

EXHIBIT 18

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO**

DANIEL ROBERT

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SSG, U.S. ARMY

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HOLLIE MULVIHILL

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SSGT, USMC

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Plaintiffs,

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v.

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Civil Action No. 1:21-CV-2228

LLOYD AUSTIN

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Secretary of Defense,

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U.S. DEPARTMENT OF DEFENSE

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Washington, D.C. 20301

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and

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XAVIER BECERRA

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Secretary of the U.S. Department of

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Health and Human Services

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U.S. DEPARTMENT OF HEALTH

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AND HUMAN SERVICES

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and

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JANET WOODCOCK, Acting

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Commissioner of the Food & Drug

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Administration

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U.S. FOOD AND

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DRUG ADMINISTRATION

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UNITED STATES OF AMERICA

Defendants.

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**AFFIDAVIT OF LTC. THERESA LONG M.D.
IN SUPPORT OF MOTION FOR A PRELIMINARY INJUNCTION**

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

1. 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.

2. 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.

3. 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

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

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.

4. 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 Casualties at Fort Detrick and USAMIIRD.

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

6. 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.

7. 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.

8. 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.

9. With that said, the majority 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.

10. 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.

11. 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.

12. 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.”

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

13. “When the 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.”

14. ¶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.”

15. The five steps of Risk management include; 1. Identify the hazards, 2. Assess the hazards, 3. Develop controls and make risk decisions, 4. Implement controls, 5. Supervise and evaluate.

16. It is therefore my responsibility and that of every leader to apply the steps of risk management to the current pandemic and countermeasures used. **The CDC and the FDA are civilian agencies that do not have the mission of National Defense placed upon the DOD.** Guidance and recommendations made by these civilian agencies must be filtered through strategic perspective of national defense and the potential risks recommendations may have on the health of the entire fighting force. Ensuring that the health of the fighting force is not compromised is a strategic imperative, for which **every** military physician is responsible to ensure.

17. **Step 1: Identify the hazards:** As defined by FM 1-02.1 Operational Terms, pg. 1-48, hazard is a condition with the potential to cause injury, illness, or death of personnel; damage to or loss of equipment or property; or mission degradation.

18. **Step 2: Assess the Hazards:** There are numerous therapeutic alternative agents (not less than 36 of them) that have been proven and safe to significantly reduce infection and therefore provide protection from the harmful effects of SARs-CoV-2 irrespective of the EUA vaccines. I have determined this based on my personal experience and research for my personal benefit due to my personal medical posture.

19. My research and discussions have led me to literature that demonstrates that natural immunity is durable, complete, and superior to any vaccination immunity to SARs-CoV-2. mRNA vaccines produced by Pfizer and Moderna both have been dispositively linked to

myocarditis per their own disclosure materials, especially in young males between 16-24 years old.³ The majority of young new Army aviators are in their early twenties. We know there is a substantial risk of myocarditis with **each** mRNA vaccination. We additionally now know that vaccination does not necessarily prevent infection or transmission of SARs-CoV-2. Therefore, individuals fully vaccinated with mRNA vaccines have at least two independent risk factors for myocarditis after vaccination. Additional booster shots add more risk. It is impossible to perform a risk/benefit analysis on the use of mRNA as counter measures to SARs-CoV-2 without further data. Use of mRNA vaccines in our fighting force, presents a risk of undetermined magnitude, in a population in which **less than 20 active-duty personnel out of 1.4 million, died of the underlying SARs-CoV-2.**

20. In fact, according to the “Big Ten Study”⁴ there is a 2.3% risk of myocarditis after infection by COVID-19 by itself. Given that the mRNA vaccines are designed to and do modify cellular function to produce the very same Spike Proteins that the infection is caused by, we are simply magnifying this risk potential with each dose. On the basis that no patients are being screened for prior infection then we are arithmetically compounding the risk of further cardiovascular damage to those people. In other words, no COVID-recovered person should receive any mRNA vaccines.

21. Aircrew Training Program (ATP) 5-19, 1-8. **Accept No Unnecessary Risk**, states, “An unnecessary risk is any risk that, if taken, **will not contribute meaningfully to mission accomplishment or will needlessly endanger lives or resources.** Army leaders accept only a level of risk in which the potential benefit outweighs the potential loss.”

