# EXHIBIT 6

# UNITED STATES SENATE
# SENATOR RON JOHNSON

**Senate Homeland Security and Governmental Affairs Committee**
328 Hart Senate Office Building
Washington, DC 20510

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**DECLARATION OF LTC. THERESA LONG M.D., M.P.H., F.S., IN FURTHER SUPPORT OF SENATOR RON JOHNSON'S INVESTIGATION INTO THE SAEFTY AND EFFICACY OF COVID- 19 VACCINES**

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I, Lieutenant Colonel **Theresa M. Long**, MD, MPH, FS being duly sworn, depose and state as follows:

I make this affidavit as a whistle blower under the Military Whistleblower Protection Act, Title 10 U.S.C. § 1034, in support of the above referenced MOTION as testimony in support thereof.

I also make this affidavit pursuant to 32 C.F.R. 516.49(c), although I have been counseled and ordered not to testify by my chain of command under the auspices of Army Regulation (AR) 27-40, "Legal Services, Litigation."[1] I have conformed my affidavit to the requirements of the rule's exception for medical personnel.

The facts and conclusions are my own and arrived at from my educational, professional, and personal experiences, along with scientific data, publications, treatises, opinions, documents, reports, and other information relevant to the subject matter.

## Experience & Credentials

I am competent to testify to the facts and matters set forth herein.

After receiving a bachelor's degree from the University of Texas Austin, I completed my medical degree from the University of Texas Health Science Center at Houston Medical School in 2008. I served as a Field Surgeon for ten years and went on to complete a residency in Aerospace and Occupational Medicine at the United States Army School of Aviation Medicine, Fort Rucker, AL. I hold a Master's in Public Health, and I have been trained by the Combat Readiness Center at Ft. Rucker as an Aviation Safety Officer. Additionally, I have trained in the Medical Management of Chemical and Biological Causalities at Fort Detrick and USAMIIRD.

I am board-certified in-flight Aerospace Medicine and board eligible in Occupational Medicine.

[1] AR 27-40 mirrors the code of federal regulations (CFR) verbatim regarding testimony by Dept. of the Army (DA) personnel. Specifically, the general rule prohibiting testimony by DA personnel has a specific exception for Army *medical* personnel.

I am currently serving as a Surgeon/physician at Ft. Rucker, Alabama. My duties included being responsible for certifying the health, mental and physical ability, and readiness for all nearly 4,000 individuals on flight status on this post.

Prior to the outset of the pandemic, I received specialized military training from Infectious Disease doctors from the Army, Navy and Air Force on emerging infectious disease threats, FEMA training, Emergency preparedness training, Medical Effects of Ionizing Radiation, OSHA, Aerospace Toxicology, Epidemiology, Biostatistics, medical research, and disaster planning. More recently I have functioned as a medical and scientific advisor to an Aviation training Brigade seeking to identify risk mitigation strategies, and biostatistical analysis of injuries and illnesses most notably SARS-Cov-2 ("COVID-19") infections in both vaccinated and unvaccinated Soldiers. In so doing, I have identified, and reviewed the treatment course and outcomes of COVID-19 pathogenic infections. I have observed vaccine adverse events following the administration of EUA vaccines and followed the success of Soldiers and civilians who obtained various COVID-19 therapies outside the military.

As a physician I am charged with the health and welfare of my patients. As a woman, spouse, daughter, and mother, I must take care of myself as well. This, along with my knowledge and experience, oath as a doctor, and concerns for my own health due to past medical complications, require me to do my due diligence regarding many issues, but most recently COVID-19 and the vaccines. I would be remiss, and I would argue negligent if I did not fully equip myself with as much knowledge about these two topics as possible for personal reasons and for the welfare of my patients. I believe any doctor who blindly follows the opinion of others without doing at least a minimum amount of research necessary to provide informed consent to their patients is acting negligently.

With that said, most of the service members within the DOD population are young and in good physical condition. Military aviators are a subset of the military population that must meet the most stringent medical standards to be on flight status. The population of student pilots I take care of are primarily in their 20s-30s, males and in excellent physical condition. The risk of serious illness or death in this population from SARs-CoV-2 is minimal, with a survival rate of 99.97%. So, I believe it was incumbent upon me to do a risk-based analysis for these patients, understand potential side effects that may impact their functionality and health, and provide informed consent.

In observing, studying, and analyzing all the available data, information, samples, experiences, histories and results of these treatments and inoculations provided, I have formulated a professional opinion, and believe the risk analysis results require me to report those findings to superiors in the chain of command and colleagues in the military. I have done so with mixed results in terms of acceptance, rejection, and threats of punishment for reporting and sharing my safety concerns.

In advance of relaying the facts and statements herein, I offer a summary conclusion to provide context for the reader. After, exhaustive attempts to engage and warn senior medical and non-medical military leaders about concerns regarding the threat of COVID vaccines to the health of the Armed Forces, I have been ignored. Research using many sources including the DoD's own Defense Medical Epidemiology Database (DMED) verified a direct correlation between the

implementation of COVID-19 vaccines and statistically significant increases in numerous debilitating and deadly illnesses. Despite numerous safety communications with to senior medical leaders, giving a sworn affidavit in Federal court and testifying as a whistleblower to Senator Ron Johnson, not a single senior leader to include the United States Army Aviation Center of Excellence general, Major General Francis, or senior medical leader has contacted me to discuss and investigate my safety concerns. I am deeply bothered by the indifference to enumerated facts and factors affecting the health and safety of our servicemembers which prompted me to look for signals of harm in the Defense Medical Epidemiology Database. I found numerous examples of statistically significant increases in numerous life-threatening conditions that can be temporally associated with the introduction of COVID-19 vaccinations, and I wish to remind the reader and DOD leadership that all mandated servicemembers are participants in a Phase 1, 2 & 3 clinical trial (experiment) per the DOD's own materials. There has never been an appropriate safety study prior to releasing these Emergency Use Authorization, Investigational New Drugs, because the entirety of the US military are the test subjects. There are literally no long-term safety studies normally associated with required or mandated vaccinations on the DOD's schedule, because the testing remains in progress at this time despite clever language designed to make participants think they are receiving an FDA approved "vaccine." The label "vaccine" remains contested in the medical industry, which is why I first applied quotation marks to the word. To be clear, there is not now, nor has there ever been an FDA approved and manufactured Covid-19 vaccine available to any Servicemember heretofore, because none have been produced for use in the United States in accordance with FDA regulations. An approved Biologic License Application (BLA) is not the same as an approved drug with proper labeling, cautions, lots, batches, tracking and quality controls in place to assure uniformity, safety, standardization, warnings, or risks based on trials and authenticity of the product provided. Despite equivalency language used in various orders from the DOD leadership, no "equivalent" vaccine, including the BioNTech versions, are actually FDA approved drugs.

