occur among the vaccinated – and this imperfection foreshadows the COVID-19 vaccines' rapid decline in efficacy as mutations develop.

Both the earlier pre-Delta Cleveland Clinic Study, and the Post-Delta Israeli Study present substantial sample sizes and clear statistical evidence. Pre-Delta, there is statistical indifference between natural immunity and the vaccine; both infection and vaccine provide strong protection. However, post-Delta, natural immunities become exceedingly more effective than the vaccine.

Sizeable Advantage of Natural Immunity over the Vaccines

From the prior studies, we can see that post-Delta, the advantage to those with natural immunities grew immensely. Prior infection provides far higher protection than does the vaccine when dealing with the Delta mutation –undisputedly the efficacy of the Covid-Vaccines decline with the variants, and thus the need for boosters.

The CDC website now explains in a Q&A:

> ### If we need a booster dose, does that mean that the vaccines aren't working?
>
> No. COVID-19 vaccines are working very well to prevent severe illness, hospitalization, and death, even against the widely circulating Delta variant. However, with the Delta variant, public health experts are starting to see reduced protection against mild and moderate disease. For that reason, the U.S. Department of Health and Human Services (HHS) is planning for a booster shot so vaccinated people maintain protection over the coming months.
>
> https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html

The more robust response of natural immunity to mutated forms of COVID is supported by the results of the next study, entitled *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells* ("Longitudinal Study"). This study analyzes the particular types of immunities that infection provides.

> Ending the COVID-19 pandemic will require long-lived immunity to SARS-CoV-2. Here, we evaluate 254 COVID-19 patients longitudinally up to 8 months and find durable broad-based immune responses. SARS-CoV-2 spike binding and neutralizing antibodies exhibit a bi-phasic decay with an extended half-life of >200 days suggesting the generation of longer-lived plasma cells. SARS-CoV-2 infection also boosts antibody titers to SARS-CoV-1 and common beta coronaviruses. In addition, spike-specific IgG+ memory B cells persist, which bodes well for a rapid antibody response upon virus re-exposure or vaccination. Virus-specific CD4+ and CD8+ T cells are polyfunctional and maintained with an estimated half-life of 200 days. Interestingly, CD4+ T cell responses equally target several SARS-CoV-2 proteins, whereas the CD8+ T cell responses preferentially target the nucleoprotein, highlighting the potential importance of including the nucleoprotein in future vaccines. ***Taken together, these results suggest that broad and effective immunity may persist long-term in recovered COVID-19 patients*** **[for those that gain natural immunities through infection]**.[5]
> (Emphasis added).

When considering the pre-Delta Cleveland Clinic Study, the post-Delta, Israeli Study, the Longitudinal Study, as well as earlier peer reviewed studies from Washington University, Cleveland Clinic and the NIH[6] we can see that natural immunities provide a more robust, broader based immune response, empowering natural immunities to extend beyond the original virus.

In contrast, the data shows that the COVID-19 vaccines become far less effective when dealing with mutations, hence the widely reported declines in efficacy and breakthrough cases that were formally confirmed by the CDC in its call for booster shots.

Clearly the CDC implicitly recognizes the reduced efficacy of the COVID-19 vaccines with the Delta variant. The Longitudinal Study identifies multiple defenses including antibodies, memory B cells and multiple T cells that all learn from the infection – the broad line of defenses help to clarify the superiority of natural immunities against COVID-19 when

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[5] Cell Reports Medicine, July 3, 2021, *Longitudinal analysis shows durable and broad immune memory after SARS-CoV-2 infection with persisting antibody responses and memory B and T cells* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8253687/

[6] Immune response to vaccination after COVID-19, the NIH, April 13, 2021, https://www.nih.gov/news-events/nih-research-matters/immune-response-vaccination-after-covid-19

compared to vaccines where the CDC admits declining effectiveness, and in doing so, confirms and corroborates studies showing post-Delta declines in effectiveness. As a result, given the clear superiority of natural immunity, we now look at the risks associated with COVID-19 vaccination.

