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* RAR0023261

DHS Request

**Reasonable Accommodation Request Summary**

Your request (RAR0023261) is currently **Open**  
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RAR0023261: COVID-19 Vaccine Exemption (for MEDICAL reasons)

* **MM**

**Meindl, Max**12d ago

RAR0023261 Created

* **MM**

**Meindl, Max 12d ago**

Journal type:

[**MEINDL-SUBMIT-FINAL MEDICAL EXEMPTION SUBMITTAL-V5A-10-28-2021.pdf**](https://dhs.servicenowservices.com/sys_attachment.do?sys_id=99c9a8ac1b6bb050c99464a8624bcb7f)  
5.5 MB

* **MM**

**Meindl, Max 2m ago**

Journal type:

[**RA FORM- MEINDL REASONABLE ACCOMMODATION-EXEMPTION REQUEST-VACCINE MANDATE-10-25-2021-REV2-2.pdf**](https://dhs.servicenowservices.com/sys_attachment.do?sys_id=3e230a941b737014b7ec2f85624bcbb4)  
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Top of Form



RA FORM- MEINDL REASONABLE ACCOMMODATION-EXEMPTION REQUEST-VACCINE MANDATE-10-25-2021-REV2-2.pdf Attached

Bottom of Form

Information About Your Request

Number

RAR0023261

State

Open

Created

12d ago

Updated

2m ago

Additional Request Details

 If you would like to edit your request, send a message describing your desired changes using the chat box to the left.

Hidden Name

Meindl, Max

Who is submitting this request?

Recipient of the request (Myself)

First Name

Max

Last Name

Meindl

Work Phone

202-374-9426

Email Address

max.meindl@fema.dhs.gov

Position Title

Emergency Management Specialist

Component

FEMA

What is the Employee Type of Person to be Accommodated?

Federal Employee

Pay Plan/Grade of Person to be Accommodated

GS 11/10

Series of Person to be Accommodated

0089

Choose the Employee Subtype

FEMA

What is your FEMA Employee Type?

CORE (Cadre on Call Employee)

Are you deployed?

Yes

Disaster Number

4611

Deployment Location

Baton Rouge (ROR)

What is your Official Duty Station?

Houston TX

Supervisor

Bergin, John

Supervisor's First Name

John

Supervisor's Last Name

Bergin

Supervisor's Email

john.bergin@fema.dhs.gov

Please select all reasonable accommodation items being requested

COVID-19 Vaccine Exemption (for MEDICAL reasons)

What is the expected duration of your medical condition?

Long Term

Please describe your job duties.

Remote/telework program delivery task force lead, coordinating and mentoring assigned program delivery managers also working remotely, assisting applicants with their recovery efforts.

I declare to the best of my knowledge and ability that the foregoing is true and correct.

false

Briefly describe your disability/medical condition.

Disability review regarding Mr. Max Meindl who is a 70-year-old male with CAD, HTN, HLD and severe hypotension following the cardiac surgery...of 04/20l9\_. He also has had proximal LAD with hematemesis. He has a history of exposure to paint, chemicals and asbestos with additional complications including dizziness since the surgery and wheezing. He has ongoing mild cardiac reduction in diffusion capacity. Additionally he has allergies that include contrast media, amlodipine and lisinopril. Mr. MeindI presently carries a 100% total body disability impairment rating as per his prior evaluations and surgeries. Current Condition: Shortness of breath, hypertensive urgency, other forms of dyspnea, unilateral primary osteoa1ihritis, right knee, high blood pressure, hypertensive heart disease, lung disorders, supraventricular rapid heart rate, chest pain, angina, abnormal electrocardiogram (ECG), (EKG), atherosclerotic heart disease of native coronary artery causing unspecific angina pectoris. Additionally, he has abnormal results of cardiovascular functional studies. Mr. Meindl' s current medical condition and medical history is consistent with Congestive Heart failure. Given Mr. Meindl's Cardiac history of progressive heart disease together with known allergic reactions he therefore should not take any substance internally or intravenously that could cause anaphylaxis shock or could be additionally injurious to his already compromised cardiac function. PEG's have a high correlation between allergies and anaphylaxis shock. This is further complicated in that due to the vaccines spike protein production that is engineered into the user's genome, each such recipient of the Covid-19 Vaccines can produce micro clots in their cardiovascular system, which considering Mr. Meindl's cardiac condition, poses a higher risk of complications and injury.

Briefly describe the specific accommodation requested

Permanent exemption from any vaccine mandate

Please explain how your disability or medical condition prevents you from receiving the COVID-19 vaccine, addressing each type available (Moderna, Johnson & Johnson, and Pfizer).

