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JENN BIGGAR
DOUGLAS COUNTY CLERK
WATERVILLE, WA
BY _____ DEPUTY

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON

IN AND FOR THE COUNTY OF DOUGLAS

BRENDA ADAMS, ANNETTE AGUIGUI, EDWARD AGUIGUI, MARISOL AGUIRRE, TIMOTHY ALRASHEDY, HOLLY BARRUTIA, CRISTIE BINGHAM, TYLER BISHOP, JULIE BRONS, TEODOR BUTUI, SHAWNA CADDY, JESSIE CASTANEDA, JOHN CHAMBERLAIN, MELISSA COLE, CASSANDRA COZART, JOY DAWE, DARCI GLASS, JENNI GROCE, ZOFIA GUZIKOWSKA, BRENDA HAMMOND, CHEYENNE HARPER, NICOLE HARPER, JULIE HART, HEATHER HENDRICKS, MARNIE HERRICK, JEAN HORAN, RITA HRUBY, MELLISSA HUSTON, MARIA JAY, NICOLE KELLY, STACY KLINGER, REBECCA LANCASTER, NATALIE LEWIS, MICHELE LOVE-WELLS, TRINA MATKINS, TAYLOR MAHER, JENESSA MARLOW, CHRISTINA MARIE, ANGELA MARTIN, JUDITH McBRIDE, MELISSA McDOWELL, JENNY McINNIS, KATIE MICHAEL, DAVID MILLER, GAIL MILLER, JENNIFER MOLENAAR, LYNDA MONCRIEF, DEBRA MOON,	NO. 22-2-00104-09 DECLARATION OF PETER McCULLOUGH, MD, MPH, IN SUPPORT OF PLAINTIFFS' COMPLAINT

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CARLY MORRISON, MOLLY MOTOOKA REBECCA MULLIN, SHELLIE NIEBUHR, KYLA OHS, ALTURA PASIC, GENELLE PEPPEL, GLENN PERRY, AMANDA PETERSEN, CYNTHIA PHILLIPS, AUBREE POTTORFF, JESSICA POTTORFF, CARI RIGGEN, TRAVIS SACKWAR, PATRICIA SCHAUER, CAROLINA SHJANDEMAAR, JULIE SIMMONS, SUE SINCLAIR, PAIGE SIRES, STACY STEINBURG, BRIAN STEVENS, JULIANN STEVENS, EDMOND THOMAS, DEBORAH TINCHER, BRYCE TUSSEY, CHRISTOPHER TUSSEY, MAY TUSSEY, MARY VARGAS, MELINDA VARGAS, SARAH VOTH, AMY WALL, LISA WAREHAM, MICHELLE WELTON, JONATHAN WHITE, KARINNE WHITEHALL, individually, and on behalf of all other persons similarly situated,

Plaintiffs,

vs.

CONFLUENCE HEALTH, a Non-Profit Washington State Health Care Institution,

Defendant.

I, Dr. Peter McCullough, do hereby declare as follows:

1. I am over eighteen years of age, and I am not suffering under any mental disability and am competent to give this sworn declaration. I am able to read and write and to give this declaration voluntarily and on my own free will and accord. No one has used any threats, force, pressure, or intimidation to make me sign this declaration. I understand that I am swearing or affirming under oath to the truthfulness of the claims made in this declaration under penalties of

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perjury; that I have read these statements in this declaration; and these statements are my understanding of the facts and that my opinion provided is based on a reasonable degree of medical certainty. At this juncture I am working on this case Pro Bono; and have not been paid by anyone to provide this opinion. I am providing this declaration as I have serious, grave concerns for these health care workers and the public-at-large.

2. I have personal knowledge and understanding of these matters, and I make this declaration in support of the truth of the contents contained herein. In short: I believe within a reasonable degree of medical certainty that the COVID-19 vaccine(s) are not safe generally. It is my belief based on a reasonable degree of medical certainty that the vaccine could cause the death of a significant number of the Plaintiffs. I believe within a reasonable degree of medical certainty that the data upon which Confluence Health has based its mandate for unvaccinated workers to be vaccinated for COVID-19 is flawed and/or inaccurate; and imposing this vaccine is not only dangerous and could cause harm to the Plaintiffs, but to the public-at-large who depend on first responders and healthcare workers. Moreover, I believe within a reasonable degree of medical certainty the following: (1) that the COVID-19 vaccines do not prevent transmission of disease among vaccinated or mixed vaccinated -unvaccinated populations; and (2) that mandatory Covid 19 vaccination for hospital and clinic employees does not increase safety for hospital or clinic employees or patients; and (3) that the very terms "unvaccinated" and "vaccinated" have little meaning for individuals who never received a COVID-19 vaccine or for individuals who did receive a COVID-19 vaccine, but whose last dose occurred more than approximately six months previous, since both individuals possess essentially no significant vaccine-induced protection from COVID-19 disease and both are just as

