DECLARATION OF DR. PETER A. MCCULLOUGH IN RESPONSE TO AMERICAN BOARD OF INTERNAL MEDICINE NOTICE OF POTENTIAL DISCIPLINARY ACTION

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 affidavit. These statements are my understanding of the evolving scientific information and that my opinion provided is based on a reasonable degree of medical certainty. I am providing this declaration as I have serious, grave concerns regarding the ABIM acts of reprisal and attacks against my free speech, evidenced-based analysis, presentation, and publication, and expressed medical opinions.

2. Attached to this Declaration as **EXHIBIT 1** is my Curriculum Vitae. 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 (ABIM 136084). I am an active scholar in medicine with roles as an author, former editor-in-chief of a peer-reviewed journals, editorialist, and

reviewer at dozens of major medical journals and textbooks.

3. I have led clinical, education, research, and program operations at major academic centers (Henry Ford Hospital, Oakland University William Beaumont School of Medicine, Baylor University Medical Center) 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 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.

4. I frequently lecture and advise on internal medicine, nephrology, cardiology, and COVID-19 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 Pennsylvania 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 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. I am the 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 the 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.

5. 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*.[1] [2] I am listed on 58 peer-reviewed publications on the COVID-19 infection cited in the National Library of Medicine (accessed June 14, 2022).[3] 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.[4] Starting in 2021, I publish a weekly contribution on *America Out Loud, TheMcCullough Report.*[5] 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 on March 31, 2021. Additionally, I testified in the New Hampshire Senate on legislation concerning the investigational COVID-19 vaccine on April 14, 2020. I also testified before the Pennsylvania Senate on March 4, 2022, and the South Carolina Committee on Medical Affairs on February 14, 2022, on various aspects of the pandemic response. In addition, on January 24, 2022, Senator Ron Johnson invited various experts (including myself) to the US Senate special panel discussion titled "COVID-19: A Second Opinion", which he chaired and I co-moderated. My expertise on the SARS-CoV-2 infection and COVID-19 syndrome, like that of infectious disease specialists, is over two years old with the review of thousands of manuscripts and with the care of many patients with acute COVID-19, post-COVID-19 syndromes, and COVID-19 vaccine injury syndromes including neurologic damage, myocarditis, venous thromboembolism 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

Epidemiology of SARS-CoV-2 Human Infection

6. The concept of herd immunity has become less relevant concerning the binary outcome of any COVID-19 illness since the Omicron variant has broken through both natural and vaccine induced immunity. We have had several outbreaks since the low in cases recorded in March 2020.

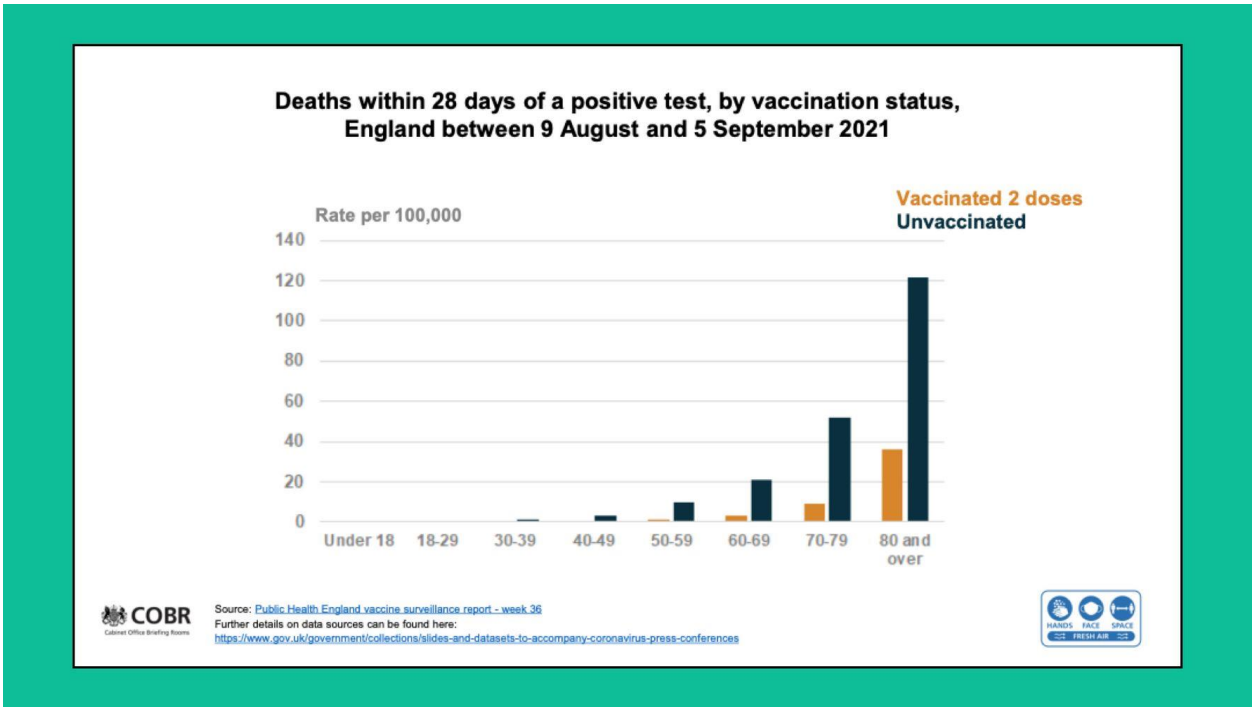
7. Further, according to my research, herd immunity is calculated by a specific formula proposed by CDC researchers, as follows: ((CC*6) + V + (.15*P)) ÷ P = HIN.