Due to previous cardiac surgery, hypertensive heart disease causing ongoing cardiac reduction and previously known allergic reactions with a history of exposure to contrast media, amlodipine and lisinopril that there is a high degree of probability that he would be allergic to polyethylene glycol (PEG) and its components as part of the Covid -19 vaccine. Additionally, there is ongoing data that suggests that Covid- 19 Vaccines can damage the cardiovascular system, which is irreparable and irrevocable. Mr. Meindl's current medical condition and medical history is consistent with Congestive Heart failure. Given Mr. Meindl"s Cardiac history of progressive heart disease together with known allergic reactions he therefore should not take any substance internally or intravenously that could cause anaphylaxis shock or could be additionally injurious to his already compromised cardiac function. PEG's have a high correlation between allergies and anaphylaxis shock. This is further complicated in that due to the vaccines spike protein production that is engineered into the user's genome, each such recipient of the Covid-19 Vaccines can produce micro clots in their cardiovascular system, which considering Mr. Meindl's cardiac condition, poses a higher risk of complications and injury. Additionally, according to the Covid-19 mRNA Vaccine BNTI 62b2 Manufacturers package leaflet, revised on 09/09/2021, "Covid-19 mRNA Vaccine should not be given if you are allergic to the active substance or any of the other ingredients of this medicine" stating that inflammation of the heart (myocarditis or pericarditis) have been reported following vaccination. This would certainly apply to Mr. Meindl. Therefore, Mr. Meindl is ineligible for any mRNA or Adenovirus Covid 19 Vaccine. 2.4. Four Immunological Problems with COVID-19 Vaccines. The Emergency Use experimental gene therapy shots, colloquially and collectively called “Covid Vaccines,” various parties are requiring you to receive are, in fact, designed to alter, impair and abrogate “normal cell growth” by virtue of the genetic modifications made to your body that cause the production of Spike proteins (sometimes “S-cells”);1 and as such may not be administered without express consent, whether the injectables or drugs are approved by the FDA or not. Broadly, the Act describes rights of disabled persons (the “Disabled”) and obligations of persons (legal and natural) interacting with the Disabled under Federal law, which is often further clarified under various States’ laws. One such right of the Disabled (such as yourself), provides for certain medical privacy protections that may be additionally regulated in companion statutes such as The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). The HIPPA statute, inter alia, protects your right for non-disclose of the nature and extent of your medical issues and disabilities to third parties. Once the ADA protections and rights are asserted, all persons, including third-parties and entities conceived or covered by the Act must provide you with “reasonable accommodation” under Section under Sec. 12111 (9) & (10) ibid. The covered entities include effectively all enterprises, schools or offices open to the public or where sufficient elements of interstate commerce are present. This includes all offices of local, state or federal governmental bodies, including but not limited to: detention facilities; government funded health care facilities; regulatory offices open to the public; Law Enforcement facilities; and legislative areas where the public would reasonably be anticipated to occasion or occupy. Likewise, private enterprises such as hospitals, hotels, restaurants, shops and airlines must provide such Reasonable Accommodation to you and your circumstances as a “disabled person” under the Act. In particular, you have suggested the mask mandates cause you medical hardship from the reduced access to and flow of oxygen available to you. Such accommodation certainly includes your ability to breathe freely without impairment, which could or would be caused by mandatory mask or filter apparatus wearing, as mandated by private businesses or public offices that you have occasion to visit. Such accommodations are recognized by the Act and are referred to as “Public Accommodations” under Title III of the Act. Failure to provide such accommodation may give rise, inter alia, to significant penalties (see: Title III supra.) and provide the basis for damage awards. Likewise, you have mentioned that protocols and methodologies relating to the taking of DNA samples for the “Covid 19”Polymerase Chain Reaction (“PCR”) test are painful, intrusive and exacerbate existing medical conditions. Recently, the PCR tests were recalled and were never intended for diagnostic purposes to begin with. Certainly DNA material for the tests need not come from your nasal passages alone; therefore you have no reason to undertake such a test as traditionally applied. Clearly there are other ways to accommodate your needs. While the now clearly established widespread cross-immunity against SARS-CoV-2 implies that most of us are safe from severe COVID-19 disease, it also means that we are vulnerable to the harms of gene- based vaccines. Due to recall immunity against the virus, vaccination will cause our immune