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likely to be infected with and transmit the COVID-19 virus. In support, I submit the following for the Court's consideration:

3. After receiving a bachelor's degree from Baylor University, I completed my medical degree as an Alpha Omega Alpha graduate from the University of Texas Southwestern Medical School in Dallas. I went on to complete my internal medicine residency at the University of Washington in Seattle, a cardiology fellowship including service as Chief Fellow at William Beaumont Hospital, and a master's degree in public health in the field of epidemiology at The University of Michigan. I am board certified in internal medicine and cardiovascular disease and hold an additional certification in clinical lipidology, and previously echocardiography. I participate in the maintenance of certification programs by the American Board of Internal Medicine for both Internal Medicine and Cardiovascular Diseases. I am an active scholar in medicine with roles as an author, editor-in-chief of a peer-reviewed journals, editorialist, and reviewer at dozens of major medical journals and textbooks.

4. I have led clinical, education, research, and program operations at major academic centers (Henry Ford Hospital, Oakland University William Beaumont School of Medicine) as well as academically oriented community health systems. I spearheaded the clinical development of in vitro natriuretic peptide and neutrophil gelatinase associated lipocalin assays in diagnosis, prognosis, and management of heart and kidney disease now used worldwide. I also led the first clinical study demonstrating the relationship between severity of acute kidney injury and mortality after myocardial infarction. I have contributed to the understanding of the epidemiology of chronic heart and kidney disease through many manuscripts from the Kidney Early Evaluation Program Annual Data Report published in the American Journal of Kidney Disease and participated in clinical trial design and

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execution in cardiorenal applications of acute kidney injury, hypertension, acute coronary syndromes, heart failure, and chronic cardiorenal syndromes. I participated in event adjudication (involved attribution of cause of death) in trials of acute coronary syndromes, chronic kidney disease, heart failure, and data safety and monitoring of antidiabetic agents, renal therapeutics, hematology products, and gastrointestinal treatments. I have served as the chairman or as a member of over 20 randomized trials of drugs, devices, and clinical strategies. Sponsors have included pharmaceutical manufacturers, biotechnology companies, and the National Institutes of Health.

5. I frequently lecture and advise on internal medicine, nephrology, and cardiology to leading institutions worldwide. I am recognized by my peers for my work on the role of chronic kidney disease as a cardiovascular risk state. I have over 1,000 related scientific publications, including the "Interface between Renal Disease and Cardiovascular Illness" in *Braunwald's Heart Disease Textbook*. My works have appeared in the *New England Journal of Medicine*, *Journal of the American Medical Association*, and other top-tier journals worldwide. I am a senior associate editor of the *American Journal of Cardiology*. I have testified before the U.S. Senate Committee on Homeland Security and Governmental Affairs, the U.S. Food and Drug Administration Cardiorenal Advisory Panel and its U.S. Congressional Oversight Committee, The New Hampshire Senate, the Colorado House of Commons, and the Texas Senate Committee on Health and Human Services. I am a Fellow of the American College of Cardiology, the American Heart Association, the American College of Physicians, the American College of Chest Physicians, the National Lipid Association, and the National Kidney Foundation; and I am also a Diplomate of the American Board of Clinical Lipidology. In 2013, I was honored with the International Vicenza Award for Critical Care Nephrology for my contribution and dedication to the emerging problem of cardiorenal syndromes.