CC= COVID-19 cases in the state
6= the current CDC multiplier
V= number of vaccinated in the state
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, in Texas on or before March 10, 2021, I testified that Texas has achieved 80% herd immunity meaning that the total of this calculation was at least 80%. As vaccines continue to fail with greater numbers of breakthrough cases,we can expect cases of COVID-19 and the meaning of herd immunity better apply to the

clinical outcomes of hospitalization and death.

8. There is negligible mortality risk for adults younger than the age of 50. As shown in the figure, for the unvaccinated and vaccinated the risk of death is negilible < 5/100,000 for death (0.0005%). Early treatment for individuals under age 50 with risk factors or presenting with severe symptoms as myself and coauthors have advised is associated with further reductions in the risks of hospitalization and death.[1 2 6 7]



9. Cao et al demonstrated in a large direct observation, measurement, and case-contact tracing study that asymptomatic spread was negligible.[8] A meta-analysis of contact tracing studies published in The Journal of theAmerican Medical Association showed asymptomatic COVID-19 spread was also negligible at 0.7%.[9]

Advances in COVID-19 Ambulatory Treatments

10. Even if the virus is contracted, the treatment of the infection has improved tremendously since the advent of COVID-19. Studies have shown severaldifferent treatment methods, which have proven effective. A combination of medications,

supported by the Association of American Physicians and Surgeons, for a minimum of five days and acutely administered supplements used for the initialambulatory patient with suspected and or confirmed COVID-19 (moderate or greater probability) has proven effective.[10] This approach has resulted in an ~85% reduction in hospitalization and death in high-risk individuals presenting with COVID-19.[6 7 11 12]

COVID-19 Vaccine Research and Development

11. Development and Emergency Use Authorization (EUA) COVID-19 vaccines was aided by The Biomedical Advanced Research and Development Authority (BARDA) is a U.S. Department of Health and Human Services (HHS) office responsible for the procurement and development of medical countermeasures, principally against bioterrorism, including chemical, biological, radiological and nuclear threats, as well as pandemic and emerging diseases, and the Wuhan Institute of Virology which includes the Wuhan Biosafety Laboratory Level 4.[13] Farkas et al has analyzed SARS-CoV-2 along the lines of bioweapon criteria and have concluded that the virus mainly conveyed through the Spike protein (which is the protein product of mRNA and adenoviral DNA COVID-19 vaccines) can become a potent bioweapon.[14]

12. The COVID-19 genetic vaccines (Pfizer, Moderna, JNJ) skipped testing for genotoxicity, mutagenicity, teratogenicity, and oncogenicity. In other words, it isunknown whether or not these products will change human genetic material, cause birth defects, reduce fertility, or cause cancer.[15] The long-term adverse event and serious adverse event profile of all COVI19 vaccines is unknown since a long period of time has not elapsed at the time of this report.