22. Research indicates that many cases of myocarditis have either no symptoms or nonspecific symptoms and therefore go undetected.⁵ Complications of myocarditis include dilated cardiomyopathy, arrhythmias, sudden cardiac death and carries a mortality rate of 20% at one year and 50% at 5 years. According to the National Center for Biotechnology Information, U.S. National Library of Medicine, “despite optimal medical management, overall mortality has not changed in the last 30 years”. Simply stated myocarditis, an unpredictable, often asymptomatic medical condition, which requires invasive testing to confirm the diagnosis, coupled with a population (young Army aviators) who are notorious for underreporting and or

³ <https://www.fda.gov/media/151733/download>

⁴ <https://pubmed.ncbi.nlm.nih.gov/34042947/>

⁵ <https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.115.306573>

minimizing any medical problems or symptoms to avoid grounding together with political pressure on medical professionals to keep pilots flying, all cumulate in the perfect storm for compromised aviation safety and deadly aircraft mishaps.

23. **Step 3: Develop controls and make risk decisions:** Because vaccination with mRNA increase the risk of myocarditis, a comprehensive screening program should be implemented immediately to identify individuals who have been affected and attempt to mitigate immediate risks and long-term disability.

24. **Step 4: Implement Controls:** Send out clear guidance to all DOD healthcare professionals on risks of-vaccination myocarditis. The compulsory SARs-CoV-2 mRNA vaccination program should be immediately suspended until research can be done to determine the true magnitude of risk of myocarditis in individuals who have been vaccinated and especially those that suffered previous infection before receiving the vaccination. We must evaluate and immediately implement alternatives to mRNA vaccines, to include Ivermectin (FDA approved 1996), Remdesivir (FDA approved 2020), Hydroxychloroquine (FDA approved 1955), Regeneron (FDA EU approved 2020). Review VAERS data for deaths from COVID for age-matched data and data from active duty COVID deaths within the DOD to perform a risk/benefit analysis.

25. **Step 5: Supervise and evaluate:** We must establish a screening program to identify those at increased risk of myocarditis, i.e., those that have, received mRNA vaccinations with Comirnaty, BioNTech or Moderna, or have any of the following symptoms chest pain, shortness of breath or palpitations. They should have screening tested performed in accordance with the CDC recommendations prior to return to flight duties. Per the CDC guidelines the initial evaluation of individuals identified according to the above criteria include; ECG, troponin level, inflammatory markers such as the C-reactive protein and erythrocyte sedimentation rate. It should be noted that, “an endo myocardial biopsy (EMB) is the only diagnostic tool for establishing etiologic diagnosis (viral or immune mediated) in myocarditis and inflammatory cardiomyopathy.”⁶

26. Given that the labels for Comirnaty and BioNTech clearly state that the vaccination should not be given to individuals that are allergic to ingredients. I have noted that one of the primary ingredients and largest component by volume of the Lipid Nanoparticle

⁶ Turk Kardiyol Dern Ars 2015; 43(8):739-748 doi:10.5543/tkda.2015.47750

delivery system is “ALC 0315” (two attachments, parts highlighted) in the Pfizer shots. The fourth attachment is the toxicity report on ALC-0315, which comprises between 30-50% of the total ingredients.⁷ The Safety Data Sheet, (attached as Exhibit B) for this primary ingredient states that it is Category 2 under the OSHA HCS regulations (21 CFR 1910) and includes several concerning warnings, including but not limited to:

- a. Seek medical attention if it comes into contact with your skin;
- b. If inhaled and If breathing is difficult, give cardiopulmonary resuscitation
- c. Evacuate if there is an environmental spill
- d. the chemical, physical, and toxicological properties have not been completely investigated
- e. Caution: Product has not been fully validated for medical applications. For research use only

26. Other journals and scientific papers also denote that this particular ingredient has never been used in humans before and that there is little or no data to support a conclusion on the actual toxicity or pathogenicity of the compound; particularly as it relates to the relatively untested effect of PEG’s (Polyethylene glycol is a derivative of ethylene oxide.) in this concentration. Notably, Polyethylene Glycol is the active ingredient in antifreeze. In fact, recent scientific studies caused a group of 57 doctors and scientists to call for an immediate halt to the vaccination program. In short, this primary ingredient is being studied for the first time in humans and according to the VAERS data, which is admittedly underreporting Serious Adverse Events by as much as 100 times, there are well more than 600,000 documented SAE’s alone, and more than 13,000 fatalities directly linked to this particular vaccine. A recent paper has confirmed the serious allergic potential of PEG in the COVID-19 vaccines.⁸