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I am a founding member of Cardiorenal Society of America, an organization dedicated to bringing together cardiologists and nephrologists and engage in research, improved quality of care, and community outreach to patients with both heart and kidney disease. I am a former President of the Cardiorenal Society of America, an expert organization dedicated to advancing research and clinical care for patients who have combined heart and kidney disease. I am a former Editor-in-Chief of *Cardiorenal Medicine*, a primary research journal listed by the National Library of Medicine which is the only publication with a primary focus on research concerning patients with combined heart and kidney disease. Finally, I am a former Editor-in-Chief of Reviews in Cardiovascular Medicine, a widely read journal that publishes reviews on contemporary topics in cardiology and is also listed by the National Library of Medicine.

6. Since the outset of the pandemic, I have been a leader in the medical response to the COVID-19 disaster and have published "Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection," the first synthesis of sequenced multidrug treatment of ambulatory patients infected with SARS-CoV-2 in the American Journal of Medicine and updated in *Reviews in Cardiovascular Medicine*. I have 47 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine. Through a window to public policymakers, I have contributed extensively on issues surrounding the COVID-19 crisis in a series of OPED's for *The Hill* in 2020. Starting in 2021, I publish a weekly contribution on *America Out Loud, The McCullough Report.* I testified on the SARS-CoV-2 outbreak in the U.S. Senate Committee on Homeland Security and Governmental Affairs on November 19, 2020. I testified on lessons learned from the pandemic response in the Texas Senate Committee on Health and Human Services on March 10, 2021, and on early treatment of COVID-19 at the Colorado General Assembly

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on March 31, 2021. Additionally, I testified in the New Hampshire Senate on legislation concerning the investigational COVID-19 vaccine on April 14, 2020. My expertise on the SARS-CoV-2 infection and COVID-19 syndrome, like that of infectious disease specialists, is approximately 18 months old with the review of hundreds of manuscripts and with the care of many patients with acute COVID-19, post-COVID-19 long-hauler syndromes, and COVID-19 vaccine injury syndromes including neurologic damage, myocarditis, and a variety of other internal medicine problems that have occurred after the mRNA and adenoviral DNA COVID-19 vaccines. I have formed my opinions in close communications with many clinicians around the world based on in part our collective clinical experience with acute and convalescent COVID-19 cases as well as closely following the preprint and published literature on the outbreak. I have specifically reviewed key published rare cases and reports concerning the possible recurrence of SARS- CoV-2 in patients who have survived an initial episode of COVID-19 illness.

As to my Expert Opinion

7. On June 23, 2021, the CDC reported the lowest number of Delta cases since March of 2020 (the beginning of the COVID-19 pandemic). Sam Baker & Andrew Witherspoon, COVID-19 cases hit lowest point in U.S. since pandemic began, AXIOS (June 3, 2021) https://www.axios.com/coronavirus-cases-infections-vaccines-success-fa7673a1-0582-4e69-aefb-3b5170268048.html.

8. Further, according to my research, herd immunity is calculated by a specific formula, as follows:

$$((CC*6) + V + (.15*P)) \div P = HIN$$

CC= COVID-19 cases in the state; 6 = the current CDC multiplier
V= number of vaccinated in the state

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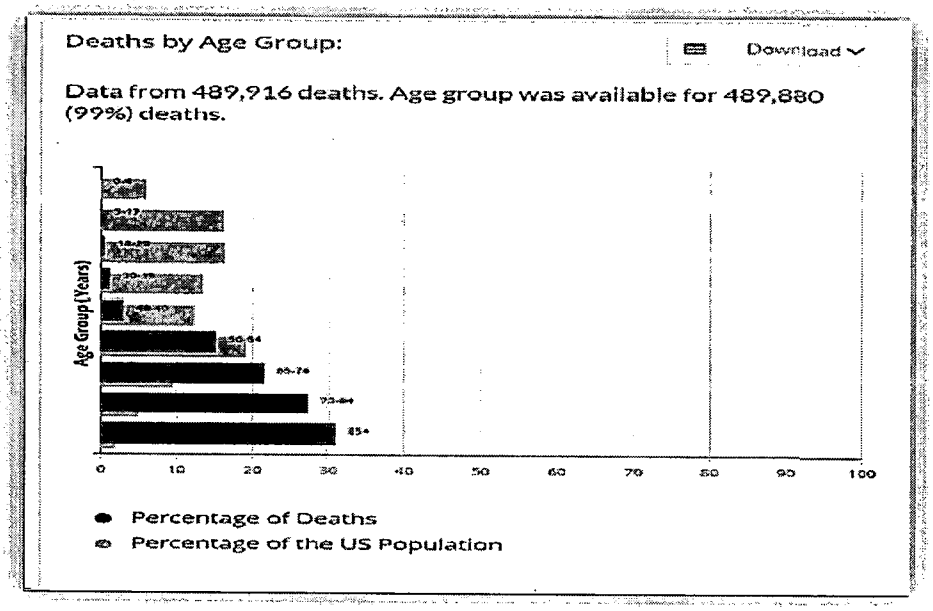
15% = the number of people in a given state that will not get COVID-19
P=Population of a state
HIN=Herd Immunity Totals