systems to fight aggressively against not only the SARS-CoV-2 spike protein, but against ourselves. This deleterious autoimmune attack must be expected to intensify with each repeated injection. The COVID-19 vaccine technology’s interaction with the immune system creates the following four specific problems: 1. Flying under the immune system’s radar with the vaccine’s genetic code 2. Delivering the spike protein into the bloodstream 3. Inducing immune attack on the blood vessel lining 4. Enhancing the severity of natural infection 2.4.1. Flying Under the Immune System’s Radar with the Vaccine’s Genetic Code To understand why COVID-19 vaccine technology is dangerous, it is necessary to first understand how the gene-based vaccines differ from traditional vaccination methods. A conventional viral vaccine can be a live virus strain derived from the pathogenic virus that has been attenuated through one or more genetic mutations, or it can consist of chemically inactivated virus particles that are no longer able to infect any cells. In both cases, protein antigens will be exposed on the surface of the vaccine particles, which can be recognized by antibodies once these have been formed. COVID-19 vaccines, on the other hand, are not protein antigens but the genetic blueprint for the SARS- CoV-2 spike protein antigen. That blueprint comes in the form of mRNA or DNA, which, after vaccination, enters our body’s cells and instructs those cells to manufacture the spike protein. The spike protein then protrudes from the cell and induces antibody formation. In response, the immune system will react not only with the spike protein, but will attack and try to destroy the entire cell. If we are injected with a traditional live virus vaccine to which we have no immunity, then these vaccine virus particles will also infect some of our body cells and propagate within them. Two kinds of immune reactions will then occur: 1. Cytotoxic T-lymphocytes (killer T-cells) (see section 2.4.3.1) that recognize viral protein fragments associated with the infected cells will proliferate, attack, and destroy the infected cells. 2. B-lymphocytes that recognize viral proteins (see section 2.4.3.2) will proliferate and start producing antibodies—soluble protein molecules that can recognize and neutralize virus particles. This immune reaction will in principle resemble that to an infection with the corresponding wild-type virus. It will be milder, since the vaccine strain of the virus has been attenuated; however, some cells will get destroyed in the process, which may sometimes cause functional organ damage. Live virus vaccines therefore tend to be more prone to adverse reactions than are inactivated virus vaccines. Now, a key point to note is that if we inject a live traditional vaccine into a person who is already immune —due to either a previous vaccination, or to prior infection with the corresponding wild-type virus—the extent of cell destruction will be much reduced. Such a person will already have antibodies to the virus; these will recognize the viral protein antigens and will bind and inactivate most of the vaccine virus particles before they manage to infect a cell. Therefore, even though the killer T-cells may be all riled up, they will not find very many infected cells to pounce on. The crucial difference between a conventional live virus vaccine and a gene-based COVID vaccine—and in particular an mRNA vaccine—is that the latter contains no protein antigens whatsoever; instead, it only contains the blueprint for their synthesis inside the infected cells. Therefore, if such a vaccine is injected into a person with antibodies and existing T-cell immunity, the vaccine particles will “fly under the radar” of the antibody defence and reach our body cells unimpeded. The cells will then produce the spike protein, and subsequently be destroyed and attacked by the killer T-cells. The antibodies, rather than preventing the carnage, will join in by also binding to the cell-associated spike protein and directing the complement system (see later) and other immune effector mechanisms against these cells. In a nutshell, pre-existing immunity mitigates the risk of conventional vaccines, but it amplifies the risk of gene-based vaccines. Importantly, before COVID, this risky gene-based vaccine technology had never before been used on a wide scale against infectious disease and is inherently experimental. The COVID-19 vaccination program is thus the largest human experiment ever performed in history. 2.4.2. Delivering the Spike Protein into the Bloodstream A dire danger of COVID-19 vaccines is that spike proteins produced by myriad endothelial cells, i.e. the innermost cells lining blood vessel walls, will be exported to the cell surface and protrude directly into the bloodstream. Moreover, a fraction of these spikes will be cleaved during their passage to the outside world. They will fall off the cells into the bloodstream and then bind to their receptors on other endothelial cells at distant sites. While at the outset of the vaccination campaign in 2020 it was unknown to what extent COVID vaccines entered the bloodstream, human data from 2021 reveal that the spike protein shows up within the circulation on the very day of the injection [15]. Similarly, animal studies submitted by Pfizer to the Japanese government [24] found that the vaccine appears in the circulation within 15 minutes of intramuscular injection, reaching maximum plasma concentration within just two hours. Very high levels have subsequently been recorded in the liver, the spleen, the adrenal glands, and the ovaries. Vaccine components have also been observed in the central nervous system (the brain and the spinal cord), albeit at lower concentrations. Such widespread distribution throughout the body via the bloodstream is a feat that the SARS-CoV-2 virus does not usually achieve. 