27. As such, I believe it is reasonable to conclude that many humans could be categorized as allergic to these dangerous and deadly toxins and therefore should not take

⁷ <https://thetattyjournal.org/2021/07/17/expert-evidence-regarding-comirnaty-pfizer-COVID-19-mrna-vaccine-for-children/>

⁸ https://www.jstage.jst.go.jp/article/bpb/37/3/37_b13-00661/_html/-char/en

vaccinations with either Comirnaty, BioNTech or the Moderna vaccines all of which use PEG's. Again, I have identified an agent that possess a significant hazard to Soldiers, which would fall under DA Pam 385-61 Toxic Safety Standards cited in 2-11.

28. My assessment is that ALC 0315 is a known toxin with little study, specifically restricted to "research only" and effectively has no prior use history, with the SDS designation of (GHS02), listed as H315 and H319, in other words, hazardous if inhaled, ingested or in contact with skin and a health hazard with the designation (P313). A review of the SDS outlines that it is not for human or veterinary use,

29. Given that these COVID-19 Vaccines were both Investigational New Drugs and Emergency Use Authorization vaccines, I have taken considerable time to understand potential risks, hazards and dangers these and any new drug or Investigational New Drug will may have on the health, safety and operational readiness or ability of pilots under my care and at this post. I have sought to research military records and track systems for recording events and Serious Adverse Events and fatalities associated with vaccines, new vaccines and Emergency Use, investigational vaccines in computer data systems recommended by the General Accounting Office in 2002 and ordered to be developed and implemented by the Secretary of Defense in 2003.

30. During my investigation to understand these risks, I also reviewed the safety data sheet to compare the risks of Moderna's COVID-19 Vaccine ingredients. Moderna's key ingredient lipid nanoparticle delivery system is referred to as "SM-102" (attached as Exhibit C). Suffice it to say that SM-102 is significantly more dangerous than the Pfizer ALC 0315 ingredient and it appears that the DOD is not actively acquiring or distributing the Moderna IND/EUA. If the DOD were to undertake use of the Moderna vaccine, one can expect a much higher Serious Adverse Event and fatality rate given that SM-102 carries an express warning "Skull and Crossbones" characterized under the GHS06 and GHS08. In other words, this Moderna ingredient is deadly.

31. A weekly MEDSITREP report fails to report the CDC data from VAERS or internal data regarding vaccine adverse events. Despite recommendations made by the Government Accountability Office in the GAO's survey of Guard and Reserve Pilots and Aircrew GAO-02-445, published Sep. 20, 2002, in which it was recommended that the

Secretary of Defense should direct the establishment of an active surveillance program (unlike the passive VAERS) to identify and monitor adverse events, which was not implemented. Unfortunately, I have been advised by an epidemiologist for PM Army Public Health Command that no active tracking system exists. Yet, the total number of suspected and confirmed cases of post-vaccination myocarditis must be made available for accurate risk/benefit assessments.

32. I have also reviewed scientific data and peer reviewed studies that discuss, analyze results, and conclude that natural immunity is at least as good if not far superior to any COVID vaccine available at this time. I have also reviewed Dr. Peter McCullough's Affidavit in support of and in relation to the Complaint filed in this case and have reviewed its supporting data. An additional peer-reviewed study not referenced in Dr. McCullough's materials also supports the same conclusions drawn and reports that natural immunity provides a 13-fold to infinitely better protection against COVID-19 infections than any currently available COVID-19 Vaccine⁹. More recently, in a meeting of the FDA Advisory Committee on September 17 of this year, fourteen of seventeen members voted against the authorization of any COVID booster vaccines in the juvenile age group having noted that the vaccine program has breached the defining test under the EUA statute as to whether the experimental treatment benefits outweigh the risks; in fact, they found the shots are far more dangerous than helpful in this age group and some voiced concerns that this would apply generally to all age groups.¹⁰

33. I am also aware of the Secretary of Defense Austin's order in relation to COVID vaccine mandates made recently. I was alarmed by information and discussions about the authorized use of force. I understood use of force was authorized against the will of a mentally competent individual, which constitutes a medical battery and universally violates medical ethics and the very notion of a voluntary defense force. I have looked and checked with colleagues throughout the military and have not found any Comirnaty version of Pfizer's vaccine available within the DOD. Despite the DOD's attempt to