By this method of calculation, the United States has achieved herd immunity meaning that the total of this calculation exceeds 100%. As vaccines continue to fail, we can expect cases of COVID-19 and the meaning of herd immunity applies to spread. Despite expected incidents and prevalent cases, my opinion is that spread will be minimized and there will be no more large outbreak curves as the country experienced in November through early January before the advent of widely deployed early treatment protocols. Because the randomized trials of all COVID-19 vaccines revealed < 1% absolute risk reductions, and the recent observation of widespread failure of COVID-19 vaccines in countries such as Israel which has a substantial population vaccinated early the pandemic, we can expect more vaccine failures in the United States and no fundamental impact of mass vaccination on the epidemic curves.

Table 1: COVID-19 Deaths by Age Group in the U.S. as of June 27, 2021.
Source: https://COVID-19.cdc.gov/COVID-19-data-tracker/#demographics



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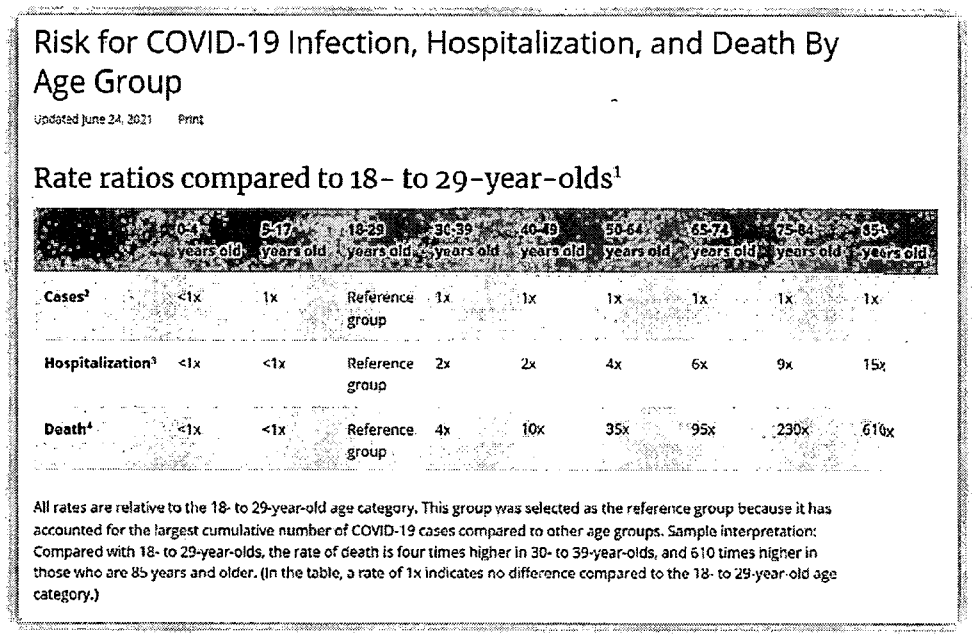
9. There is negligible risk for adults younger than the age of 60. For example, for each 18-29-year-old that dies from COVID-19, four 30–39-year-old individuals die, ten 40-49-year-olds, thirty-five 50-64-year-olds die, ninety-five 65-74-year-olds die, 230 75-84-year-olds die, and 610 over 85 years of age die. See Table 2.