13. The Pfizer, Moderna, and JNJ vaccines are considered “genetic vaccines”,

or vaccines produced from gene therapy molecular platforms which according to US FDA regulatory guidance are classified as gene delivery therapies and should be under a 15-year regulatory cycle with annual visits for safety evaluation by the research sponsors.[16]

14. The FDA has "advised sponsors to observe subjects for delayed adverse events for as long as 15 years following exposure to the investigational gene therapy product, specifying that the long-term follow-up observation should include a minimum of five years of annual examinations, followed by ten years of annual queries of study subjects, either in person or by questionnaire." FDA Gene Therapy Guidance at 4. The COVID-19 genetic vaccines have a dangerous mechanism of action in that they all cause the body to make an uncontrolled quantity of the pathogenic wild-type spike protein from the SARS-CoV-2 virus for at least two weeks probably a longer period based on the late emergence of vaccine injury reports.[17] This is unlike all other vaccines where there is a set amount of antigen or live-attenuated virus. This means for Pfizer, Moderna, and JNJ vaccines it is not predictable among patients who will produce more or less of the spike protein. The Pfizer, Moderna, and JNJ vaccines have not been updated for new SARS-CoV-2 mutations since their original EUA market release and are understood to produce libraries of antibodies to the now extinct wild-type spike protein. We know the spike protein produced by the vaccines was potentially obsolete as an antigen as the 17th UK Technical Report on SARS-CoV-2 Variants issued June 25, 2021, and the CDC's latest Variant Report both indicate the SARS-CoV-2 wild type virus to which all the vaccines were developed is now extinct.[18] [19]

15. The SARS-CoV-2 and vaccine-induced spike protein itself has been

demonstrated to injure vital organs such as the brain, heart, lungs, as well as damage blood vessels and directly cause blood clots.[20] [21] [22] Additionally, because these vaccines infect cells within these organs, the generation of spike protein within heart and brain cells, in particular, causes the body's own immune system to attack to these organs.[23] [24] This is apparent with the escalating number of cases of myocarditis or heart inflammation, including fatal, autopsy proven cases by Gill, Choi, and Verma.[25] [26] [27]

16. It is my opinion, it is not good clinical practice to widely support novel biological products in populations that have not been tested adequately in randomized, placebo-controlled randomized trials. For COVID-19 vaccines, this includes COVID-19 survivors, those with prior suspected COVID-19 infection, those with positive SARS-CoV-2 serologies, pregnant women, and women of childbearing potential who cannot assure contraception. These groups were all excluded from randomized trials performed by the vaccine manufacturers and submitted to Vaccines and Related Biological Products Advisory Committee (VRBAC) for original EUA approval. No large adequately powered randomized trials have been completed in these groups demonstrating acceptable safety or efficacy.

17. It is my understanding that all of the COVID-19 vaccines offered voluntarily to the population are under EUA and are not sold commercially to patients or healthcare providers. Thus, the EUA COVID-19 consent forms indicate “clinical investigation” or “research”. It is my understanding that the necessary structures to ensure the safety and protection of human subjects are not provided in the US COVID-19 vaccine program. These structures include a critical event committee, data safety monitoring

board, and human ethics committee. These groups are essential for 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 there has not been a joint, periodic, comprehensive safety review of the COVID-19 vaccines. It is my assessment, that the COVID-19 clinical investigation has provided no meaningful risk mitigation for subjects (restricting groups, a special assessment of side effects, follow-up visits, or changesin the protocol to ensure or improve the safety of the program).

COVID-19 Vaccine Risks and Benefits

18. The COVID-19 public vaccination program operated by the CDC and the FDA is a clinical investigation and it is my opinion that no physician, healthcare provider, or patient can receive any pressure, coercion, or threat of reprisal on their free choice of supporting or not supporting the program. Violation of this principle of autonomy by any entity in my opinion violates principles of medical ethics.

19. The current COVID-19 vaccines are not sufficiently protective against contracting COVID-19 to support its use beyond the current voluntary participationin 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 early as April 30, 2021. Among these cases, 6,446 (63%) occurred in females, and the median patient age was 58 years (interquartile range = 40–74 years). Based on preliminary data, 2,725 (27%) vaccine breakthrough infections were asymptomatic,995 (10%) patients were known to be hospitalized, and 160 (2%) patients died. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalizedfor a reason unrelated to COVID-