The following paragraphs outline a brief, yet non-comprehensive research, discoveries, and an accounting of my attempts, inter alia, to engage senior military and medical leaders regarding my legitimate safety concerns about the COVID-19 vaccines; particularly their experimental use across the entirety of our military juxtaposed to the emerging evidence of harm that has been broadly ignored. These events are presented to the best of my recollection, based off email correspondences, regulations, research, recordings, and communications.

**Foundation**

In 2018 I was selected for Aerospace and Occupational Medicine Residency training at the United States Army School of Aviation Medicine in conjunction with the University of West Florida. An academic requirement of my training was to get a Master of Public Health from the University of West Florida. During my studies in public health, I had to complete a research project. For my research project I was encouraged by senior medical military officers to use the Defense Medical Epidemiology Database ("DMED") to perform my MPH research**.**

In my job as a flight surgeon, the application of risk management is critical to the safety and success in both medicine and aviation. Aerospace Medicine is a specialty devoted to safety of

flight by the aeromedical dispositioning and treatment of flight crew members, as accomplished by the consistent and careful application of risk mitigation and management strategies. Aircrew Training Program (ATP) 5-19, 1-3. Risk Management (RM)[2] outlines a disciplined approach to express a risk level in terms readily understood at all echelons. My observations and experiences expressed herein are based on this perspective as is required of my job and profession.

In furtherance of my career as a Flight Surgeon and training, I attended the Senior Preventative Medicine Leadership course in May of 2021. The Covid 19 response was nascent at the time, and I was expecting a broad discussion with peers on the various ways the DOD would respond to this new challenge. Instead of coming away from the program informed, I was so bothered by the experience that I later wrote a Memorandum (immediately below) for my recollection based on a previously submitted course evaluation that memorialized my memory of the conversations at the educational symposium.

My first concern raised in the course evaluation was the DOD's decision or neglect to treat SARs-CoV-2 as a bioweapon as was mandated by my training. I questioned why we did not take up a bio-defensive posture and in response, but I was called a "Conspiracy theorist" and mocked by senior leaders. I pointed out to the senior leaders that my concerns arose from training at Ft. Detrick and USAMIIRD, which is the Department of Defense's school for the Medical Management of Biological and Chemical Causalities. In this role, I was trained to critically analyze the emergence of threats like those presented by SARs-CoV-2 as a potential bioweapon. It struck me as odd that none of my training in the DOD's own bioweapon school had any impact on the nature of my ridicule. I remained bothered about this and filled out a course evaluation and emailed a copy to myself for my record,per the below:

[2] adminpubs.tradoc.army.mil/regulations/TR385-2withChange1.docx

**Senior Leader Preventative Medicine Course (UNCLASSIFIED)**

4 messages

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Thu, Jun 17, 2021 at 10:27 AM

CLASSIFICATION: UNCLASSIFIED

This was probably the worst course in the Occupational Medicine year. I was embarrassed that I was going into a specialty when these were the people at the top. In an open discussion I asked the following questions. 1) Why when COVID came out of China near the virology lab did we not assume this was a bioweapon and take a defensive poster with the military taking the lead, until proven other wise. I was called a "Conspiracy theorist" and no intelligent response other than we all know it came from the wet market was the response.

Q2) So we skipped the normal two years of phase 2 clinical trial testing on the vaccine and the 3 years of the phase 3 testing of the clinical trials and we have NO long-term safety data what so ever on these vaccines, yet we are vaccinating the entire fighting force against a virus with a 99% survivability in our age population. RESPONSE: "you are damn right LTC, and you should get everyone you can to take the vaccine so that we will have enough data points to determine IF THE VACCINE IS SAFE. Q3) So the model that was used to predict that the US would lose 2 million people to COVID was way off, it destroyed our economy, shut down our schools, hospitals, brought our military to a stand still...so was your model, your estimates closer or further from the actual 500,000 deaths that we saw? RESPONSE: "I didn't do my own model, I just used theirs" When I asked why we didn't use HCQ before the vaccine came out, I was told it is dangerous. When the group did a round table where all the top leaders told us where they got their information to make all their decisions (for how to protect the military) for they last year- 100% answered Dr. Fauci and the CDC. They stated that Dr. Fauci was worthy of emulation, that he had performed flawlessly and was a "true role model". All of these individuals completely failed to recognize 1) the danger of group think 2) that Dr. Fauci and the CDC do NOT have the same mission of protecting the fighting force as Army physicians do. This was a complete embarrassment to me as an Army doctor and an Army officer. There was no critical or strategic thinking occurring whatsoever. You do not risk the health of the entire fighting force on only 2 months of safety data on an experimental vaccine against a virus with better than 99% survivability rate in our population and only 12 deaths. Not a single word regarding the independent strategic risk/benefit analysis that went on here.

Theresa Marie Long, MD, MPH

LTC, MC, FS

Aerospace Medicine Specialist

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During this period and in response to my experiences in the symposium and casual dismissal of my concerns, I began a research journey that led me to various forms and forums of government or official information worrying that I had misunderstood the risk, some facts I was unaware of or more obvious information. I began with the CDC and my first query was, "**What are the plans for continued monitoring of COVID-19 vaccines authorized by FDA for emergency use?** The CDC States:

> FDA expects vaccine manufacturers to include in their EUA requests a plan for active follow-up for safety, including deaths, hospitalizations, and other serious or clinically significant adverse events, among individuals who receive the vaccine under an EUA, to inform ongoing benefit-risk determinations to support continuation of the EUA…**Post-**

> **authorization vaccine safety monitoring is a federal government responsibility shared primarily by FDA and the U.S. Centers for Disease Control and Prevention (CDC), along with other agencies involved in healthcare delivery**. Post-authorization safety monitoring during the COVID-19 pandemic vaccination program will aim to continuously monitor the safety of COVID-19 vaccines to rapidly detect safety problems if they exist. There will be multiple, complementary systems in place with validated analytic methods that can rapidly detect signals for possible vaccine safety problems. The U.S. government has a well-established post-authorization/post-approval vaccine safety monitoring infrastructure that will be scaled up to meet the needs of a large-scale COVID-19 vaccination program. The U.S. government – in partnership with health systems, academic centers, and private sector partners – will use multiple existing vaccine safety monitoring systems to monitor COVID-19 vaccines in the post-authorization/approval period. Some of these systems are the **Vaccine Adverse Event Reporting System (VAERS)**, the Vaccine Safety Datalink (VSD), the Biologics Effectiveness and Safety (BEST) Initiative, and Medicare claims data.