2.4.2.1. Open Questions in the Ongoing Experiment But how do COVID-19 vaccine particles enter the circulation in the first place? The vaccine is injected intramuscularly, and the vaccine particles are too large to passively diffuse across blood vessel walls. Most obviously, the vaccines will follow the conventional, relatively time-consuming path which takes them via the draining lymph nodes to the blood circulation. But additionally, two possibilities for very rapid entry into the bloodstream should be heeded. The first is via direct uptake by vessels that are damaged during insertion of the needle. Secondly, it is possible that the vaccine particles undergo ‘transcytosis’, a process that enables large molecules to be transported across intact cell layers. Whatever the case may be, although Pfizer knew before the onset of clinical trials that their vaccine reached the bloodstream rapidly, either they failed to file these findings with medical regulators in Europe, the US and other Western countries, or the regulators failed to act upon the findings [25]. This is a critical oversight where patient safety is concerned. Given that the gene-based vaccines induce the body’s cells to become immune targets, where in the body this takes place is of critical concern. While immune-mediated cell death is never favourable, it is particularly detrimental and dangerous if it afflicts the blood vessel walls. 2.4.3. Attacking the Vessel Walls: Clotting and Leaky Vessels While all vaccines seek to stimulate an immune response, not all immune responses are created equal. Some are safe and well-modulated whereas others can be misdirected and out of control. Immune responses are problematic when they attack the self, as in autoimmune conditions, and/or when they are excessively intense and severe. COVID-19 vaccines incur problematic immunity in both key ways. First, they can be expected mobilise a self-to-self immune response against the endothelial cells lining blood vessel walls. Second, by boosting SARS-CoV-2 immunity, they can be expected to incite an increasingly aggressive response with each administration of the vaccine. To understand the realities of these processes it is necessary to first understand the basics of the underlying immune response. There are three key components of the immune system relevant to risks from COVID- 19 vaccines: T-cells, antibodies and the complement cascade. 2.4.3.1. T-cells Once the body’s cells have been infected with a virus, immune cells known as cytotoxic T-cells or T-killer cells attack and destroy the infected cells. This prevents infected cells from replicating the virus and spreading the infection throughout the body. After the initial battle with a certain pathogen is over, some of the specifically adapted T-cells enter a state of dormancy to become memory T-cells. In case the same virus is encountered again, these dormant T-cells can be swiftly reawakened and propagated to mount a faster and more vigorous response next time. Known as a secondary or memory-type response, it will also occur with viruses that are not exactly the same as the one initially encountered but sufficiently similar to be recognised. This latter phenomenon is referred to as cross-immunity. It has been known since mid 2020 that we are protected against SARS-CoV-2 by cross-reactive memory T-cells [7–11]. As with antibodies, this is based on previous encounters with common cold coronaviruses, and with the SARS virus in a small number of people. Such prior experience has been found to confer “robust” [7] and lasting T-cell cross-immunity to COVID-19. T-cell memory for the SARS virus is known to last at least 17 years [7], but it likely lasts a lifetime. 2.4.3.2. Antibodies Before the new discoveries of 2021, scientists’ concerns about clotting and bleeding were based primarily on the prediction that killer T-cells would attack spike-producing endothelial cells, causing lesions on vessel linings and promoting blood clots. While this mechanism remains valid, we now know that a memory-type antibody response will join the attack on the vessel walls as well. Whereas killer T-cells attack their targets cell-to-cell, antibodies are proteins that exert their effect by binding to signature structures on the pathogen’s surface, known as epitopes. Instead of destroying cells directly, once attached to an epitope, antibodies help to defeat invaders by “calling out the cavalry” on infected cells. This leads to the second process by which cells coated with viral spikes will inadvertently come under immune attack. “Calling out the cavalry” means that the antibodies attached to the unnaturally created spikes will trigger activation of the complement system, which thereupon will mount a massive attack on the