EXHIBIT 4

IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF VIRGINIA

ISRAEL ALVARADO, *et al.*	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Civil Action No. 1:21-cv-00876-AJT
	)	
LLOYD J. AUSTIN, III, *et al.*,	)	
	)	
Defendants.	)	

DECLARATION OF PETER A. MCCULLOUGH

I, Peter A. McCullough, hereby state and declare as follows:

1. I am a medical doctor with extensive expertise treating patients with, and conducting research on, SARS-CoV-2 (COVID-19). I have published 56 peer-reviewed research articles concerning COVID-19. Of particular note is my "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 subsequently updated in *Reviews in Cardiovascular Medicine*.

2. 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. I went on to complete my internal medicine residency at the University of Washington, my cardiology fellowship including service as Chief Fellow at William Beaumont Hospital, and a master's degree in public health at the University of Michigan.

3. I am board certified in internal medicine and cardiovascular diseases. I am skilled and experienced in managing acute COVID-19 as well as advising on the administration of

COVID-19 vaccination. I have seen and examined patients suffering from COVID-19 vaccine injuries.

4. On November 19, 2020, I testified before the US Senate Committee on Homeland Security and Governmental Affairs concerning early ambulatory treatment of high-risk patients with COVID-19. On January 24, 2022, I co-moderated and testified at the US Senate Panel "COVID-19: A Second Opinion" led by Senator Ron Johnson. During 2021-2022, I have testified in the following state senates on pandemic response: Texas, South Carolina, New Hampshire, and Pennsylvania.

5. I have also extensively published my research on subjects other than COVID-19. I have published on a range of topics in medicine with over 1000 publications and over 660 citations in the National Library of Medicine. My works have appeared in the *New England Journal of Medicine*, the *Journal of the American Medical Association*, *Lancet*, the *British Medical Journal* and other top-tier journals worldwide. I am the former editor-in-chief of *Reviews in Cardiovascular Medicine* and *Cardiorenal Medicine*, and the current senior associate editor of the *American Journal of Cardiology*.

6. I have served as member or chair of data safety monitoring boards of 24 randomized clinical trials.

7. I have reviewed the scientific claims regarding COVID-19 and the COVID-19 vaccines made by the Defendants in the above-captioned case, and I find many of them to be inaccurate, as explained below.

8. At this time, we can say with confidence that the COVID-19 vaccinations do not reduce the chances that a person will contract COVID-19 resulting in serious outcomes such as hospitalization or death. The US FDA has not granted any of the vaccine manufacturers a claim

from randomized trials that any of the COVID-19 vaccines reduce the risk of hospitalization and death. This is particularly true regarding the Omicron variant and subsequent variants, which are not slowed or impeded in any way by the vaccines. The Omicron variant is the mutated form of SARS-CoV-2 and thus has subvariants or strains with subsets of the Omicron mutations including BA1, BA2, XE, XD, XF. None of the vaccine manufactures have demonstrated in a conclusive, randomized, placebo-controlled trial that the COVID-19 vaccines reduce the risk of Omicron infection or any of its complications.

9. At this time, we also know that the COVID-19 vaccinations do not impede the chances that a person will transmit the virus to another person. This is particularly true regarding the Omicron variant and subsequent variants. In its December 10, 2021, communication in the MMWR, the CDC disclosed that 79% of Omicron patients were fully vaccinated, indicating complete failure of vaccination against this variant.

10. Requiring universal vaccination does nothing to reduce the transmission of the virus among people sharing a confined area for an extended period of time, such as airmen aboard an aircraft. Published reports from Chau, Acharya, Reimerisma, and Accorsi indicate that when tested, the fully vaccinated with one, two, or three injections have equal viral loads in the nasopharynx as determined by PCR testing as those who are unvaccinated.[1] Singanayagam et al. have demonstrated that 39% of all transmission of the Delta variant is from fully-vaccinated to fully-vaccinated.[2] This rate is likely higher with Omicron which has demonstrated resistance to

[1] *See e.g.,* Charlotte B. Acharya et al., "No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups When Infected with SARS-CoV-2 Delta Variant," medRxiv (Oct. 5, 2021), https://www.medrxiv.org/content/10.1101/2021.09.28.21264262v2.full

[2] Anika Singanayagam et al., "Community transmission and Viral Load Kinetics of the SARS-Cov-2 Delta (B.1.617.2) Variant in Vaccinated and Unvaccinated Individuals in the UK: A Prospective, Longitudinal, Cohort Study," *The Lancet* (Feb. 1, 2022), Community transmission

the COVID-19 vaccinations all of which are coded to the original Wuhan wild-type Spike protein, which is now extinct. The Omicron Spike protein is substantially different from the wild-type as shown by Venkatakrishnan et al., and this explains why the vaccines are obsolete against Omicron.[3]

11. Natural immunity acquired by contracting and recovering from COVID-19 is superior to any immunity that might be conveyed by a COVID-19 vaccine. It is incorrect for the Defendants in this case to claim that "much" is "unknown" about natural immunity. Natural immunity is durable, robust, and substantially complete in giving protection against subsequent infection with SARS-CoV-2 leading to serious outcomes such as hospitalization or death. Omicron infection that can occur in a minority of individuals with natural immunity is typically milder than the common cold and results in immunity to Omicron and its subvariants, but also back-immunity to the Delta variant.[4]

12. The Defendants in this case claim that "protection from a prior infection increases following vaccination." That statement is incorrect and is not supported by the available data. On the contrary, a person with a prior infection should avoid being vaccinated. The COVID-19 vaccines are only clinically indicated and can be considered electively in persons who have not previously contracted COVID-19 as established in the registrational randomized trials that led to FDA EUA approval of the products. Once a patient has contracted COVID-19 and recovered, it

