Documentation to Support Equal Opportunity Concerns
Regarding COVID-19 Testing of Unvaccinated Personnel

Equal Opportunity Concerns:

1. I believe the Department of Defense (DoD) is engaging in religious discrimination by treating personnel who work for the DoD with a sincere religious belief materially worse than employees who provide evidence of vaccination. Members who have submitted a religious accommodation request for the COVID-19 vaccine are disproportionately impacted by this policy. Adverse actions include more restrictive measures that are not placed on federal employees, both civilian and military, who have provided documentation of vaccination, as well as disciplinary measures, up to and including removal from Federal service.

2. I believe the DoD is also engaging in perceived disability discrimination by treating DoD employees with a medical condition, both civilian and military, materially worse than employees who provide evidence of vaccination. DoD perceives individuals who have not provided proof of vaccination as suffering from an Americans with Disabilities Act (ADA) and Rehabilitation Act-defined disability (communicable disease) and are discriminating against them due to the perception that the unvaccinated either currently have or will imminently become infected with COVID-19. Adverse actions include more restrictive measures that are not placed on federal employees, both civilian and military, who have provided documentation of vaccination, as well as disciplinary measures, up to and including removal from Federal service.

Religious Discrimination:

Despite Executive Order 13991, which required executive departments and agencies to comply with Centers for Disease Control (CDC) guidelines, and an Office of Management and Budget Memo (M-21-15; COVID-19 Safe Federal Workplace: Agency Model Safety Principles) issued in January 2021, as well as a recommendation from the CDC to implement testing across the Federal workforce in April 2021, weekly testing of the unvaccinated was not implemented throughout the DoD until the COVID-19 vaccine mandate deadline for each service[1]. DoD COVID-19 testing mandates coincided with mandatory vaccination deadlines, deadlines that marked the final dates an administrative accommodation could be submitted, over ten months after the President's executive order. These deadlines varied for civilians and each military component, indicating a lack of a specific event or threat that was precipitating the need for testing of the unvaccinated.

A significant number of military personnel sought religious accommodation from the COVID-19 vaccine. By 22 December 2021, there were 10,766 members who had requested religious accommodations for the COVID-19 vaccine in the Air Force alone.[2] These members would have taken the COVID-19 vaccine, like any other vaccination they had received in their careers, were it not for

[1] The Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance, guidance issued on 04 April 2022, states: "Once the applicable mandatory vaccination date has passed, COVID-19 screening testing is required at least weekly for Service members who are not fully vaccinated, including those who have an exemption request under review or who are exempted from COVID-19 vaccination and are entering a DoD facility located in a county or equivalent jurisdiction where the CDC COVID-19 Community Level is high or medium."
[2] https://www.af.mil/News/Article-Display/Article/2882742/daf-processes-religious-accommodations-requests/

sincerely held religious beliefs – beliefs protected by the Constitution of the United States. The majority of personnel who refused vaccination outright have been discharged from the military.

I have not located consolidated DoD data that is unclassified without caveats, so I will use Navy data to demonstrate the disproportionate impact testing policies that single out the unvaccinated have on personnel with sincere religious beliefs. As of June 22, 2022, 3,371 active-duty Navy members remained unvaccinated.[3] Of those, 3,368 members had submitted a religious accommodation request. Only three active-duty members remain in the Navy who did not have religious concerns. As a result, 99.9% of all unvaccinated personnel in the Navy submitted a religious accommodation request. As such, the policy disproportionately impacts those of faith. This is religious discrimination.

DOD Instruction 1300.17 establishes DoD policy providing that an expression of sincerely held beliefs (conscience, moral principles, or religious beliefs) may not, in so far as practicable, be used as the basis of any adverse personnel action, discrimination, or denial of promotion, schooling, training, or assignment. Additionally, it implements requirements in Section 2000bb-1 of Title 42, United States Code (U.S.C), also known as "The Religious Freedom Restoration Act" (RFRA), and other laws applicable to the accommodation of religious practices for DoD to provide, in accordance with the RFRA, that DoD Components will normally accommodate practices of a Service member based on a sincerely held religious belief.

Perceived Disability Discrimination:

The only ethical reason to require regular testing of asymptomatic unvaccinated personnel in the workplace is if unvaccinated personnel present an increased risk of COVID-19. This threat could be due to increased prevalence of disease or transmission. If there is a belief that unvaccinated either currently have or will imminently become infected with COVID-19, periodic testing may be justified.