endothelial cells. Importantly for deciphering the recent discoveries on SARS-CoV-2 immunity, the first time that the immune system encounters a new pathogen, new antibodies in a shape capable of binding to that pathogen’s epitopes must be formed (by immune cells known as B-cells). First-time antibody production is slow, taking approximately four weeks. Should the same pathogen or family of pathogens invade again, however, memory-type antibodies are then manufactured more rapidly, within one to two weeks. This is a cardinal sign that the immune system has seen that pathogen before. Another defining feature of a memory antibody response concerns the order in which antibody sub-types are produced. If a pathogen is new, IgM is the first type of antibody to arrive on the scene. It is followed later by IgG and IgA. The next time the pathogen arrives, however, IgG and IgA will be the first to arrive, indicating that the virus, or its relatives, have invaded before. Importantly, this is precisely what we see with COVID-19. Several research groups found in 2021 that upon first exposure to SARS-CoV-2, and following COVID-19 vaccination, the antibody response was characteristic of the memory type, due both to the timing and nature of antibodies measured. [xv-xvii] As a result, we now know that our immune systems recognise SARS-CoV-2 at first sight, even “on the slightest viral challenge” [5]. In other words, SARS-CoV-2 is not a novel coronavirus after all. With respect to variants and the need for booster shots, memory B-cells, like memory T-cells, can recognise not only a specific virus, but a whole family of viruses bearing related epitopes. It is unsurprising, therefore, that memory B-cells recognise SARS-CoV-2 from the common cold. With cross immunity this robust, closer relatives of SARS-CoV-2 in the form of variants will pose no obstacle to our antibody response. The rising “cases”, hospitalisations and deaths attributed to Delta and other variants are therefore almost certainly driven by false positive PCR results and misclassification than by a true increase in COVID-19 disease. Indeed, according to Public Health England data, the Delta variant is non- lethal in those under 50, and less than half as lethal as earlier strains in older age groups [26]. But why haven’t circulating antibodies to SARS-CoV-2 been detected in populations before? The answer is that neither the antibodies nor T-cells associated with a memory-type response circulate in the bloodstream. Once they are no longer needed, they become dormant, existing as a memory alone. Unless elicited by re-exposure to a virus, they remain invisible in the bloodstream. The dormant antibodies will, however, be ready and waiting to re-activate and call out the cavalry on the spike protein, in the form of the complement cascade. 2.4.3.3. Complement Recent findings indicate that complement activation is a serious concern with respect to COVID-19 vaccine-immune interactions. In light of the newly characterised antibody response to SARS-CoV-2, when antibodies attach to spike- producing endothelial cells on vessel walls following vaccine administration, activated complement proteins can be expected attach to the endothelial cells, and perforate their cell membranes [27,28]. The ensuing death of the endothelial cells will expose the tissue underneath the epithelium, which will initiate two significant events. It will induce blood clotting, and will cause the vessel walls to leak [6]. This pathogenic mechanism has been documented in biopsies taken from SARS-CoV-2-infected patients [19,29]. Those studies have described a “catastrophic microvascular injury syndrome mediated by activation of complement” [29] as part of the SARS-CoV-2 spike protein immune response. It is precisely this immune response that COVID-19 vaccines seek to induce. Such vaccine-immune interactions are consistent with adverse events involving visible capillary rupture under the skin that have been documented and reported following COVID-19 vaccination [30–33]. 2.4.3.4. Leaky Vessels—The Promise of Booster Shots Given that booster shots repeatedly boost the immune response to the spike protein, they will progressively boost self-to-self immune attack, including boosting complement-mediated damage to vessel walls. Clinically speaking, the greater the vessel leakage and clotting that subsequently occurs, the more likely that organs supplied by the affected blood flow will sustain damage. From stroke to heart attack to brain vein thrombosis, the symptoms can range from death to headaches, nausea and vomiting, all of which heavily populate adverse reactions to COVID-19 vaccines [2]. As well as damage from leakage and clotting alone, it is additionally possible that the vaccine itself may leak into surrounding organs and tissues. Should this take place, the cells of those organs will themselves begin to produce spike protein, and will come under attack in the same way as the vessel walls. Damage to major organs such as the lungs, ovaries, placenta and heart can be expected ensue, with increasing severity and frequency as booster shots are rolled out. 2.4.4. Enhancing the Severity of Wild Coronavirus Infection Finally, as with the Dengue virus and several other viruses [34], antibodies to coronaviruses can ultimately aggravate rather than mitigate illness. This is called antibody-dependent enhancement of disease. The underlying mechanisms remain to be elucidated but it is already clear that the net effects are severely detrimental. Attempts to develop vaccines to the original SARS virus, which is closely related to SARS-CoV-2, repeatedly failed due to antibody-dependent enhancement of disease [35–37]. The vaccines induced antibodies, but when the vaccinated animals were subsequently infected with the wild-type virus, they became more ill than the unvaccinated animals, in some cases mortally so [38]. References 1. Open VAERS, (2021) VAERS COVID vaccine data. 2. 