As time went on, I noticed that weekly COVID-19 update briefs, were shockingly devoid of information regarding vaccine adverse events in the DOD or nationwide. I had my own observations considered and despite the military publishing some of the first research regarding the risk of myocarditis and pericarditis after COVID vaccination, up-to-date information on emerging trends were not presented.

I called and emailed the Director of the Unites States Army Aeromedical Activity, COL Scott Salmon, regarding the emergency meeting regarding the increased risk of myocarditis and pericarditis. When he quired the Aeromedical Cardiology constants, the General Aerospace Consultant Chairman, FAA Federal Air Surgeon Cardiology Consultant, Dr. Davenport, wrote, "**educating the physicians and patients to look for this is important data**…and "**I highly encourage that everybody take part in the Vaccine Adverse Event Reporting System (VAERS) which is a great non-industry sponsored CDC monitored reporting system that has given us this data**." Despite this advice no communication was sent out to flight surgeons or Army physicians regarding the emerging risk.

Continuing to seek resources, on or about August 27, 2021, I emailed an Epidemiologist at the Defense Health Agency (DHA) for Army Public Health Command advised about monitoring of these risks and was informed that, "**There is no current internal military monitoring system for reporting and tracking of vaccine adverse events.**" I also looked at the DHA Immunization Healthcare Division which published on their website "DoD Clinical Guidelines for Post-Vaccination Associated Myopericarditis.

On or about August 28, 2021, I accessed the Defense Medical Epidemiology Database (DMED) to look at the prevalence of acute pericarditis and myocarditis in the DOD from January 2016 to August 2021, two months after the FDA and CDC announced the increased prevalence of pericarditis and myocarditis following vaccination with the mRNA COVID-19 vaccines. I wrote down the query results in a notebook. DOD totals for Acute Myocarditis 2017 (833) 2018 (857) 2019 (971) 2020 (856) **Jan-July2021 (1,239).**

Upon seeing these statistics, I met with and contacted several key senior medical leaders concerned about this gross oversight in pharmacovigilance during the rollout of an experimental drug to our entire Armed Forces. I was reassured that there was a system in place, but no one could give me any answers regarding the number and type of adverse events that were occurring on Ft. Rucker, Army Aviation or across the DoD. At one point I was told by Medical Director of Immunization for DHA, that the CDC's VAERS is the system of record for reporting and tracking adverse events.

Unsatisfied that this could be the case, I continued to look for the data because it is imperative to performing necessary and on-going risk assessment of the risk/benefit of COVID-19 vaccines. This data was unavailable and the DHA and the risk communication strategy, focused solely on the risk of SARs CoV-2 infections, while ignoring the risk of introducing mandatory experimentation on the entirety of the Armed Forces; much less with an Investigational New Drug (IND), that utilized new Lipid Nanoparticle delivery systems for the first time in a large clinical trial. All such injectables approved for use were experimental and none had even the least amount of clinical testing, no long-term data, and very little short-term data. In fact, it is accurate to say that this experimental drug therapy had the least amount of clinical research in modern history prior to use, based on my professional experience.

Given the unprecedented speed with which it was developed, brought to market, and made available to the public without any notion of Informed Consent (as required by law), I believe this risk profile warranted a hyper-pharmacovigilance, with global transparency and unfettered access to emerging data.

Around this time in early August of 2021, I had encountered other military professionals with similar concerns about news reports that the DOD was intending to mandate compulsory experimental inoculations with the Use of Force authorized. Several of these colleagues had consulted with legal counsel and I began a dialogue about the foregoing and my concerns over lack of transparency, of data, of interest in the foundational science of the shots themselves and the lack of concern over the rights of Servicemembers to not be used as laboratory animals in the largest human experiment in the history of our species.

I expressed my concerns to these colleagues and their legal counsel about the failure of transparent, active surveillance system in place, jeopardy to force health, medical readiness, and aviation safety. I had found that leaders prioritized protecting and promoting a narrative over their duty to protect the health of the fighting force. It appears that similarly there was no established risk communication strategy for senior combatant commanders to be kept abreast of the emerging risks and negative health impact the vaccine was having on our service-members. I was seeing what appeared to be vaccine injuries that were brushed aside as hearsay by senior leaders who could not make informed decisions on the risks and benefits of the vaccine.

After my queries of leadership and colleagues alike on the lack of current data available, the United States Army Aviation Center of Excellence (USAACE) Surgeon, COL Powell-Dunford informed me that only three medical providers on post were identified and authorized to provide medical exemptions from the vaccinations, and that I was not among them.

The relevant OPORD states that "soldiers who think they need a medical exemption will make an appointment with the PCM or equivalent" and I am the 1st Aviation Brigade Surgeon. Numerous Soldiers called me attempting to make an appointment for a medical exemption or to express concern that when they attempted to follow orders to make an appointment with the PCM, they told by Lyster Army Health Clinic staff that Lyster would not make appointments with PCMs for medical exemptions. LTC Murray from Lyster further advised me that the three physicians authorized to provide medical exemptions were herself, COL Powell-Dunford and MAJ Fowler.

On or about 9 September 2021, I attempted to relay my concerns about the foregoing, COVID-19 vaccine safety, and my frustration that DHA was not interested in the use of prophylactic medications like Ivermectin. I spoke with Dr. Margaret Ryan, Medical Director, DHA Immunization Healthcare Division and expressed these concerns, particularly in relation to the safety of the pilots that I am responsible for and servicemembers in general, as a matter of national security.