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and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study - The Lancet Infectious Diseases

[3] AJ Venkatakrishnan et al., "Omicron Variant of SARS-Cov-2 Harbors a Unique Insertion Mutation of Putative Viral or Human Genomic Origin," Open Science Framework (Dec. 2, 2021), https://osf.io/f7txy/

[4] Khadija Khan et al., "Omicron Infection Enhances Neutralizing Immunity Against the Delta Variant," medRxiv (December 27, 2021), https://www.medrxiv.org/content/10.1101/2021.12.27.21268439v1

is too late for a vaccine to have any clinical benefit. There are no randomized placebo-controlled randomized trials of COVID-19 vaccination given to persons who have already had the infection demonstrating any clinical benefit in reducing any serious outcome of the illness including hospitalization and death. The US FDA and the vaccine manufacturers excluded COVID-19 recovered persons from the randomized trials of vaccination. Such exclusions are because that group had no opportunity to benefit or had unacceptable safety risks. Three studies have demonstrated that when COVID-19 recovered patients either advised or mandated to take a COVID-19 vaccination, they suffer unacceptably high side-effects including hospitalization.[5]

13. Although the tests available for COVID-19 are not perfect, they are accurate as diagnostic aids in patients who are acutely ill with suspected COVID-19. A regime of testing symptomatic airmen and isolating those who test positive would do far more than the current vaccine mandate to slow the transmission of COVID-19 among airmen.

14. The Defendants in this case claim that with the Delta variant, fully vaccinated individuals had a five-fold decrease risk of infection, citing two CDC websites referring to April-November 2021 data. This data is flawed for the following reasons: 1) patients were not randomized, 2) there is no ascertainment of whether or not patients had verified COVID-19 or false positive tests, 3) the unvaccinated are routinely tested during other health encounters more than the vaccinated, 4) health records provided no evidence that had the actual vaccine

[5] Rachael K. Raw et al., "Previous COVID -19 Infection But Not Long-COVID is Associated with Increased Adverse Events Following BNT 162b2/Pfizer Vaccination," medRxiv (April 22, 2021), https://www.medrxiv.org/content/10.1101/2021.04.15.21252192v1; Florian Krammer et al., "Robust Spike Antibody Responses and Increased Reactogenicity in Seropositive Individuals After a Single Dose of SARS-coV-2 mRNA Vaccine," medRxiv (February 1, 2021), https://www.medrxiv.org/content/10.1101/2021.01.29.21250653v1; Alexander G. Mathioudakis et al., "Self-Reported Real-World Safety and Reactogenicity of COVID-19 Vaccines: A Vaccine Recipient Survey," *PubMed* (Mar. 17, 2021), https://pubmed.ncbi.nlm.nih.gov/33803014/

administration data, 5) there was no proof that the vaccinated were within a six month window of their last shot in order to claim any protection from the vaccine, 6) the vaccinated may be less likely to seek testing during viral syndromes than the unvaccinated.

15. The Defendants in this case claim vaccination reduces the severity of COVID-19, including the chances of hospitalization and death. No randomized, placebo-controlled trial of any COVID-19 vaccine has demonstrated statistically significant reductions in hospitalization or death. In the largest clinical trials program reported to date, there were more deaths with the Pfizer/BioNTech COVID-19 vaccine than with the placebo.[6]

16. The fact that an airman may be deployed in a country without hospitals as advanced as those in the United States does not mean that he or she is at greater risk of suffering severe consequences from COVID-19. We now know that hospitalization is not necessary or even desirable in treating COVID-19. I have testified in the US Senate on January 24, 2022, that advanced therapeutics, which can be administered in any American airbase and the administration of sequenced multidrug therapy for high-risk acute COVID-19 is expected to reduce the risk of hospitalization and death by 95%.

17. Vaccination is not the best way to minimize the risk posed by COVID-19 to military readiness. COVID-19 vaccination has led to record fatal and nonfatal organ injury syndromes according to over 1,000 publications in the preprint and PUBMED citation systems. There are over 200 published papers on COVID-19 vaccine-induced myocarditis reported with all the genetic vaccines. The FDA has warnings on the investigation products from Pfizer/BioNTech and Moderna for the risks of myocarditis (heart damage). Myocarditis has also been reported in the

[6] S.J. Thomas, et al., "Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine through 6 Months," New Eng. J. Med (Nov. 4, 2021), 1761-1773, https://www.nejm.org/doi/10.1056/NEJMoa2110345.

literature with the Janssen and AstraZeneca vaccines. Fatal cases of myocarditis have been reported by Gill, Choi, and Verma. Fatal cases of vaccine-induced thrombocytopenic purpura, hepatitis C reactivation, venous thromboembolism, and anaphylaxis have been published indicating the COVID-19 as the proximate cause of death. The US CDC VAERS system which is known to represent an under-reporting of verified events has disclosed that COVID-19 vaccination has led to more than 12,000 deaths and more than 13,000 permanently disabled Americans.[7] Because US military readiness depends on the health of our service men and women, and these data suggest the COVID-19 vaccines markedly decrease health and lead to disability and death, COVID-19 vaccination is not the best way to protect our military.

I have knowledge of the matters set forth in this Declaration, and if called as a witness, I could and would testify under oath accordingly. I declare under penalty of perjury that the foregoing is true and correct. Executed on April 23, 2022.

23-APR-2022

PETER A. MCCULLOUGH,
MD, MPH

[7] "VAERS COVID Vaccine Adverse Event Reports," Open VAERS, (April 8, 2022), https://openvaers.com/covid-data/ (last visited April 22, 2022).