- Risk of Disease:

The CDC's COVID-19 Community Levels page[4] is used as the basis for Department of Defense (DoD) HPCON level determinations for COVID-19, as referenced in the Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance. The webpage opens with the following: "**With current high levels of vaccination and high levels of population immunity from both vaccination and infections, the risk of medically significant disease, hospitalization, and death from COVID-19 is greatly reduced for most people**." The guidance continues on to direct initiation of testing and masking requirements based on community levels. However, there is no recommendation for testing of personnel based on vaccination status. Instead, the following actions are recommended with regard to testing when community levels are medium and high:

- "Consider implementing screening testing or other testing strategies for people who are exposed to COVID-19 in workplaces, schools, or other community settings as appropriate."

- "Follow CDC recommendations for isolation and quarantine, including getting tested if you are exposed to COVID-19 or have symptoms of COVID-19."

[3] https://www.navy.mil/us-navy-covid-19-updates/
[4] https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html

Nowhere in the CDC guidance is testing of asymptomatic unvaccinated personnel recommended.

Additionally, the CDC guidance indicates immunity due to infection, otherwise known as "natural immunity." DoD natural immunity considerations are not aligned with CDC guidance, as required by Executive Order 13991. The Consolidated Department of Defense Coronavirus Disease 2019 Force Health Protection Guidance only provides unvaccinated personnel 90 days of reprieve from COVID-19 testing. Specifically, "[p]ersonnel who have tested positive for COVID-19 are exempted from regular screening testing for 90 days following the documented date of their initial positive test of COVID-19." However, as of 29 October 2021, prior to implementation of unvaccinated testing requirements, the CDC briefed that available evidence showed fully vaccinated individuals **and those previously infected** with SARS-CoV-2 each have a low risk of subsequent infection for *at least 6 months*.[5] Requiring testing prior to six months after infection is arbitrary, capricious, and wasteful.

This is not new. Multiple studies in different settings have consistently shown that infection with SARS-CoV-2 and vaccination each result in a low risk of subsequent infection with antigenically similar variants for at least six months.[6, 7] In a letter to the CDC8, Siri and Glimstad, LLC references over 50 studies that show those previously infected with COVID-19 (the "naturally immune") have superior protection from becoming infected with and transmitting SARS-CoV-2 than those vaccinated for COVID-19. The studies reviewed hundreds of thousands of people, comparing the naturally immune to the vaccine immune, and found the rate of infection among the naturally immune is far lower than the rate among the vaccinated ("breakthrough cases"). They cite data from "the UK's official government COVID-19 data over 7 months which reflects a probable reinfection rate of 0.025% (and a confirmed reinfection rate of 0.0026%) but a breakthrough rate [among the vaccinated] of 23% of all Delta cases." Another analysis showed COVID-19 cases were "29-fold lower in California and 15-fold lower in New York in those who had been infected but never vaccinated."[9]

Current policy also fails to account for the time since an individual was vaccinated against COVID-19. Regarding durability of COVID-19 vaccines, the CDC's Frequently Asked Questions website[10] states, "public health experts are seeing decreases in the protection COVID-19 vaccines provide over time, especially for certain groups of people." Despite this known increased risk among vaccinated personnel, there is no corresponding testing requirement based on time elapsed from last COVID-19 shot.

COVID-19 vaccines are non-sterilizing in that they do not stop infection, transmission, death, or hospitalization. Vaccinated personnel are contracting COVID-19. This is evidenced daily and can be verified by organizations that track COVID-19 infections, such as OPNAV. Multiple cases within the same office are not unheard of, indicating anecdotal evidence of transmission among the vaccinated as well.