In response to my concerns, oddly Dr. Ryan noted them and simply offered me a one-year medical exemption to the vaccine mandate. In the exemption letter Dr. Ryan notes in reference to me, “She reports no prior concerns about vaccines, but she describes substantial concerns about COVID-19 vaccines overall. She is concerned that adverse events following immunization (AEFIs) are under-reported and under-investigated. She is concerned about mRNA technology, and she is uncomfortable with federal recommendations in the current pandemic. She advocates for alternative approaches, and she is taking Ivermectin as a personal prophylaxis for COVID-19…This office also endeavored to address LTC Long’s AEFI concerns and increase her trust in federal partners. COL Tonya Rans, Dr. Renata Engler, and Dr. Bruce McCenathan have additionally been engaged in communication with LTC Long on her concerns.”

Defense Health Agency
Public Health Division
Immunization Healthcare

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09 Sep 2021

**Medical Consult – for attachment to AHLTA or MHS-GENESIS electronic health record**

*NOTE: This document contains information covered under the Privacy Act of 1974, 5 USC 552(a), and the Health Insurance Portability and Accountability Act (PL 104-191), is protected under 10 USC, Section 1102.*

This document supports the medical care of **LTC Theresa Long (DoD ID 1083012079, DOB 02 May 1974).** This office was consulted on immunization care and this note represents a summary of discussions with patient on 09 Sep 2021.

History: LTC Long is a physician (aerospace medicine) active duty Army officer in Fort Rucker, AL. She has a complex medical history that is most notable for cardiomyopathy that began postpartum in 2010. A series of complications followed original dx, including subtotal colectomy in 2016, potentially associated with unrecognized Chagas disease. Cardiac challenges were notably exacerbated by pacemaker replacement procedure in 2019, complicated by cardiac perforation and subsequent pericarditis. She remains under the care of Baylor University (TX) Cardiology. She reports that, due to this hx, her Cardiologist recommends exemption from COVID-19 vaccination.

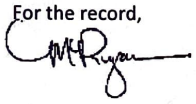
OccHx: LTC Long reports that she remains on active duty, but unable to perform PT or deploy. She travels to TX for care but reports no international travel. She cares for healthy military patients in an outpatient setting; she is not actively caring for patients with known COVID-19 infection.

She reports no prior concerns about vaccines, but describes substantial concerns about COVID-19 vaccines overall. She is concerned that adverse events following immunization (AEFIs) are under-reported and under-investigated. She is concerned about mRNA technology, and she is uncomfortable with federal recommendations in current pandemic. She advocates alternative approaches, and she is taking ivermectin as personal prophylaxis for COVID-19.

**A/P. Other specified counseling Z71.89** [related to vaccination]

- Complex cardiac history, as above, is reasonable justification for medical exemption from mRNA COVID-19 vaccination, in order to limit potential for myo/pericarditis exacerbation.
- Protection from COVID-19 infection is nonetheless strongly recommended for patient with complex medical history. LTC Long is aware that non-mRNA vaccine (Janssen) is an option for her, but she is uncomfortable with COVID-19 vaccination overall. [Since military vaccine mandate only applies to Pfizer product, no formal exemption is required for declination of Janssen product.]
- **This office, therefore, recommends medical exemption from COVID-19 vaccine.**
- This exemption may be coded as 'temporary' and revisited in one year. Vaccine recommendations may be revisited sooner if risk-benefit parameters change and/or if new vaccine options or recommendations become available.
- LTC Long understands that, while she remains less than fully-vaccinated against COVID-19, she must adhere to command-required infection precautions, which may include continuous mask-wearing, regular COVID-19 testing, and potential limitations on travel and duty assignments.
- This office also endeavored to address LTC Long's AEFI concerns and increase her trust in federal partners. Col Tonya Rans, Dr Renata Engler, and Dr Bruce McClenathan have additionally been engaged in communication with LTC Long on her concerns.

For the record,



Subsequently, I was encouraged to forward cases of concern for AEFI, to some of the above-named individuals and assured of their eagerness to investigate them; yet was questioned why I

was sending information and asking questions when I did. Despite lengthy discussions about my concerns, there was no change in transparency, Medical Situation Reports (MEDSITREP), and COVID-19 weekly briefs continued to be devoid of information on adverse events following immunizations (AEFI) in the DOD.

Frustrated with my exclusion from any influence over the health of my patients and pilots after seeing more anomalous injuries that could only have come from the vaccination program, I questioned the logic of only grounding pilots for 12 hours after vaccination given that the CDC reports the onset of myocarditis/pericarditis is typically within several days after mRNA COVID-19 vaccination. I understood that civilian pilots were given 48 hours of no-flight duty and discovered peer-reviewed literature which reported that 92% of patients who developed myocarditis/pericarditis presented it within 7 days. In light of the 12-hour rule, I questioned COL Powell-Dunford, as the senior most flight surgeon and Aerospace Medicine Specialist for USAACE and her response was that "we need to get them [pilots] back to training." At the same time, she defended the logic of quarantining asymptomatic individuals for 10 days. It seemed illogical and hypocritical to mandate10 days of quarantine for mere COVID-19 exposure while grounding pilots for only 12 hours after vaccination with an experimental drug with what the CDC reported, higher than normal incidence of a serious cardiovascular issues (myocarditis and pericarditis); not to mention that the experimental shots utilize a delivery mechanism used for the first time in large human clinical trials. Again, this struck me as significant with potential safety issues that creates and perpetuates a political narrative that COVID-19 is having a tremendous negative impact on our ability to perform our mission. At the same time, it seemed obvious that mandating an experimental vaccine with minimal grounding time and virtually non-existent screening is/was an obvious strategic failure of the highest order.

Having shared my concerns with legal counsel who brought the case Robert v. Austin (1:21 CV 02228 Colo. Fed. Dist. Ct.), I swore an affidavit in support thereof on or about September 24, 2021, my affidavit ("Affidavit") that relayed much of these findings including details about the toxic contents Moderna and Pfizer shots being provided. A draft version of my affidavit was released on the internet without the permission of myself or my attorney and went viral around the world eventually landing with my brigade commander who immediately ordered me not to talk to anyone regarding my Affidavit and to only speak through the public affairs office in regard to any media queries or interview requests. I was also admonished that despite my many years of higher education, training, medical degree, licensure as a physician and board-certified specialist in Aerospace Medicine, that I am not an expert in this area and should not render any opinions in relation thereto.