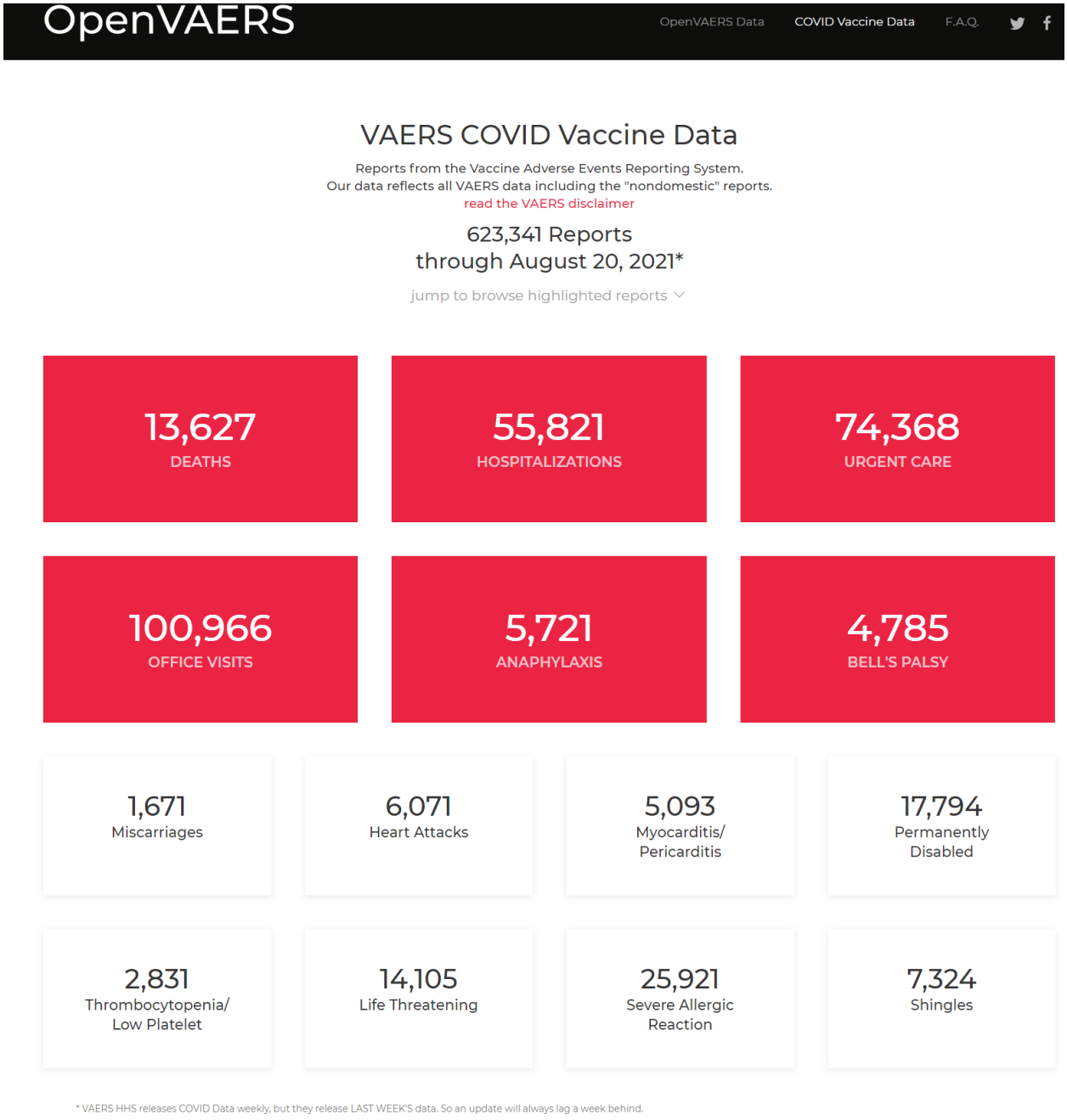
The Costs and Risks of the Vaccine versus the Declining Benefits