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[5] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html

[6] https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/vaccine-induced-immunity.html#anchor_1635540449320

[7] https://www.reuters.com/business/healthcare-pharmaceuticals/prior-covid-infection-more-protective-than-vaccination-during-delta-surge-us-2022-01-19/

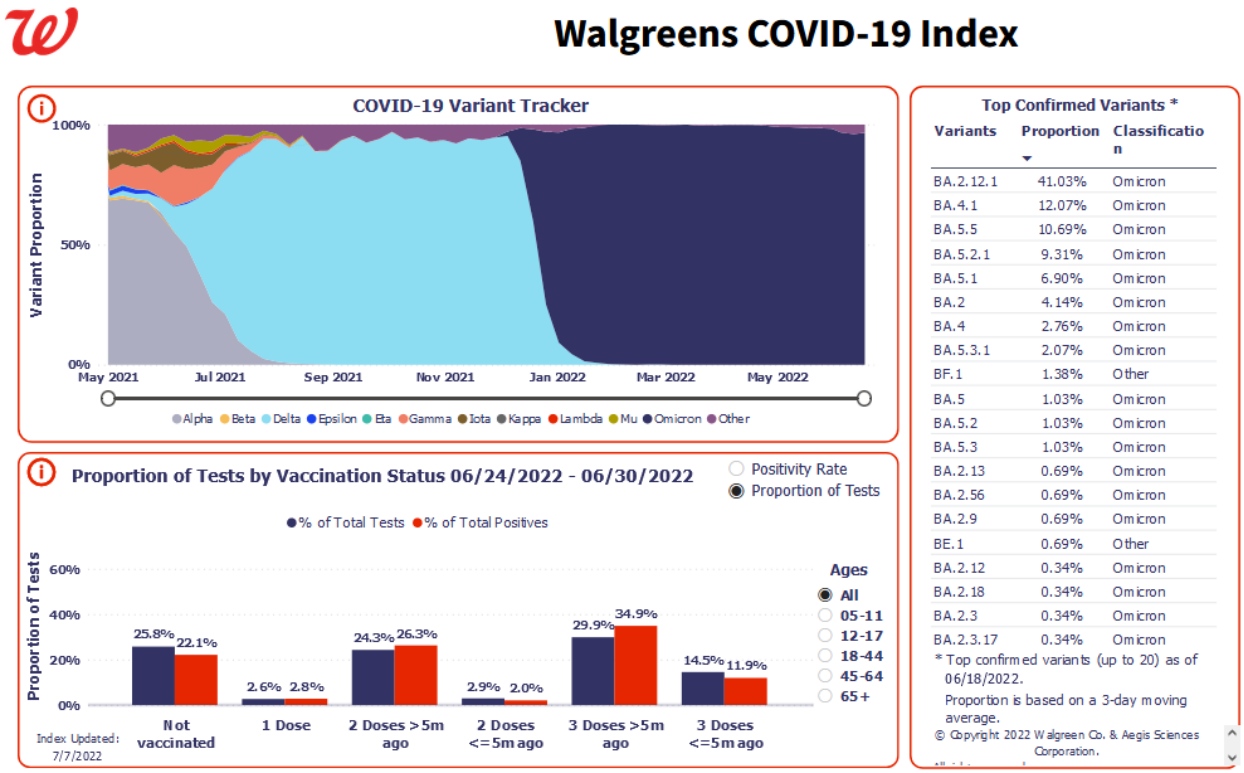
[8] Email and Federal Express from Siri and Glimstad, LLC to the CDC on October 21, 2021:"Reply Regarding Citizen Petition To Lift Restrictions On The Naturally Immune To The Extent Lifted On The Vaccinated."

[9] https://www.oregonlive.com/coronavirus/2022/01/is-immunity-strongest-from-prior-covid-19-infection-or-vaccination-new-study-has-some-hints.html?outputType=amp

[10] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html

That observation is supported by research – vaccinated and unvaccinated personnel transmit COVID-19 at a similar rate. Additionally, research shows the vaccinated are becoming infected with COVID-19 multiple times.

The Walgreens COVID-19 Index[11] indicates vaccinated Americans are contracting COVID-19 at a significantly higher rate than unvaccinated Americans. For the week of 24-30 June 2022, the unvaccinated only accounted for 22.1% of all positive tests. The rest were vaccinated.