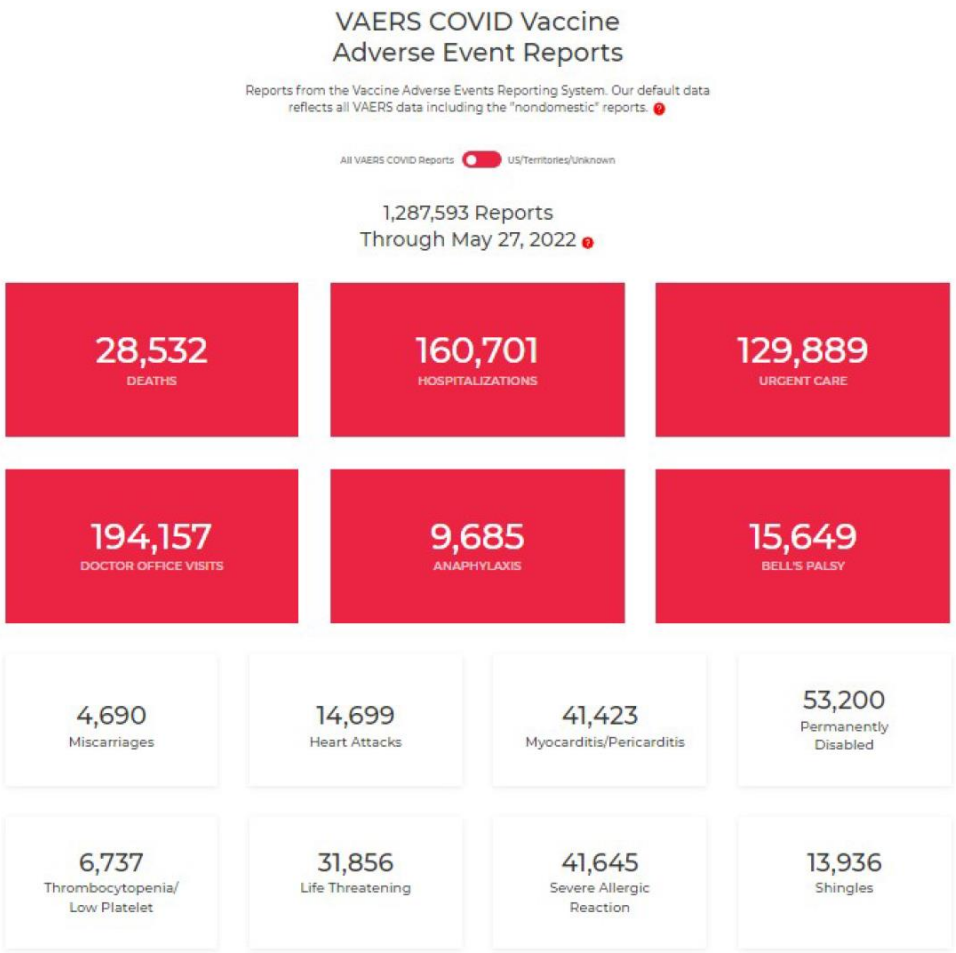
19. The median age of patients who died was 82 years (interquartile range = 71–89 years); 28 (18%) decedents were asymptomatic or died from a cause unrelated to COVID-19. Sequence data were available from 555 (5%) reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern, including B.1.1.7 (199; 56%), B.1.429 (88; 25%), B.1.427 (28;8%), P.1 (28; 8%), and B.1.351 (13; 4%). None of these variants are encoded in theRNA or DNA of the current COVID-19 vaccines. In response to these numerous reports, the CDC announced on May 1, 2021, that community breakthrough cases would no longer be reported to the public and only those vaccine failure cases requiring hospitalization will be reported, presumably on the CDC website.[28]

20. The COVID-19 vaccines do not stop spread of the SARS-CoV-2 among groups of people as indicated by the CDC since both unvaccinated and vaccinated have similar viral loads of SARS-CoV-2 when tested from the nasopharynx.[29] Multiple studies have demonstrated similar viral loads among the unvaccinated and vaccinated in the context of asymptomatic and symptomatic testing.[30] [31] [32] [33] Thus, it is my opinion that COVID-19 vaccination cannot be justified to "protect others." There has been no randomized trial demonstrating that COVID-19 vaccination reduced spread of SARS-Co-V2 to close contacts or reduced the risk of adjudicated serious outcomes including COVID-19 hospitalization or death.

21. On December 10, 2021, the CDC COVID-19 Response Team published that 79% of Americans contracting the Omicron variant were fully vaccinated.[34] It is my opinion that the COVID-19 vaccines do not offer meaningful protection against the infection when the majority of individuals with the illness are fully vaccinated.