The Benefits are rapidly diminishing with the Delta mutation, and thus the recommendations by the CDC for boosters and the Pfizer-BioNTech Fact Sheet also make clear, under Benefits, that the "*duration of Protection is currently unknown.*" The costs of the vaccine are increasingly being seen in terms of the deaths and other harm through the VAERS reporting system[7] and can be tracked at https://www.openvaers.com/covid-data. However, adverse events from vaccines are historically substantially underreported, with less than one percent reported to the Food and Drug Administration (FDA).[8] "Low reporting rates preclude or delay the identification of "problem" vaccines, potentially endangering the health of the public." *Id.*

If only 1% of COVID related incidents are reported to VAERS, then the current reports would need to be multiplied by 100. This would vastly increase the actual incidents far above the reported 13,627 reported deaths and the many multiples more of severely harmed persons to arrive at a more realistic estimate of the actual harms by this vaccine to date. As of the OpenVAERS website on August 29, 2021:

[7] VAERS COVID Vaccine Data, https://www.openvaers.com/covid-data

[8] *See* Electronic Support for Public Health - Vaccine Adverse Event Reporting System (ESP:VAERS) (Massachusetts), https://digital.ahrq.gov/ahrq-funded-projects/electronic-support-public-health-vaccine-adverse-event-reporting-system



Additional questions about its growing safety concerns and lack of confidence in future efficacy also abound:

- The Pfizer Fact Sheet, revised 25 June 21 makes clear that Myocarditis (inflammation of the heart muscle) and pericarditis (inflammation of the lining

outside the heart) have occurred in some people who have received the Pfizer-BioNTech COVID-19 Vaccine.[9]

- The fact sheet was again recently updated on August 12, 2021 to add new symptoms to include *nausea, diarrhea and vomiting, lymphadenopathy, along with the catch-all qualification: "These may not be all the possible side effects of the Pfizer-BioNTech COVID-19 Vaccine. Serious and unexpected side effects may occur. Pfizer-BioNTech COVID-19 Vaccine is still being studied in clinical trials."*[10]
- There are No Long-Term Studies supporting Safety and Efficacy of EUA COVID-19 vaccines.
- At the time of The Pfizer-BioNTech COVID-19 vaccine ("Pfizer Vaccine") Emergency Authorization, December 11, 2020, the U.S. Food and Drug Administration noted, "At this time, data are not available to make a determination about how long the vaccine will provide protection, nor is there evidence that the vaccine prevents transmission of SARS-CoV-2 from person to person."[11]

When we consider the potentially far greater incidence of harm based on under-reporting to the VAERS site and consider the relative strength of the natural immunities that I and others have, a cost-benefit analysis would undoubtedly support continued application of the exemption from the vaccine due to prior infection.

Disregarding AR 40-562

It appears that decision-makers choose to follow policy and disregard legal requirements regarding the exemptions set forth in AR 40-562, which violates the Administrative Procedure Act ("APA"). In fact, under the APA, a cost benefit analysis would be part of the review. Any determination to follow CDC guidance in conflict with existing rules, would likely require notice and comment given the weight of the issue and any procedure for agency rulemaking in accordance with 5 U.S.C. § 553.

The current rule permitting exemption for those previously infected is supported by the evidence cited in this letter.

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[9] FACT SHEET FOR RECIPIENTS AND CAREGIVERS, EMERGENCY USE AUTHORIZED (EUA) OF THE PFIZER-BIONTECH COVID-19 VACCINE TO PREVENT CORONAVIRUS DISEASE 2019 (COVID-19) IN INDIVIDUALS 12 YEARS AND OLDER, Revised 25 June 2021, p. 3: https://www.fda.gov/media/144414/download

[10] Pfizer Fact Sheet at: https://www.fda.gov/media/144414/download/

[11] FDA.gov, FDA Takes Key Action in Fight Against COVID-19, https://wayback.archive-it.org/7993/20201217195048/https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19

COMIRNATY is Not Available

Finally, I can only even consider taking a vaccine that is fully licensed, as this is consistent with the *Memorandum for Senior Pentagon Leadership Commanders of the Combatant Commands Defense Agency and DOD Field Activity Directors* dated August 24, 2021[12] that provides:

> Mandatory vaccination against COVID-19 will only use COVID-19 vaccines that receive full licensure from the Food and Drug Administration (FDA), in accordance with FDA-approved labeling and guidance.