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Vaccine 23:2273-9 38. Bolles, M. et al. (2011) A double-inactivated severe acute respiratory syndrome coronavirus vaccine provides incomplete protection in mice and induces increased eosinophilic proinflammatory pulmonary response upon challenge. J. Virol. 85:12201-15 39. World Medical Association, (2017) WMA Declaration of Geneva Japan drops vax rollout, goes to Ivermectin, ENDS COVID almost overnight (27 October 2021) The ongoing COVID-19 nonsense here in the United States exists solely and exclusively because our governments have failed to use the correct treatment. They used so-called "vaccines" when Japan has just proven, in less than ONE MONTH, that Ivermectin can wipe out the disease. Sweden's Public Health Agency on Wednesday recommended a temporary halt to the use of the Moderna COVID-19 vaccine among young adults, citing concerns over rare side effects to the heart. It said the pause should initially be in force until December 1, explaining that it had received evidence of an increased risk of side effects such as inflammation of the heart muscle (myocarditis) and inflammation of the pericardium (pericarditis). {link to CBS News (Secure)] Finland, Denmark and Norway have also moved away from the COVID vaccines. Finland last Thursday joined Sweden, Denmark and Norway in recommending against use of Moderna Inc.’s Covid-19 vaccine in younger age groups, citing risks of rare cardiovascular side effects they said warranted the precautionary steps. Finland’s Institute for Health and Welfare said last Thursday it would pause use of the Moderna vaccine among men under the age of 30, following a similar step last Wednesday by Swedish regulators. Denmark last Wednesday said it wouldn’t offer the Moderna vaccine to under-18s as a precautionary measure. Norway on Wednesday advised that all under-18s shouldn’t be given the Moderna vaccine, even if they had already received one dose, and recommended that men under 30 consider getting the vaccine developed by Pfizer Inc. and BioNTech instead. Norwegian officials cited U.S., Canadian and Nordic data, saying the absolute risks remain low and calling the advice “a precautionary measure.” The European Medicines Agency said Thursday that new preliminary data from the Nordic countries supports a warning the agency adopted in July that inflammatory heart conditions called myocarditis and pericarditis can occur in very rare cases following vaccination with Covid-19 shots made by Moderna and Pfizer-BioNTech. By far, however, the absolute superstar among foreign nations dealing with COVID is Japan. Japan has PULLED the vaccines and substituted Ivermectin - and in one month, wiped COVID out in that country! \* Safe? Japan pulls Moderna vax, ends nationwide vax drive after “magnetic” “metals” found to contaminate jabs: [link to asia.nikkei.com (secure)] \* Three lots of Moderna jabs recalled in Japan over stainless steel contamination: \* Several Japanese cities report white stuff floating in jab vials: \* Japan minister of health tells docs to recommend IVM: [link to rclutz.com (secure)] \* Japan now a MAJOR SUCCESS STORY after it BEATS COVID rapidly: [link to www.msn.com (secure)] Any questions? Just so you understand the timeline. By September deaths from the COVID-19 Vaccine jabs were being investigated. At roughly that time, the vials were under scrutiny and metal "magnetic" material was found in them. Very shortly thereafter, the Japanese minister of health announced doctors could prescribe Ivermectin. A month later, the Western press is shocked that COVID has all but disappeared from the island. Get it? Understand? This is what it looks like in a country that still has rule of law. The governemnt responds to reports of death and contaminated vaxes, moves to real treatment, people get better, and the virus disappears. Now compare that to what is happening in the United States and in Australia and New Zealand. All three countries are in dismal failure in their handling of COVID-19, and that failure has resulted in staggering loss of freedom and destruction of commerce. This is the biggest news story right now. Japan has ended COVID. It did it after it stopped the vax rollout and went to Ivermectin. Period. Hard stop. REFERENCES [1] “There are currently no licensed mRNA vaccines in the United States.” https://www.covidhealth.com/article/understanding-explaining-mrna-covid19-vaccines [2] The most updated list of licensed vaccines in the U.S. is at FDA.gov. https://www.fda.gov/vaccines-bloodbiologics/ vaccines/vaccines-licensed-use-united-states [3] Moderna “The vaccine contains a nucleoside-modified messenger RNA encoding the viral spike (S) glycoprotein of SARS-CoV-2 formulated in lipid particles. It is an investigational vaccine not licensed for any indication.” See FDA letter 2/25/01 to Moderna granting “Emergency Use Authorization (EUA)”. Pfizer Bio-NTech Covid-19 vaccine: “The vaccine contains a nucleocide-modified messenger RNA (modRNA) encoding the viral spike (S) glycoprotein of SARS-CoV-2 formulated in lipid particles. It is an investigational vaccine not licensed for any indication.” See FDA letter 2/25/01 to Pfizer Bio-NTech granting “Emergency Use Authorization (EUA).” [4] mRNA Vaccines Are New, But Not Unknown There are currently no licensed mRNA vaccines in the United States. However, researchers have been studying them for decades. https://www.cdc.gov/vaccines/covid- 19/hcp/mrna-vaccine-basics.html [5] Janssen Biotech, Inc.” https://www.janssencovid19vaccine.com/hcp/how-its-designed.html … “The vaccine contains a recombinant, replication-incompetent human adenovirus serotype 26 (AD26) vector, encoding the SARS-CoV-2 viral spike (S) glycoprotein, stabilized in its pre-fusion form. It is an investigational vaccine not licensed for any indication.” See FDA letter 2/27/01 to Janssen Biotech, Inc. granting “Emergency Use Authorization (EUA).” [6] https://www.nytimes.com/interactive/2020/health/oxford-astrazeneca-covid-19-vaccine.html [7] https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained Page 22 of 63 [8]‘Over more than 3 decades, promising lipids studied in the lab often failed to live up to their potential when tested in animals or humans. Positively charged lipids are inherently toxic, and companies struggled for years before landing on formulations that were safe and effective. When injected intravenously, the particles invariably accumulated in the liver, and delivery to other organs is still an obstacle. Reliably manufacturing consistent LNPs was another challenge, and producing the raw materials needed to make the particles is a limiting factor in the production of COVID-19 vaccines today.’ Without these lipid shells, there would be no mRNA vaccines for COVID-19, by Ryan Cross, Chemical & Engineering News, March 6, 2021. https://cen.acs.org/pharmaceuticals/drug-delivery/Without-lipid-shells-mRNAvaccines/ 99/i8 [9] ADVERSE EFFECTS OF MESSENGER RNA VACCINES An Evidence Review from the Penn Medicine Center for Evidence-based, Practice December 2020, director Nikhil K. Mull, MD (CEP) Lead analyst: Matthew D. Mitchell, PhD (CEP)Clinical review Patrick J. Brennan, MD. (CMO)http://www.uphs.upenn.edu/cep/COVID/mRNA%20vaccine%20review%20final.pdf at p.11, Primary Studies. [10] 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 https://www.law.cornell.edu/uscode/text/21/360bbb-3 [11] (II) of the significant known and potential benefits and risks of such use, and of the extent to which such benefits and risks are unknown. 21 USCS § 360bbb-3 https://www.law.cornell.edu/uscode/text/21/360bbb-3 How will vaccine recipients be informed about the benefits and risks of any vaccine that receives an EUA? FDA must ensure that recipients of the vaccine under an EUA are informed, to the extent practicable given the applicable circumstances, that FDA has authorized the emergency use of the vaccine, of the known and potential benefits and risks, the extent to which such benefits and risks are unknown, that they have the option to accept or refuse the vaccine, and of any available alternatives to the product. Typically, this information is communicated in a patient “fact sheet.” The FDA posts these fact sheets on our website. https://www.fda.gov/vaccines-blood-biologics/vaccines/emergency-use-authorization-vaccines-explained [12] “The federal EEO laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEO considerations discussed below. These principles apply if an employee gets the vaccine in the community or from the employer.” https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-adarehabilitation- act-and-other-eeo-laws [13] Fetal Cell Lines Were Used to Make the Johnson & Johnson COVID Vaccine—Here’s What That Means 3/4/2021, MSN.com, https://www.msn.com/en-us/health/medical/fetal-cell-lines-were-used-to-make-thejohnson- and-johnson-covid-vaccine%E2%80%94heres-what-that-means/ar-BB1efi8p Page 23 of 63 [14] PHI is an acronym of Protected Health Information, while PII is an acronym of Personally Identifiable Information — while you can always waive your privacy rights, you have the right to determine your own release of private medical information. https://www.hipaajournal.com/what-is-considered-phi/ [15] On May 17, 2021, the CDC stated: The VaST session on May 17, 2021, included several presentations on myocarditis following mRNA vaccines, from the Department of Defense (DoD), the Vaccine Adverse Event Reporting System (VAERS), and Vaccine Safety Datalink (VSD). There were also brief updates from the Veteran’s Administration (VA) and the Clinical Immunization Safety Assessment (CISA) groups about their plans for future investigation of myocarditis. COVID-19 VaST Work Group Technical Report – May 17, 2021. https://www.cdc.gov/nchs/nvss/vsrr/covid\_weekly/index.htm?fbclid=IwAR2- muRM3tB3uBdbTrmKwH1NdaBx6PpZo2kxotNwkUXlnbZXCwSRP2OmqsI [16a] https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html#print (citing f.n. 39.) [16b] Nobel Prize Winner Warns Vaccines