My testimony was focused on the very concerns I've relayed herein along with legitimate concerns about the toxicity of the ingredients of these shots; particularly the Moderna and Pfizer shots, each of which utilize large quantities of Polyethylene glycol ("PEG"), which again is the first time it's been used as an injectable (inter vivos) in a large human study where peer reviewed data indicates that more than 70% of the human population is allergic to it in some form. A Journal article published by the National Institutes of Health, PubMed.gov, "A cautionary note: Toxicity of polyethylene glycol 200 injected intraperitoneally into mice", noted, "our results demonstrate that although PEG 200 is generally considered to be harmless, it can be toxic when injected i.p. and is painful." https://doi.org/10.1177%2F0023677219873684

Immediately thereafter, several hundred individuals, both civilian and military, contacted me through various means, regarding their adverse events following mRNA COID-19 vaccination, including their experiences of coercion, intimidation, threats, and harassment to get the COVID-19 vaccination. Individuals who contact me included, but was not limited to numerous JAG attorneys, doctors, pilots, senior commanders at the tactical, operational, and at strategic levels, and other high-ranking officers. Many of them informed me that they had attempted to contact me through my work at Lyster Army Health Clinic or the 1st Aviation Brigade but had been told that I had never worked at Lyster Army Health Clinic or that it could not be confirmed that I was the 1st Aviation Brigade Surgeon.

Thereafter, I was limited on my duties as the brigade flight surgeon to only seeing patients with no command authority or administrative decision-making ability. Shortly thereafter and on or about September 29, 2021, I was presented with five patients to examine, and I noted that three out of the five patients were vaccinated with the Covid 19 mRNA shots; all of them were student pilots. Upon review and examination including interviews, and in accordance with my obligations as a Flight Surgeon responsible for the safety of air crew, I had to recommend that two of the pilots be grounded for pericarditis and the third pilot for "brain fog", i.e., cognitive deficit. I was shocked to find out that the CDC directed labs to help evaluate for myocarditis and pericarditis were not available at Lyster Army Health Clinic and had to be "sent out".

I emailed my Brigade Commander, COL Richard Tucker, with my concerns about having to ground three out of three pilots for vaccine injuries and expressed my concerns regarding the risks the mRNA COVID-19 vaccines pose to our pilots, especially in light of the short 12-hour grounding period post inoculation.

The following day, on or about 30 September 2021, I was scheduled to see 5 patients in the afternoon. When I returned from lunch and checked my schedule, it showed "patient cancelled" for each of the five patients. I questioned the clinic supervisor, who conceded that none of the five had really canceled their own appointment and I surmised that Lyster Command staff had canceled the appointments, so as to prevent me from uncovering any more potential myocarditis. Later I was told by COL Powell-Dunford that my charts were pulled for review, and I would no longer be allowed to see acute patients, only pilots without medical problems for their flight physicals.

On October 7, 2021, five months after the CDC had held its emergency meeting to address myo/pericarditis, the DOD, DHA Immunization Healthcare Division, published Clinical Guidelines for Post-Vaccination Associated Myo/pericarditis. I am not aware, that these clinical guidelines were distributed to all DOD physicians, unlike the universal distribution of CDC COVID and vaccine information deemed important throughout the pandemic. These guidelines and the Neurologic Dysfunction Following Vaccination Algorithm should have been disseminated down to every healthcare provider in the DOD, with corresponding monthly updates on emerging data on these adverse events. The DHA has the capability to run reports actively monitoring for the input of these ICD codes, neurologic or cardiac symptoms within the designated 30- and 42-day latency period as outline in these documents.

On or about November 2, 2021, I testified for Senator Ron Johnson in Washington D.C. regarding my safety concerns and my observations of COVID-19 vaccine side effects. I also testified regarding the retaliatory actions taken against me for reporting my safety concerns regarding the COVID-19 vaccine and the increased risk it posed to our pilots and aviation safety. I testified that I had to ground 3/5 pilots in one morning for vaccine injuries (two with pericarditis with of the two having concern for myocarditis and one with brain fog). After coming forward as a whistle blower under the Military Whistleblower Protection Act, Title 10 U.S.C. § 1034 my medical exemption given by Medical Director, Defense Health Agency Immunizations Healthcare Division, was revoked and replaced with a temporary administrative exemption set to expire on 13 March 2022.

Upon return to my unit, I again attempted to discuss my concerns with the TRADOC Surgeon COL Meyring. He stated that he was told that the two individuals I spoke of having pericarditis, did not in-fact have pericarditis, or they had resolved. One pilot was evaluated by another flight surgeon, told he did not have pericarditis, advised not to continue with treatment and was returned to flight status. The other pilot, I treated aggressively for pericarditis and had resolution of EKG changes several weeks later when he saw the Cardiologist. Despite ordering a cardiac MRI on the day I saw this pilot; it was never performed. Yet the pilot did undergo an echocardiogram, EKG, and stress test all of which were all normal and the Cardiologist recommended that the pilot return to duty without restrictions. Thereafter, I insisted that the Cardiologist complete the cardiac MRI as previously requested and after five months of delay, the MRI **results showed an on-going myocarditis with significant damage to the heart.** In other words, the damage from the shots is perhaps only apparent with a cardiac MRI which is a relatively simply screening test that has yet to be ordered for any or all pilots who received the inoculations. This necessarily means that there is a population of pilots flying equipment armed with munitions who may not know they have severe heart problems and seemingly the Army does not care to know this fact.

Despite many efforts to get clear communication on the pharmacovigilance regarding the number and type of vaccine adverse events on Ft. Rucker and within the DOD generally, this information has proven unavailable. I have been advised by the Medical Director of the DHA Immunization Healthcare Division, that the CDC's VAERS is the reporting system of record for vaccine adverse events in the military. Despite VAERS being designated as the safety system the DOD is using to monitor for signals of harm, information regarding the number and type of VAERS reports pertaining to service-members and Medical Situation Reports have failed to mention these VAERS reports. The lack of clear and transparent risk communication in the midst of the largest immunization mandate with an experimental “vaccine” that uses novel gene technology was and remains extremely concerning.

The FDA and the CDC reassured the public that this robust and technically advanced safety system was in place (VAERS), for this Emergency Use Authorized (EUA), Investigational New Drug (IND), with no significant short or long-term safety studies. They assured the public and military that the shots are “safe and effective” despite legal prohibitions to so characterizing them at this phase of development, yet stated that all could become vaccinated with the confidence that safety was being closely monitored.