COVID-19 vaccine data indicates breakthrough cases among fully vaccinated individuals are common. Within the U.S., the CDC only reports on breakthrough cases which lead to hospitalization and death. U.S. surveillance relies on passive and voluntary reporting, leading to incomplete data that significantly undercounts SARS-CoV-2 infections among fully vaccinated persons. Despite this dearth of comprehensive data, we can draw some conclusions from various case studies / locations throughout the country. Examples provided are drawn from data available prior to implementation of the policy to test the unvaccinated to highlight the lack of scientific rigor and discriminatory nature of the policy. As of 25 August 2021, Louisiana alone had 14,650 breakthrough infections.[12] Cornell University, despite a 95% vaccination rate for students and faculty, had more than five times the number of confirmed positive cases during its first week this academic year than it did during its first week of the 2020-21 academic year.[13] As of September 27, 2021, Harvard, despite boasting a rate of 96% faculty vaccinated

[11] https://www.walgreens.com/businesssolutions/covid-19-index.jsp
[12] https://www.politico.com/news/2021/08/25/cdc-pandemic-limited-data-breakthroughs-506823
[13] https://www.thecollegefix.com/despite-95-vaccination-rate-cornell-today-has-five-times-more-covid-cases-than-it-didthis-time-last-year/

and 95% students vaccinated, moved its business school remote due to "a 'steady rise' in breakthrough COVID-19 infection."[14]

Data from the UK Office for National Statistics[15] has indicated an increased likelihood of contracting the Omicron variant of the COVID-19 virus among the vaccinated. They reported the following:

Category	Estimated likelihood of testing positive for COVID-19 with an Omicron probable result (odds ratio)
Not vaccinated (*Reference*)	1
1 dose	1.57
2 doses, more than 14 days ago	2.26
3 doses, more than 14 days ago	4.45

The data clearly shows the greater the number of vaccines, the more likely the individual is to contract Omicron. This disturbing trend is reflected in a recent scientific study preprint[16] that demonstrated increased COVID-19 cases in the vaccinated population (including those who have taken a third "booster" dose) among UK citizens over 18 years old during the Omicron variant surge. The vaccinated, particularly among the elderly, were associated with significantly higher hospitalizations and deaths, while cases decreased among the unvaccinated population and had a corresponding decrease in hospitalizations and deaths. For the Omicron variant, which accounts for 100% of current cases in the United States[17], vaccination has a negative impact on health of the DoD and increases likelihood of sickness (and transmission) among the force.

A September 2021 article in the European Journal of Epidemiology[18] discussed vaccine ineffectiveness:

> At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days. In fact, **the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people**. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated.

[14] https://www.bloomberg.com/news/articles/2021-09-27/harvard-moves-first-year-mba-students-online-amid-virus-outbreak

[15]https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/conditionsanddiseases/adhocs/14107coronaviruscovid19infectionsurveyukcharacteristicsrelatedtohavinganomicroncompatibleresultinthosewhotestpositiveforcovid19

[16] Venkata R. Emani et. al, "Increasing SARS-CoV2 cases, hospitalizations and deaths among the vaccinated elderly populations during the Omicron (B.1.1.529) variant surge in UK, https://doi.org/10.1101/2022.06.28.22276926

[17] https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8481107/

Across the US counties too, the median new COVID-19 cases per 100,000 people in the last 7 days is largely similar across the categories of percent population fully vaccinated. Notably there is also substantial county variation in new COVID-19 cases *within* categories of percentage population fully vaccinated. There also appears to be no significant signaling of COVID-19 cases decreasing with higher percentages of population fully vaccinated.

This trend is evidenced globally and additional information can be provided upon request. Another example is a recent study of COVID-19 infections in Qatar[19], which found no discernable differences in protection against symptomatic Omicron (BA.1 and BA.2) infection with previous infection, vaccination, and hybrid immunity. Of note, the effectiveness of vaccination among individuals who received two doses of Pfizer-BioNTech (BNT162b2) and no previous infection was **−**1.1% (95% CI, −7.1 to 4.6), meaning those with no prior COVID-19 infection who have only received the initial two doses of mRNA COVID-19 vaccine were **more likely to become sick with COVID-19 than if they had not been vaccinated at all**. In other words, people who were vaccinated and have not gotten COVID-19 are more likely than the unvaccinated to become sick with and transmit COVID-19 in the workplace.