Table 2: COVID-19 Rate Ratios by Age



Risk for COVID-19 Infection, Hospitalization, and Death By Age Group

Updated June 24, 2021 Print

Rate ratios compared to 18- to 29-year-olds[1]

	0-4 years old	5-17 years old	18-29 years old	30-39 years old	40-49 years old	50-64 years old	65-74 years old	75-84 years old	85+ years old
Cases[2]	<1x	1x	Reference group	1x	1x	1x	1x	1x	1x
Hospitalization[3]	<1x	<1x	Reference group	2x	2x	4x	6x	9x	15x
Death[4]	<1x	<1x	Reference group	4x	10x	35x	95x	230x	610x

All rates are relative to the 18- to 29-year-old age category. This group was selected as the reference group because it has accounted for the largest cumulative number of COVID-19 cases compared to other age groups. Sample interpretation: Compared with 18- to 29-year-olds, the rate of death is four times higher in 30- to 39-year-olds, and 610 times higher in those who are 85 years and older. (In the table, a rate of 1x indicates no difference compared to the 18- to 29-year-old age category.)

https://www.cdc.gov/coronavirus/2019-ncov/COVID-19-data/investigations-discovery/hospitalizationdeath-by-age.html

10. In my expert medical opinion, the epidemic spread of COVID-19, like all other respiratory viruses, notably influenza, is driven by symptomatic persons; asymptomatic spread is trivial and inconsequential.

11. A meta-analysis of contact tracing studies published in The Journal of the American Medical Association showed asymptomatic COVID-19 spread was negligible at 0.7%. Zachary J.

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Madewell, Ph.D.; Yang Yang, Ph.D.; Ira M. Longini Jr, Ph.D.; M. Elizabeth Halloran, MD, DSc; Natalie E. Dean, Ph.D., Household Transmission of SARS-CoV-2: A Systematic Review and Meta-analysis, JAMA Network Open, available at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774102 (last visited June 20, 2021).

12. Accordingly, a rational and ethical prevention measure to reduce the spread of COVID-19 is a simple requirement, as part of formal policies, that persons with active symptomatic, febrile (feverish) respiratory illnesses, like COVID-19, should isolate themselves. Indeed, during the H1N1 influenza A pandemic, fully open, unmasked college campuses were advised by federal health officials, "Flu-stricken college students should stay out of circulation" and "if they can't avoid contact, they need to wear surgical masks." Great Falls Tribune, Advice: Flu-stricken college students should stay out of circulation, August 21, 2009, page 5, section A, available at https://www.newspapers.com/image/243611045/.

COVID 19 Vaccine Transmission and Risk

13. It is never good research practice to perform a large-scale clinical investigation without the necessary structure to ensure the safety and protection of human subjects. These structures include a critical event committee, data safety monitoring board, and a human ethics committee. These groups in large studies work to objectively assess the safety of the investigational product and research integrity. The goal is mitigating risk and protecting human subjects. It is my understanding that the COVID-19 vaccine program is sponsored by the CDC and FDA and has none of these safety structures in place. It is my assessment, that the COVID-19 clinical investigation has provided no

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meaningful risk mitigation for subjects (restricting groups, a special assessment of side effects, follow-up visits, or changes in the protocol to ensure or improve the safety of the program).

The COVID-19 public vaccination program operated by the CDC and the FDA is, therefore, a clinical investigation and under no circumstance should any person receive pressure, coercion, or threat of reprisal in relation to their free choice to participate or not participate in a public vaccination program. Violation of this principle of autonomy by any entity constitutes reckless endangerment with a reasonable expection of causing personal injury, disability, or death.

14. In 1990, the Vaccine Adverse Event Reporting System ("VAERS") was established as a national early warning system to detect possible safety problems in U.S. licensed vaccines. VAERS is a passive reporting system, meaning it relies on individuals to voluntarily send in reports of their experiences to the CDC and FDA. VAERS is useful in detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. The total safety reports in VAERS for all vaccines per year up to 2019 was 16,320. The total safety reports in VAERS for COVID-19 Vaccines alone through October 1, 2021, is 778,683. Based on VAERS as of October 1, 2021, there were 16,310 COVID-19 vaccine deaths reported and 75,605 hospitalizations reported for the COVID-19 vaccines (Pfizer, Moderna, JNJ). By comparison, from 1999, until December 31, 2019, VAERS received 3167 death reports (158 per year) adult death reports for all vaccines combined. Thus, the COVID-19 mass vaccination is associated with at least a 39-fold increase in annualized vaccine deaths reported to VAERS. COVID-19 vaccine adverse events account for 98% of all vaccine-related AEs from December 2020 through the present in VAERS. There are emerging trends showing that the vaccine is especially risky for those 12- 29 in my expert medical opinion with complications in the cardiovascular, neurological, hematologic, and