I have filled out numerous VAERS reports on service-members. The VAERS reports are made under penalty of perjury and are mandated by law for any medical provider who has knowledge of any vaccine adverse event. The VAERS reports have a box that must be checked if the individual experiencing the adverse event is in the US military. I have been contacted by numerous individuals who have experienced a significant adverse event after the vaccine, who report that their doctors refuse to admit or acknowledge that the vaccine could have caused the adverse event, thus ensuring that no such data is entered into the VAERS system. Ironically, many the adverse events that have been reported to me, or I have first-hand professional knowledge of, were listed in October of 2020 in FDA Safety Surveillance of COVID-19 Vaccines DRAFT working list of possible adverse event outcomes; this was two weeks before the FDA granted Emergency Use Authorization and is often referred to as the infamous "Page 16 paper" and officially titled the "FDA Vaccines and Related Biological Products Advisory Committee presentation."

I have asked COL Richardson, chief consultant to the Surgeon General, for this information during a COVID-19 weekly brief, but to date I still have not received a response. I submitted a request to the CDC's VAERS system administrator and statisticians to get the number of VAERS reports that involved military members, and I received the following information within 24 hours:

> *Domestic VAERS data as of February 11, 2022, when filtering the V_ADMINBY (Vaccine Administered By) variable using "MIL" (Military).*
> *There are 0 (zero) entries in the foreign data set when filtering by V_ADMINBY = MIL.*
> *A Serious Adverse Events (SAE) is defined by the VAERS handbook as Death, Hospitalization, ER visit, Life threatening, Disabled or Birth defect.*
>
> ***Total REPORTS: 9,428***
> *Total Serious Adverse Events Reports: 2,143 (23%) (119;626;1895;238;300;16)*
> *Total Deaths:* ***119***
> (Oct 2020 Army Public Health Command reported a **total of 8** active duty servicemembers had died of COVID infection) see attachment.
>
> *Total ER/Hosp: 2,521 (626;1895)*
> *Total Disabled:* ***300***
> ***Total Deaths: 119***
> *Total Spontaneous abortions:* ***31***
> *Total Cancer AEs: 83*
> *Total Anaphylactic AEs: 120*
> *Total Cardiac arrest AEs: 7*
> *Total Pulmonary embolism AEs:* ***255***
> *Total Guillaine Barre: 6*
> *Total Tuberculosis: 1*
> *Total Eczema AEs: 11*
> *Total Sepsis AEs: 10*
> *Total Still births:* ***3***

*Total Myocarditis AEs:* ***155***
*Total Female reproductive issue AEs: 213*
*Total Neurological AEs: 4,063*
*Total Cardiovascular AEs:* ***3,921***
*Total Hepatological AEs: 126*
*Total Immunological AEs:* ***4,434***
*Total Depression/Anxiety AEs: 297*
*Total Diabetic AEs: 84*

These numbers alone clearly indicate that the health risk and degradation of medical readiness, as indicated by VAERS, the safety monitoring system of record for the DOD, outweighs those that occurred as a result of infection with COVID-19. These numbers should be no surprise to any of the generals who have endorsed and executed vaccine mandates. These risks are readily apparent even without factoring in the under-reporting of adverse events as previously determined in studies. I personally have submitted numerous VAERS reports and have an additional 24 to submit, as of last week. Although the diagnosis and treatment of COVID-19 has been financially incentivized, specifically in the civilian sector through the CARES Act, reporting of vaccine adverse events, though mandated by law, are disincentivized by virtue of a time-consuming, cumbersome, and uncertain process. Even when a professional invests the time in accurately documenting this critical information in VAERS, the same agencies that mandate reporting, justify ignoring the overwhelming signals of harm, by citing the limitations of such a reporting system. As such, these same agencies, and institutions, including the DOD, have directly and indirectly undermined the critical importance of this safety system and consequently the safety and health of our Servicemembers and citizens generally; especially considering the underreporting that captures only a small fraction of actual adverse events".[3]

It is therefore safe to assume that the overall VAERS reporting of some 25,000 fatalities and more than 1,150,000 (as of March 4, 2022) of registered Adverse and Serious Adverse events is highly under reported and the military's own reported **9,428** total adverse events with 2,142 classified as highly likely to be under reported. Assuming so, what true impact these vaccines are having on the **medical readiness** of our Armed Forces?

In my own experience and pursuant to my role as the 1st Aviation Brigade Surgeon responsible for the oversight of 4,000 pilots, aircrew, and other Soldiers, I have personally seen maladies including but not limited to: stroke, infarct of the thalamus, several cases of testicular cancer, esophageal cancer, unprovoked thromboembolism of the splenic vein and portal vein of a 24 year-old, brain fog (unexplained cognitive deficit), debilitating migraines, pericarditis, myocarditis, angina, spinal tumor, breast, renal and mediastinal and spinal tumors, thyroid dysfunction, numerous cases of chest pain in 20 and 30 year olds, intermittent and persistent facial swelling, migraines, unexplained hypertensive crises, tinnitus, irregular heartbeats and gastrointestinal bleeding. To emphasize this point, these patients are a group of people with some of the highest standards for health and fitness within the US military and among the World's militaries.