- Risk of Transmission:

Throughout history, individuals have been vaccinated to prevent disease. However, in the case of COVID-19 vaccines and as indicated in the previous paragraphs, vaccinated individuals often experience "(vaccine) breakthrough infections" and are infected with COVID-19. The CDC warns that "people who get vaccine breakthrough infections can spread COVID-19 to other people."[20] On 2 December 2021, the Department of State updated its policy and required a COVID-19 test within one day for all international travelers coming to the U.S.[21], regardless of vaccination status. This policy shift indicated the U.S. government did not recognize any appreciable difference in a traveler's ability to contract or transmit COVID-19, regardless of vaccination status. Of note, testing is no longer required at all to enter the United States, regardless of the transmission level of the country of origin.

Scientific studies have confirmed COVID-19 vaccines do not stop transmission of the virus.[22] An Israeli case study demonstrated the **high transmissibility of COVID-19 from vaccinated individuals** to other individuals, regardless of vaccination status. [23] Peak viral load is similar for vaccinated individuals with "breakthrough cases" and unvaccinated individuals who contracted the Delta variant of COVID-19.[24] Additionally, some research has indicated vaccinated individuals may be more likely to have a high viral load when asymptomatic than unvaccinated individuals.[25] This is particularly concerning for

[19] https://www.nejm.org/doi/full/10.1056/NEJMoa2203965?query=featured_home
[20] https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html
[21] https://travel.state.gov/content/travel/en/traveladvisories/covid-19-travel-information.html
[22] P Y Chia, et. al, "Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine-breakthrough infections: a multi-center cohort study," Singapore, 31 July 2021.
[23] P. Shitrit, "Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021," www.eurosurveillance.org, 30 September 2021.
[24] K B Pouwels, et. al., "Impact of Delta on viral burden and vaccine effectiveness against new SARS-CoV-2 infections in the UK," United Kingdom, 24 August 2021.
[25] K K Riemersma, et. al., "Shedding of Infectious SARS-CoV-2 Despite Vaccination when the Delta Variant is Prevalent - Wisconsin, July 2021," Madison, WI, 11 August 2021.

confined workplaces where social distancing may not be possible, such as aboard ships or aircraft, particularly when vaccinated crews incorrectly perceive their risk of transmission is low.

The Consolidated DoD COVID-19 Force Health Protection Guidance[26] assurance that "[a]s data becomes available, science-based evidence emerges, and the CDC, OSHA, and other cognizant agencies, departments, and other elements of the Federal Government revise and develop new recommendations to protect the workforce, the DoD will incorporate them into its current and future policies and guidance as appropriate" does not appear to be accurate. In requiring regular testing of asymptomatic individuals based solely on vaccination status, individuals who have not provided proof of vaccination are treated as suffering from an Americans with Disabilities Act (ADA) and Rehabilitation Act-defined disability, specifically a communicable disease. This mentality is reflected throughout the Consolidated DoD COVID-19 Force Health Protection Guidance, for example "Vaccination status of the Service member should be considered in granting an exception, **as more risk will be assumed in granting an exception for a Service member who is not fully vaccinated**." This is particularly problematic because this perception is not reflected in reality. Vaccinated personnel are becoming infected with COVID-19, in some cases, at a greater rate than the unvaccinated. Once infected, scientific studies have demonstrated vaccinated personnel are transmitting the COVID-19 virus at a rate that is at least on par with unvaccinated personnel.

- Disparate Treatment

DoD employees who have demonstrated a sincere religious belief and/or have a perceived disability related to COVID-19 are treated materially worse than employees who provide evidence of vaccination. Adverse actions include more restrictive measures that are not placed on federal employees, both civilian and military, who have provided documentation of vaccination, as well as disciplinary measures, up to and including removal from Federal service. Examples from the Consolidated DoD COVID-19 Force Health Protection Guidance include:

- "Personnel subject to screening testing are **required to have a negative COVID-19 screening test result for entry into a DoD facility**."

- "DoD Components **may bar DoD civilian employees** who refuse required screening testing from their worksites on the installation or facility to protect the safety of others."

- "For any in-person meetings in a county or equivalent jurisdiction where the CDC COVID-19 Community Level is high or medium, the meeting organizer **will require all attendees**, including Service members and DoD civilian employees, **to show** a completed DD Form 3150, 'Contractor Personnel and Visitor **Certification of Vaccination**.' " Testing is not listed as an alternative option.