22. 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.

23. 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 May 27, 2022, is 1,287,593. Based on VAERS as of May 27, 2022, there were 28,532 total cases where death was mentioned on the case report form COVID-19 (13,150 domestic) and 160,701 hospitalizations reported for the COVID-19 vaccine associated fatal and nonfatal injuries (Pfizer, Moderna, JNJ). I performed my own query of VAERS for death after COVID-19 vaccination on June 14, 2022, restricting the sample to domestic cases checked for death as a variable on the entry and the result yielded 10,569 deaths. By comparison, over 20 years, 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 massive increase in vaccine deaths reported to VAERS.



24. COVID-19 vaccine adverse events account for 99% of all vaccine-related AEs from in the history of the VAERS database from December 2020 through the present in VAERS.[38]

25. A federal lawsuit filed July 19, 2021, used CMS data and vaccine administration data, VAERS, and population estimates and concluded that the total number of Americans at that time estimated to have died after COVID-19 vaccination was at least 45,000.[35]

26. An analysis from Pantazatos and Seligmann estimate that the upper bound of the confidence interval for death after COVID-19 vaccination in the United States could be as high as 187,000 through December 2021.[36]

27. The deaths reported after COVID-19 vaccination by externally consistent among safety databases and are approximately reported below.[38]

Table 8: Number of Deaths Reported by Database: Covid-19 Vaccines

VigiAccess	EudraVigilance	UK Yellow Card	VAERS
~ 22 000	~ 800	~ 2100	~ 28 000

https://worldcouncilforhealth.org/resources/covid-19-vaccine-pharmacovigilance-report/

28. On November 29, 2021, The World Council for Health Called for an Immediate Stop to the Covid-19 Experimental "Vaccines". The World Council for Health declared that it is time to put an end to this humanitarian crisis. Further, the Council also declared that any direct or indirect involvement in the manufacturing, distribution, administration and promotion of these injections violates basic principles of common law, constitutional law and natural justice, as well as the Nuremberg Code, the Helsinki Declaration, and other international treaties.[37]

29. Based upon a report published on June 11, 2022, the World Council for Health has called for a recall of the COVID-19 vaccines used worldwide.[38] This report was prepared by the World Council for Health. The report was prepared to determine whether sufficient pharmacovigilance data exists on WHO VigiAccess, CDC VAERS, EudraVigilance, and UK Yellow Card Scheme to establish a safety signal on Covid-19 vaccines. Pharmacovigilance databases, such as those examined in the report, rely on passive surveillance. Adverse events are underreported Covid-19 products are

unique in that they were developed quickly and administered to large populations while still under clinical investigation. In 1967, the American government rushed a mass vaccination campaign for swine flu. Information emerged about the nature of the virus and adverse reactions linked to the vaccine, and the campaign was halted in less than a year. Data from VAERS and FAERS reveals that The Polio Vaccine was recalled in less than 1 year after 10 reported deaths, the Swine Flu Vaccine was recalled in less than 1 year after 53 reported deaths. The COVID-19 vaccine, with over 28 000 associated reports of death, has not been recalled after two years. There is sufficient evidence of adverse events relating to Covid-19 vaccines to indicate that a product recall is immediately necessary.

Risks of COVID-19 Vaccines for Those Recovered from COVID-19

30. There is recent research on the observation that the COVID-19 vaccine is potentially dangerous for those who have already had COVID.[39] These patients were excluded fromthe FDA-approved clinical trials performed by Pfizer, Moderna, and JNJ. From thesetrials the safety profile was unknown when the products for approved for EUA in 2020 and 2021. There has been no randomized study demonstrating acceptable safety or reductions in adjudicated COVID-19 hospitalization and death with vaccination in those who have well documented or even suspected prior COVID-19 illness. Therefore, it is my opinion there is no clinical indication or medical necessity for a COVID-19 recovered patient to take a COVID-19 vaccine.

31. Raw et al found that COVID-19 recovered patients who underwent COVID-19 vaccination experienced more moderate to severe symptoms than the study group

that did not previously have COVID-19.[39] The symptoms included fever, fatigue, myalgia-arthralgia, and lymphadenopathy. Id. Raw found that in 974 individuals who received the BNT162b2/Pfizer vaccine, those with a prior history of SARS-CoV-2 or those who had positive antibodies at baseline had a higher rate of vaccine reactions than those who were COVID-19 naive.