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immune systems. (See, Rose J, et al). Increasingly the medical community is acknowledging the possible risks and side effects including myocarditis, Bell's Palsy, Pulmonary Embolus, Pulmonary Immunopathology, and severe allergic reaction causing anaphylactic shock. See Chien-Te Tseng, Elena Sbrana, Naoko Iwata- Yoshikawa, Patrick C Newman, Tania Garron, Robert L Atmar, Clarence J Peters, Robert B Couch, Immunization with SARS coronavirus vaccines leads to pulmonary immunopathology on challenge with the SARS virus, https://pubmed.ncbi.nlm.nih.gov/22536382/, (last visited June 21, 2021); Centers for Disease Control and Prevention, Allergic Reactions Including Anaphylaxis After Receipt of the First Dose of Pfizer-BioNTech COVID-19 Vaccine—United States, December 14– 23, 2020 (Jan 15, 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7002e1.htm, (last visited June 26, 2021). The Centers for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis. It is known that myocarditis causes injury to heart muscle cells and may result in permanent heart damage resulting in heart failure, arrhythmias, and cardiac death. These conditions could call for a lifetime need for multiple medications, implantable cardio defibrillators, and heart transplantation. Heart failure has a five-year 50% survival and would markedly reduce the lifespan of a child or young adult who develops this complication after vaccine-induced myocarditis (ref McCullough PA Reach Study). Further, the CDC just announced that the vaccine is "likely linked" to myocarditis. Advisory Board, CDC panel reports 'likely association' of heart inflammation and mRNA COVID-19 vaccines in young people, (June 24, 2021) https://www.advisory.com/daily-briefing/2021/06/24/heart-inflammation. The CDC recently released data stating that there have been 267 cases of myocarditis or pericarditis reported after receiving one dose of the COVID-19 vaccines and 827 reported cases after two doses through June 11. There are 132 additional cases

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where the number of doses received is unknown. Id. There have been 2466 reported cases of myocarditis that have occurred, and the median age is thirty. Id. https://openvaers.com/covid-data, (accessed July 17, 2021).

The current Covid 19 vaccines are not sufficiently protective against contracting Covid 19 to support their use beyond the current voluntary participation in the CDC-sponsored program. A total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021. Among these cases , 6446 (63%) occurred in females, and the median patient age was 58 years (interqaurtile range = 40-74 years). Based on preliminary data, 2725 (27%) vaccine breakthrough infections were asymptomatic, 995 (10%) of patients were known to be hospitalized, and 160 (2%) of patients died. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalized for a reason unrelated to COVID-19. The median age of patients who died was 82 years (interquartile range = 71-89 years); 28 (18%) of decedents were asymptomatic or died from a caused unrelated to COVID-19. Sequence data was available from 555 (5%) of reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern. None of those variants are encoded in the RNA or DNA of the current COVID-19 vaccines.

15. As of December 16, 2021 the Delta variant of SARS-CoV-2 accounted for 98.9% of the then present cases in the United States. Because of progressive mutation of the spike protein, the virus had achieved an immune escape from the COVID-19 vaccines with the most obvious example being Israel where indiscriminate vaccination achieved 80% immunization rates. This had promoted the emergence of the Delta variant as the dominant strain, and because it was not adequately covered by the Pfizer COVID-19 vaccine, greater than 80% of Israeli COVID-19 cases occurred in persons fully vaccinated.

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17. The CDC has published a report titled: "Outbreak of SARS-CoV-2 Infections, Including COVID-19 Vaccine Breakthrough Infections, Associated with Large Public Gatherings- Barnstable County, Massachussetts, July, 2021" demonstrating complete failure of the Covid 19 vaccines in controlling spread of SARS-CoV-2 in congregate settings. My interpretation of this report is that vaccines are not sufficiently effective to make the elective, investigation vaccine recommended for use beyond individual preference. https;//www.cdc.gov/mmwr/volumes/70/wr/mm7031e2.htm

18. Reported cases of breakthrough infections demonstrate that the COVID-19 vaccines do not prevent transmission. According to the CDC, as of July 26, 2021, there were 161 million people in the United States fully vaccinated, with 6,587 reported breakthrough infections resulting in hospitalization or death. As of August 23, 2021, the number and rate of breakthrough infections markedly increased; 171 fully vaccinated, with 11,050 breakthrough infections resulting in hospitalization or death. Multiple studies have shown that fully vaccinated individuals who are infected with COVID-19 have a similar risk of transmitting the disease as those who are unvaccinated.