- "Individuals who are not fully vaccinated, or who decline to provide information about their vaccination status, are **limited to mission-critical official travel**, both domestic and

[26] https://media.defense.gov/2022/Jul/01/2003029092/-1/-1/0/CONSOLIDATED-DOD-COVID-19-FHP-GUIDANCE-REVISION-1-29-JUNE-2022.PDF

international." Once again, testing in lieu of vaccination is not provided as a standard option to support non-mission critical official travel.

These policies single out members who are unvaccinated, the majority of whom have expressed a sincerely held religious belief. They subject affected individuals to undue scrutiny by non-medical personnel, who may subsequently change their behavior towards the unvaccinated person based on perceived risk of communicable disease (COVID-19) or disapproval of their personal medical decision. This is particularly worrisome for in-person meetings during medium or high COVID-19 community levels, as meeting organizers are not limited to the chain of command. Additionally, training, schooling, and assignment opportunities are limited for the unvaccinated. Since there is no testing option to support individuals as their religious accommodation requests for COVID-19 vaccination (the underlying condition that leads to the testing requirement), this loss of opportunity has significant potential to limit promotion opportunities, which is contrary to DOD Instruction 1300.17. Additional negative treatment includes the threat (and execution) of punitive action if personnel do not agree to submit to COVID-19 testing measures.

There are tens of thousands of DoD employees, both military and civilian, are being negatively impacted due to discriminatory DoD testing policies. Testing policy implementation has consistently served to create hardship for unvaccinated DoD employees with no apparent benefit to productivity or workplace performance. As outlined above, scientific research has long indicated there are no force health protection benefits gained by singling out unvaccinated personnel for periodic testing. It is clear testing policies are discriminatory, coercive, and used punitively against the unvaccinated, the majority of whom have sincerely held religious beliefs.

Force health protection guidance is also not being implemented in its entirety. Testing requirements have been levied against the unvaccinated, however occupancy restrictions have not been implemented in many locations as required by the Consolidated DoD COVID-19 Force Health Protection Guidance. Table 1 of the guidance outlines occupancy requirements based on community spread / HPCON level. During low COVID-19 community levels, less that 100% of normal occupancy in the workplace, with telework as appropriate, is required. During moderate community levels, less than 80% of normal occupancy is required and liberal telework is to be permitted where possible. During high community levels, less than 50% of normal occupancy is allowed in the workplace and telework is supposed to be maximized "to the greatest extent practical." Severe community levels further restrict occupancy. This requirement has not been adhered to, indicating the arbitrary implementation of policy, which favors those measures which discriminate against unvaccinated personnel.

In addition to the aforementioned considerations, Executive Order 13991 stated "[t]he heads of executive departments and agencies (agencies) shall immediately take action, **as appropriate and consistent with applicable law**… Heads of agencies may make categorical or case-by-case exceptions… to the extent that doing so is necessary or required by law, and consistent with applicable law." Available COVID-19 tests, including polymerase chain reaction (PCR) tests administered in hospitals, have not been approved by the Food and Drug Administration (FDA).[27] Under an EUA, the FDA may allow the use of unapproved medical products in an emergency to diagnose, treat, or prevent serious or life-threatening diseases when there are no adequate, approved, and available alternatives. Under Title 21 U.S. Code §355(i)(4) and 21 U.S. Code § 360bbb–3(e) (1) (a)(ii), individuals have the right to informed

[27] https://www.fda.gov/medical-devices/coronavirus-disease-2019-covid-19-emergency-use-authorizations-medical-devices/in-vitro-diagnostics-euas-antigen-diagnostic-tests-sars-cov-2

consent and must be informed of the option to accept or refuse administration of an EUA product. Title 10 U.S. Code 1107a grants the President authority to waive the notification of informed consent for service members receiving EUA products only in the event the President determines, in writing, that notification of informed consent is not in the interests of national security. A Presidential waiver has not been granted at this time. Informed consent is required to administer any EUA test to DoD employees, both civilian and military. The CDC's Workplace SARS-CoV-2 Testing: Consent Elements and Disclosures page[28] highlights this right, stating "[w]orkplace-based testing should not be conducted without the employee's informed consent. Informed consent requires disclosure, understanding, and free choice, and is necessary for an employee to act independently and make choices according to their values, goals, and preferences." DoD has implemented testing mandates, which violate applicable law and the rights of American citizens.

[28] https://www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/workplace-testing-consent-elements-disclosures.html