The mandate only applies to the fully licensed Pfizer vaccine that will get labelled in accordance with the BLA as "COMIRNATY." COMIRNATY, compliant with the BLA, is not yet available. I am invoking my option to refuse[13] [14]any vaccine authorized under

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[12] Memorandum for Mandatory Coronavirus Disease 2019 Vaccination of Department of Defense Service Members

13 According to the Section 564 of the Federal Food, Drug, and Cosmetic Act, a lawful application of the terms of a lawful emergency use authorization ("EUA") pursuant includes (e)(1)(A)(i)(III):

> (III) of the option to accept or refuse administration of the product, of the consequences, if any, of refusing administration of the product, and of the alternatives to the product that are available and of their benefits and risks.

21 USCS § 360bbb-3

[14] The OLC EUA Vaccine Opinion, OLC, 45 Op. O.L.C. __ (July 6, 2021), *Whether Section 564 of the Food, Drug, and Cosmetic Act Prohibits Entities from Requiring the Use of a Vaccine Subject to an Emergency Use Authorization ("OLC EUA Vaccine Opinion*) attempted to distinguish the Court's decisions in *Doe v. Rumsfeld*, 297 F. Supp. 2d 119 (D.D.C. 2003) ("*Rumsfeld* I") and *Doe v Rumsfeld* cases at 341 F. Supp. 2d 1 (D.D.C. 2004) ("*Rumsfeld* II")(relying on 10 U.S.C. § 1107) and (same). But the OLC opinion failed to address this Court's 2005 decision in *Doe v. Rumsfeld*, 2005 WL 1124589 (D.D.C. Apr. 6, 2005) ("Rumsfeld III") where this Court modified the injunction granted in *Rumsfeld* II:

ORDERED that the Court's injunction of October 27, 2004, is modified by the addition of the following language:

> *""This injunction, however, shall not preclude defendants from administering AVA, on a* ***voluntary basis,*** *pursuant to the terms of a lawful emergency use authorization (""EUA"") pursuant to section 564 of the Federal Food, Drug, and Cosmetic Act, without prejudice to a future challenge to the validity of any such EUA. The Court expressly makes no finding as to the lawfulness of any specific EUA that has been or may be approved by the Department of Health and Human Services.""*

Rumsfeld III, 2005 WL 1124589, at *1.

The *Rumsfeld* decisions explicitly recognized the option to refuse to take an unauthorized vaccine under federal law governing EUAs and enjoined the mandatory use of unapproved anthrax vaccines. *id.*, In *Rumsfeld I*, this Court found the U.S. government could not mandate use of an unapproved vaccine in accordance with labeling

Emergency Use Authority, including any Pfizer vaccine manufactured under EUA authority. For example, differences include, but are not limited to liability protection under the PREP Act for EUA vaccines, whereas Pfizer BioNTech's COMIRNATY would not constitute a "covered countermeasure[15]." And a vaccine is both a drug and biological product, making it subject to strict federal requirements. See FDCA 201(g), 21 U.S.C. 321(g); 42 USC 262(i)(l).

Request for Exemption due to Prior Infection

I request that my legal right to the exemption apply in my circumstance given the rules and evidence presented in this letter. If I am to be denied, then I request that you please adjust any vaccine order to incorporate the time needed to properly manufacture and deliver COMIRNATY. This proper delay will also enable requests such as mine, for a full and rational exemption based on natural immunity to have time to be considered.

I hope to continue to proudly serve, and yet avoid the risks of a vaccine that I need not take given my prior infection.

Sincerely,

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requirements (CFR § 201.56) in addition to 10 U.S.C. § 1107. *See Rumsfeld I*, 297 F.Supp.2d at 134. Requirements on content and format of labeling for human prescription drug and biological products further supports the position that experimental vaccines cannot be forced on people. 21 CFR 201.56.

[15] Congressional Research Service, The PREP Act and COVID-19: *Limiting Liability for Medical Countermeasures,* Updated March 19, 2021, The Public Readiness and Emergency Preparedness Act Scope of Immunity from Liability https://crsreports.congress.gov/product/pdf/LSB/LSB10443