[3] https://vaers.hhs.gov/data/dataguide.html

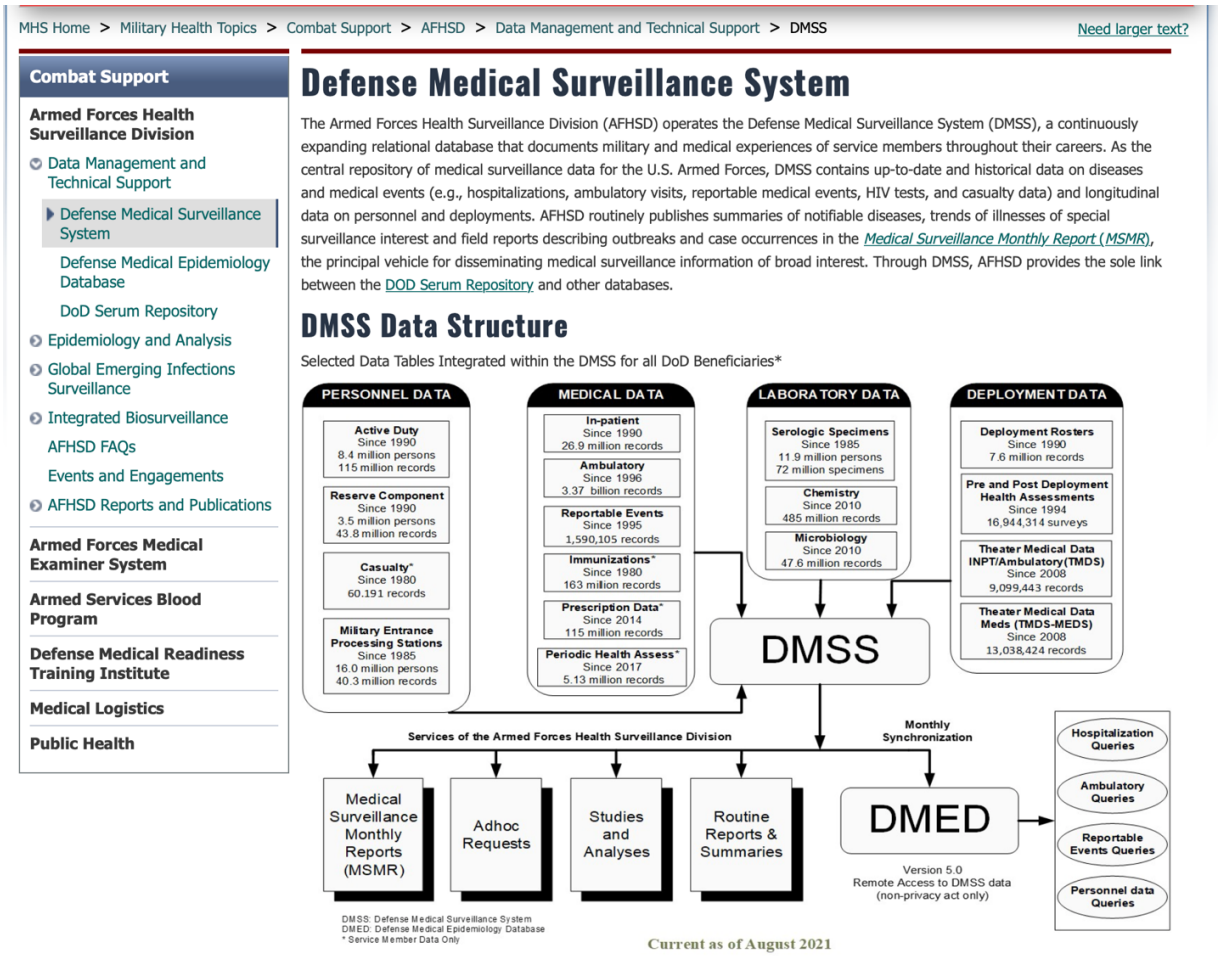
The objectives of VAERS are: 1) detect new, unusual, or rare vaccine adverse events; 2) monitor increases in known adverse events; 3) determine patient risk factors for particular types of adverse events; 4) identify vaccine lots with increased numbers or types of reported adverse events; and 5) assess the safety of newly licensed vaccines. Based on the adverse events I saw as one doctor; I am confident vaccine injuries are not being investigated and/or reported.

Given the overwhelming messaging of "safe and effective" echoed from the FDA, CDC, and DOD through the DHA to military healthcare professionals, it becomes obvious that we were being misdirected away from the real underlying issue; the vaccines themselves.

By contrast, when there was a recall on CPAP machines, I received two email messages and an AERO (Army Aviation) message to inform me of this unexpected issue and provided guidance on how patients affected by the recall should be treated. To date I am unaware of any email communication to bring attention to healthcare professionals regarding any of the increased risk of cardiac and neurologic complications after vaccination. I did receive one AERO message, which read "There are no new requirements for surveillance of personnel on flight status who are asymptomatic (cardiac or otherwise)" … ."

Through research and a community chat, I was able to find Health.mil, "the Armed Forces Health Surveillance Division (AFHSD) which operates the Defense Medical Surveillance System (DMSS). Not one person in a command position directed me to this resource. DMSS contains up-to-date and historical data on diseases and medical events (e.g., hospitalizations, ambulatory visits, reportable medical events, HIV tests, and casualty data) and longitudinal data relevant to personnel, deployment experience for all active duty and reserve component service members. The DMED application, a subset within the DMSS, provides a user-friendly interface to perform queries regarding disease and injury rates and relative burdens of disease in active component populations. The purpose of DMED is to standardize the epidemiologic methodology used to collect, integrate, and analyze active component member personnel and medical event

data, and to provide authorized users with the summarized data. Using client-server technologies and database optimization, DMED users have unprecedented access to epidemiologic data on active component service members and tailored queries that respond in a timely and efficient manner" per the below:




In military medicine, risk communication is critical part of protecting the health of our Armed Forces, yet critical safety information regarding surveillance and emerging trends in vaccine adverse events has been withheld for reasons unknown to me. The lack of risk communication on potentially debilitating and deadly complications of this novel vaccine, while vigorously communicating about less consequential issues, further promotes a blind spot in medical surveillance at the point of care level. If the healthcare professional fails to accurately identify and diagnose a medical condition at the point of care, computer-based bio-surveillance systems will fail to get signals of harm. The military medicine has a long and established history of sound risk communication practices. Most healthcare providers have come to rely on the notion that if there was an emerging safety concern, they would receive timely email notification to alert them of this risk. Despite the CDC and FDA communicating the risk of myocarditis and

pericarditis in military age men, with mRNA vaccines, Army Aviation authorities failed to relay these risks and recognize the catastrophic effect it could pose to Army aviation. As an example, juxtapose and compare the risk communication regarding CPAPs, which are well known devices in use for decades; the silence on deadly diseases such as myocarditis/pericarditis from health and DOD leadership is deafening.

Information from VAERS and emerging trends in DMED should have been included in every Medical Situation Report, COVID-19 brief and extensively discussed. Critical information on **AEFI** in active-duty members should have been briefed to military healthcare professionals.