Natural Immunity; Likelihood of Re-infection and Transmission.

19. It is my opinion that SARS-CoV-2 causes an infection in humans that results in robust, complete, and durable immunity, and is superior to vaccine immunity which, by comparison has demonstrated massive failure including over 10,000 well-documented vaccine failure cases as reported by the CDC before tracking was stopped on May 31,2021. To my knowledge, there are no trustworthy studies that demonstrate the clinical benefit of COVID-19 vaccination in COVID-19 survivors or those with suspected COVID-19 illness or subclinical disease who have laboratory

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evidence of prior infection. Thus, it is my opinion that the COVID-19 vaccination is contraindicated in COVID-19 survivors, many of whom are likely to be in healthcare settings.

20. Multiple laboratory studies conducted by highly respected U.S. and European academic research groups have reported that convalescent mildly or severely infected COVID-19 patients who are unvaccinated can have greater virus-neutralizing - especially more versatile, long-enduring T-cell immunity- relative to vaccinated individuals who were never infected. *See* Ahina Kippelainen, *et al*, Highly Functional Cellular Immunity in SARS-CoV-2 Non-Seroconverters is Associated with Immune Protection, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.05.04.438781vl (last visited June 26, 2021); Tongcui Ma, *et al.*, Protracted yet coordinated differentiation of long-lived SARS-CoV-2-specific CD8+ T-cells during Covid-19 convalescence, bioRxiv (pre-print), https://www.biorxiv.org/content/10.1101/2021.o5.11.21256578vl (last visited June 21, 2021).

21. The Cleveland Clinic studies their employees for the effects of natural immunity in unvaccinated people as summarized by Block (Block J., Vaccinating people who have had COVID-19; why doesn't natural immunity count in the U.S.? BMJ.2021 Sep 13;374:n2101. Erratum in BMJ. 2021 Sep 15;374:n2272.PMID: 34518194.) They found zero SARS-CoV-2 reinfections during a 5-month follow-up among n=1359 infected employees who were naturally immune and remained unvaccinated. They concluded such persons are "unlikely to benefit from COVID-19 vaccination." Among those who were vaccinated, unlike the naturally immune, there were vaccine failure or breakthrough cases of COVID-19 *Id.*

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(<1%) of COVID-19 over the long term. Murchu found no evidence of waning immunity over time suggesting no possibility that future vaccination would be indicated for any reason https://onlinelibrary.wiley.com/doi/10.1002/rmv.2260.

23. A published article in *Nature* reported that prior infection induces long-lived bone marrow plasma cells, which means that antibodies to prevent reinfection of COVID-19 are long lasting. Jackson S. Turner *et. al.* SARS-CoV-2 infection induces long-lived bone marrow plasma cells in humans, (May 24, 2021) https://www.nature.com/articles/s41586-021-03647-4.

24. An even more recent report (September 13, 2021) in the BMJ (formerly named *British Medical Journal*), titled "Vaccinating people who have had COVID-19; why doesn't natural immunity count in the US?" (https://hcn.health/hcn-trends-story/vaccinating-people-who-have-had-covid-19-why-doesnt-natural-immunity-count-in-the-us/z) provides an excellent summary of the current state of medical science on natural immunity to COVID-19, including how other countries have factored natural immunity into their public health policies. The report quotes a vaccinologist and professor in global health at the University of Southern Denmark as stating; "If natural immunity is strongly protective, as the evidence suggests it is, then vaccinating people who have had COVID-19 would seem to offer nothing or very little to benefit, logically leaving only harms–both the harms we already know about as well as those still unknown." I fully agree.

Conclusion

In my expert opinion, the *mandatory* administration of COVID-19 vaccines in employees does not prevent transmission among the vaccinated or unvaccinated in the workplace and does not improve workplace safety. This has been well established scientifically since at least the middle of

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2021. The use of other preventative measures, particularly testing, is far more effective and far less intrusive to employee and patient autonomy and to the right of personal safety.

I declared and affirm under penalty of perjury that the foregoing is true and correct this 23 day of March, 2022.

Peter A. McCullough, MD.,MPH

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