32. Mathioudakis et al. reported that in 2020 patients who underwent vaccination with either mRNA-based or vector-based COVID-19 vaccines, COVID-19-recovered patients who were vaccinated had higher rates of vaccine reactions.[40]

33. Krammer et al. reported on 231 volunteers for COVID-19 vaccination, 83of whom had positive SARS-CoV-2 antibodies at the time of immunization.[41] The authors found: "Vaccine recipients with preexisting immunity experience systemic side effects with a significantly higher frequency than antibody naïve vaccines (e.g.,fatigue, headache, chills, fever, muscle or joint pains, in order of decreasing frequency, $P < 0.001$ for all listed symptoms, Fisher's exact test, two-sided)."

Natural Immunity to COVID-19

34. It is my opinion that SARS-CoV-2 causes an infection in humans that results in robust, complete, and durable immunity to subsequent severe outcomes of hospitalization and death and is superior to vaccine immunity. This is based upon my collaboration with Dr. Paul Alexander and listing of >150 studies supporting the clinical value of natural immunity after SARS-CoV-2 infection in humans.[42]

35. 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

immunity— especially more versatile, long-enduring T- cell immunity—relative to vaccinated individuals who were never infected.[43] [44]

36. Cleveland Clinic studied their employees for the effects of naturalimmunity in unvaccinated people in the pre-Omicron era.[45] They found zero SARS-CoV-2 reinfections during a 5-month follow-up among n=1359 infected employees who were naturallyimmune remained unvaccinated and concluded such persons are "unlikely to benefitfrom COVID-19 vaccination." Among those who were vaccinated, unlike the naturally immune, there were vaccine failure or breakthrough cases of COVID-19. *Id*.

37. An analysis by Murchu et al in the pre-Omicron era demonstrated in 615,777 individuals whichincluded well-documented COVID-19 as well as subclinical infections with positiveserologies, there was a negligible incidence (<1%) of COVID-19 over the long term.[46] Murchu found no evidence of waning immunity over time prior to the Omicron outbreak suggesting no possibilitythat future vaccination would be indicated for any reason.[1]

CONCLUSION

In my expert medical opinion which is and is within a reasonable degree of medical certainty, based upon my medical education, review of scientific information, and clinical experience, I conclude:

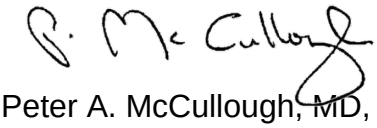
1) People who have recovered from COVID-19 have robust and durable immunity against the severe outcomes of adjudicated COVID-19 hospitalization and death recognizing that the Omicron variant has broken

through natural immunity.

2) There is no medical necessity or clinical indication for vaccination of a COVID-19 recovered patient since they have already had the condition for which the vaccines are indicated to prevent; these patients were excluded from clinical trials, and multiple studies demonstrate this practice is not sufficiently safe.
3) The Texas population had achieved 80% herd immunity by March 10, 2021, according to CDC equations.
4) There is no scientific rationale, medical necessity, or clinical indication for people under age 50 or 60 in general to receive a COVID-19 vaccine since the risks of adjudicated COVID-19 hospitalization and death are < 1% and can be further reduced with early treatment and since all the vaccines present tangible risks of injury, hospitalization, disability, and death. The decision to undergo COVID-19 vaccination must be voluntary and fully informed decision free of any pressure, coercion, or threat of reprisal from any individual or organization.
5) There is negligible asymptomatic spread of SARS-CoV-2 in the best available clinical studies.
6) The exact total number of American's who have died after COVID-19 vaccination is unknown but could be as high as 187,000 through December 2021. This means the total number of American lives lost could have been in excess of 50,000 as asserted in a federal lawsuit in the first half of 2021 when there was a surge in mass vaccination.

7) Development of EUA COVID-19 vaccines was aided by The Biomedical Advanced Research and Development Authority (BARDA) is a U.S. Department of Health and Human Services (HHS) office responsible for the procurement and development of medical countermeasures, principally against bioterrorism, including chemical, biological, radiological and nuclear threats, as well as pandemic and emerging diseases, and the Wuhan Institute of Virology which includes a Biosafety Laboratory Level 4 dedicated to bioterrorism research. SARS-CoV-2 and its spike protein has been considered a bioweapon.

Respectfully submitted,



Peter A. McCullough, MD, MPH

Dated: 14th Day of June 2022:

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