Only upon a court order under a Freedom of Information Act request, did we learn that the DOD had a 158 Risk Management Plan (RMP) titled "Comirnaty (COVID-19 mRNA Vaccine) Risk Management Plan" which included detailed plans to study DOD data regarding service-members' response to the COVID-19 vaccines. It states in part:

> *In addition to the studies in the EU, in support of the US EUA application, Pfizer will conduct 3 US studies for safety surveillance of COVID-19 mRNA. These studies include study using secondary data from administrative claims/electronic medical records for military and civilian personnel and their families in the Department of Defense Military Health System (C4591011). Study C4591011 US "will describe the incidence of myocarditis/pericarditis following Comirnaty vaccination overall, and stratified by age group, gender, race/ethnicity (if feasible), dose, and risk interval using structured information and following case confirmation via medical record review where* feasible. *To assess the magnitude of risk, these studies include comparative methods (self-controlled analyses involving a separate comparator group.*

Further, a document titled "Pharmacovigilance Plan" highlights the study of C4591011, the Department of Defense Military Health System, for Myocarditis and Pericarditis as it relates to BNT; Pfizer's BioNTech vaccine. "As noted below, the sponsor (DoD) has agreed to provide updates regarding post-EUA studies that continue as voluntary studies post-licensure in periodic safety update reports (PSURs). C4591011: **Active surveillance of the Pfizer-BioNTech COVID-19 vaccine in the U.S. Department of Defense population following Emergency Use Authorization.**" With the DoD having establish such close ties and agreement regarding vaccine safety monitoring for the research benefit of Pfizer, it would be logical that the DoD would ensure that all their healthcare professionals were well informed on the, "FDA Safety Surveillance of COVID-19 Vaccines DRAFT Working list of possible adverse event outcomes" as presented by the FDA on 10/22/2020 in the "FDA Vaccines and Related Biological Products Advisory Committee presentation" **prior to the approval of the Emergency Use Authorization.** Were it not for the FOIA decision in the court, most military and civilian doctors would have never heard that these complications were pre-identified by the FDA as known risks associated with animal studies. In fact, it is therefore understandable why many military medical professionals still refuse to entertain the possibility that the same complications listed are, in fact adverse event outcomes that they should associate with vaccination where a temporal association in the onset of symptoms, exists.

In the "Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization Review Memorandum" page 45 outlines, states, "Mandatory reporting by the Sponsor (DoD) of the following events to Vaccine Adverse Event Reporting System (VAERS) within 15 days: Serious adverse events (irrespective of attribution to vaccination), Cases of Multisystem Inflammatory Syndrome in children and adults, cases of COVID-19 that results in hospitalization or death." The document goes on to outline, three planned active surveillance studies, "**Study Protocol Number C4591011**. This study is an active safety surveillance evaluation conducted within the Department of Defense Health System Databases using data derived from electronic health records and medical service claims among covered U.S. military and their families. Rates of safety events of interest in vaccinated subjects will be compared to unvaccinated subjects. The study will be conducted for 30 months. It further states, available data are insufficient to make conclusions about benefit in individuals with prior SARS-CoV-2 infection.

This is a complete failure of public health and government and other regulatory agencies such as the FDA, to forewarn users and providers of the inherent risks associated with the largest clinical field trial in the history of humanity. **The DoD and DHA negligently or with willful blindness, abdicated their leadership and medical decision and strategic decision making to financially interested parties, like Dr. Anthony Fauci and regulatory agencies associated to him, without regard to the true effect on Force readiness and National Security.** These individuals and agencies do not have the same mission, security vetting standards, prohibitions on financial conflicts of interest as servicemen and women subject to the Uniform Code of Military Justice**.** I struggle to imagine who made the flawed decision to test the entirety of the United States Military with an experimental, first time ever delivery system containing highly toxic ingredients at the same time, while knowing the FDA's own internal audit function warned of the very serious risks detailed in the pre-EUA authorization infamous "Page 16" study aforementioned. It is now public knowledge that these vaccines generate $97 million dollars a day and the inference is that profits exceeded the importance of a standing and ready military in perhaps the most dangerous period of recent human history.

**Questions Remain**

Why would the DoD make data available to a for-profit civilian corporation for the use of its product and the valuable study data that would normally cost a pharmaceutical company hundreds of millions or even billions of dollars?

How is sharing the medical information on Active Duty servicemembers and their families with a foreign corporation not recognized as a national security risk, information breach and violation of HIPAA?

Why would the DoD readily share this critical information with a civilian corporation and not with its own healthcare professionals and combatant commanders?

Why is it that the Joint Ethics Regulation 3-209, DOD Directive 5500.07-R prohibits the endorsement of any civilian product, yet the DOD spent enormous sums of money and doing exactly that?

Why did the DOD leadership risk the entirety of its fighting force in a grand, dangerous, and deadly experiment in violation of its own laws, policies, procedures, and mandate given that the risk of death among the military population from Covid 19 was a .0038% chance?

What caused the Secretary of Defense to violate 10 USC 1107 & 1107a in pursuit of this national catastrophe?
What caused the DOD to ignore the vaccine exemptions detailed in AR 40-562, which are regulatorily provided for FDA approved vaccinations, much less experimental ones?

**Conclusion**

The military Risk Management system is an excellent guide to identify risks to our National Security. I believe the following steps are applicable in most any setting where lives are at risk, especially the lives of Americans as well as our service members. The following is taken from the Army's own course materials and should be required reading for policy makers:

*(ATP) 5-19, 1-3*. Risk Management ("RM")[4] outlines a disciplined approach to express a risk level in terms readily understood at all echelons.

*ATP* 1-6 states:

> *A risk decision is a commander, leader, or individual's determination to accept or not accept the risk(s) associated with an action he or she will take or will direct others to take. RM is only effective when specific information about hazards and risks is passed to the appropriate level of command for a risk decision. Subordinates must pass specific risk information up the chain of command.*
>
> *Conversely, the higher command **must** provide subordinates making risk decisions or implementing controls with the established risk tolerance—the level of risk the responsible commander is willing to accept. RM application must be inclusive; those executing an operation and those directing it participate in an integrated process.*

*ATP* 1-7 states: "In the context of RM, a control is an action taken to eliminate a hazard or to reduce its risk. Commanders establish local policies and regulations if appropriate".

The accepted five steps of RM include:

(1) Identify the hazards,
(2) Assess the hazards,
(3) Develop controls and make risk decisions,
(4) Implement controls,
(5) Supervise and evaluate.

[4] adminpubs.tradoc.army.mil/regulations/TR385-2withChange1.docx

It is therefore my responsibility and that of every leader to apply the steps of Risk Management to the current and future national emergency challenges and countermeasures to be used .

I declare under penalty of perjury that the foregoing is true and correct.

Executed on the 9th day of March 2022.

Signature: _____

LTC THERESA M. LONG, MD, MPH, FS

NOTARY PUBLIC
Expires
08/10/2025
George C Chambers
My Commission #
HH 139829
STATE OF FLORIDA

Hillsborough County, FL
March 9th 2022
George C. Chambers
NOTARY

Expires 08/10/2025

Witness: _____

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