Facilitate Development of Deadlier COVID Variants, Urges Public to Reject Jabs, by Veronika Kyrylenko, The New American, May 20, 2021: https://thenewamerican.com/french-nobelprize- winner-warns-vaccines-facilitate-development-of-deadlier-covid-variants-urges-the-public-to-reject-jabs/ [17] Exclusive: Athlete Who Recovered From COVID Facing ‘Very Different Future’ After Second Dose of Pfizer Vaccine Triggers Myocarditis, by Megan Redshaw, 06/21/21, the Defender, Children’s Health Defense https://childrenshealthdefense.org/defender/greyson-follmer-pfizer-vaccinemyocarditis/? utm\_source=salsa&eType=EmailBlastContent&eId=faf15c81-fc5a-4174-bb39-70c908f37be8 [18] CD8+ T cell responses in COVID-19 convalescent individuals target conserved epitopes from multiple prominent SARS-CoV-2 circulating variants – PubMed https://na01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fpubmed.ncbi.nlm.nih.gov%2F33594378%2F &amp;data=04%7C01%7C%7Cf496c029c7a546320c2508d8f90cf35b%7C84df9e7fe9f640afb435aaaaaaaaaaaa%7C1 %7C0%7C637533181300658523%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI 6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&amp;sdata=daj%2FesDTdKPA8V669M48HmIOBTkXVmFrGKu5pqJZAZE%3D &amp;reserved=0 [19] Lasting immunity found after recovery from COVID-19, National Institutes of Health, January 26, 2021 https://www.nih.gov/news-events/nih-research-matters/lasting-immunity-found-after-recovery-covid- 19?fbclid=IwAR0NvW6PWXlK4xIf7yTulxhYagh6qAaSL4cZbVCJXmjuON-q4Lsz6A9Wa24 [20] Frequently Asked Questions about COVID-19 Vaccination, “If I have already had COVID-19 and recovered, do I still need to get vaccinated with a COVID-19 vaccination? https://www.cdc.gov/coronavirus/2019- ncov/vaccines/faq.html [21] CDC, Definition of Terms https://www.cdc.gov/vaccines/vac-gen/imzbasics. htm#:~:text=Definition%20of%20Terms,- Let’s%20start%20by&text=Vaccine%3A%20A%20product%20that%20stimulates,or%20sprayed%20into%20the%20 nose. [22] See the Petition for a Temporary Restraining Order filed this week in the U.S. District Court for the Northern District of Alabama by America’s FrontLine Doctors, 2:21-cv-00702, CLM. [23] https://finance.yahoo.com/news/hydroxychloroquine-90-percent-chance-helping-155637974.html Page 24 of 63 [24] https://finance.yahoo.com/news/hydroxychloroquine-90-percent-chance-helping-155637974.html [25] https://pubmed.ncbi.nlm.nih.gov/33278625/ [26] https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-june-25-2021 REFERENCES 2: The Lozier Institute Lists a number of COVID-19 Vaccines which utilize aborted fetal cells - https://lozierinstitute.org/update-covid-19-vaccinecandidates- and-abortion-derived-cell-lines/ 3: The Pfizer Vaccine utilized aborted fetal cells - https://www.biorxiv.org/content/10.1101/2020.09.08.280818v1.full 4: The Moderna Vaccine utilized aborted fetal cells - https://www.nature.com/articles/s41586-020-2622-0 5: The Johnson & Johnson Vaccine utilized aborted fetal cells - https://www.janssen.com/emea/emea/janssen-vaccine-technologies 6: Sputnik V Vaccine citing trial tests of their manufacturers = https://sputnikvaccine.com/about-vaccine/human-adenoviral-vaccines/ 7: Sputnik V manufacturers acknowledge usage of aborted fetal cells - http://actanaturae.ru/2075-8251/article/view/10302/106 8: The UK Government acknowledges AstraZeneca’s usage of aborted fetal cells - https://www.gov.uk/government/publications/regulatoryapproval- of-covid-19-vaccine-astrazeneca/information-for-healthcare-professionals-on-covid-19-vaccine-astrazeneca-regulation-174 9: The Vaxxart Vaccine utilized aborted fetal cells - https://www.biorxiv.org/content/10.1101/2020.09.04.283853v1.full 10. 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The Arcturus Vaccine utilized aborted fetal cells – https://www.biorxiv.org/content/10.1101/2020.09.03.280446v1 19. The Imperial College Vaccine utilized aborted fetal cells - https://www.biorxiv.org/content/10.1101/2020.04.22.055608v1 20. The Providence Vaccine utilized aborted fetal cells - https://www.biorxiv.org/content/10.1101/2021.05.11.443286v1 21. CoronaVac utilized aborted fetal cells - https://science.sciencemag.org/content/suppl/2020/05/05/science.abc1932.DC1 22. The CanSino Vaccine utilized aborted fetal cells - https://science.sciencemag.org/content/suppl/2020/05/05/science.abc1932.DC1 23. The ImmunityBio Vaccine utilized aborted fetal cells – https://www.biorxiv.org/content/10.1101/2020.07.29.227595v1.full 24. The Institut Pasteur Vaccine utilized aborted fetal cells - https://www.pnas.org/content/pnas/117/51/32657.full.pdf 25. The Rega Vaccine utilized aborted fetal cells - https://www.nature.com/articles/s41586-020-3035-9 26. The Anhui Zhifei Vaccine utilized aborted fetal cells - https://www.cell.com/cell/fulltext/S0092-8674(20)30812-6 27. The Clover Vaccine utilized aborted fetal cells - https://www.biorxiv.org/content/10.1101/2020.09.24.311027v1.full Page 25

If permitted an exemption or delay in taking the vaccine, what types of accommodation would enable you to perform your job duties without presenting a risk of transmission to others?

Continued remote/telework option as I've been doing for 20+ months while self quarantining.

Have you contacted anyone regarding this reasonable accommodation request?

No

Do you work in a SCIF?

No

I have read the Privacy Act Statement

true