⁹ <https://www.sciencemag.org/news/2021/08/having-sars-cov-2-once-confers-much-greater-immunity-vaccine-no-infection-parties>

¹⁰ <https://www.thegatewaypundit.com/2021/09/fda-hearing-doctors-experts-testify-government-data-demonstrates-COVID-shots-dangerous-may-kill-save-video/> & <https://www.youtube.com/watch?v=WFph7-6t34M>

characterize Pfizer's BioNTech as being the same as Comirnaty, service members can read and discover the very vial of vaccine solution being used states in large font "Emergency Use Authorization" on the label. As such, Informed Consent is required for that particular substance and should not be involuntarily or forcefully given to the service member.

34. Finally, I have reviewed a recent study *entitled "US COVID-19 vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, All Cause Severe Morbidity,"* by J. Bart Classen, MD and published in *Trends in Internal Medicine*; August 25, 2021. Attached as Exhibit D.

35. I have also seen policies, memoranda, and guidance as it relates to exemptions for vaccinations as fully detailed in Army Regulation 40-562, which purport to eliminate any exemption for prior immunity by our military personnel.

Personal Opinion

36. I have reviewed the Motion for a Preliminary Injunction which discusses the issue of prior immunity benefits outweighing the risks of using experimental COVID-19 vaccines, together with proposed exhibits and materials cited therein. In my personal opinion on this subject matter, I am also drawing my own conclusions that will be put into practice in my current position as a doctor knowing full well the horrific repercussions this decision may befall me in terms of my career, my relationships and life as an Army doctor.

37. I personally observed the most physically fit female Soldier I have seen in over 20 years in the Army, go from Colligate level athlete training for Ranger School, to being physically debilitated with cardiac problems, newly diagnosed pituitary brain tumor, thyroid dysfunction within weeks of getting vaccinated. Several military physicians have shared with me their firsthand experience with a significant increase in the number of young soldiers with migraines, menstrual irregularities, cancer, suspected myocarditis and reporting cardiac symptoms after vaccination. Numerous soldiers and DOD civilians have told me of how they were sick, bed-ridden, debilitated, and unable to work for days

to weeks after vaccination. I believe the illnesses and injuries observed are the proximate and causal effect of the COVID-19 vaccinations. I have also recently reviewed three flight crew members' medical records, all of which presented with both significant and aggressive systemic health issues. I cannot attribute anything other than the COVID-19 vaccines recently received as the source of these maladies, which has resulted in their grounding. Correlation by itself does not equal causation, however, significant patterns do exist that raise correlation into a probable cause; and the burden, the burden of proof falls on governmental authorities such as the CDC, FDA, and pharmaceutical manufacturers to prove the vaccination did not cause these medical issues.

38. I can report of knowing over fifteen military physicians and healthcare providers who have shared experiences of having their safety concerns ignored and being ostracized for expressing or reporting safety concerns as they relate to COVID-19 vaccinations. The politicization of SARs-CoV-2, treatments and vaccination strategies have completely compromised long-standing safety mechanisms, open and honest dialogue, and the trust of our service members in their health system and healthcare providers.

39. The subject matter of this Motion for a Preliminary Injunction, COVID-19 vaccines, and their devastating effects on members of the military compel me to conclude, based on my personal knowledge, experience, and the extensive research I have completed for personal reasons as well as for the health and welfare of my patients. There are multiple scientific and research articles available to support my personal beliefs below. Therefore, it is my personal opinion that:

- a) None of the ordered Emergency Use COVID-19 vaccines can or will provide better immunity than an infection-recovered person;
- b) All three of the EUA COVID-19 vaccines (Comirnaty is not available), in the age group and fitness level of my patients, are more risky, harmful and dangerous than having no vaccine at all, whether a person is COVID-19 recovered or facing a COVID-19 infection;
- c) Direct evidence exists and suggests that all persons who have received a COVID-19 vaccine have potential pathophysiologic mechanism for cardiovascular damage from

- spike proteins being produced by their own bodies which exacerbates and increases the risks of cardiovascular damage;
- d) The pathogenic spike protein has been shown to cause endothelial dysfunction and increase the risk of micro clots in the cardiovascular system thereby presenting greater danger and risk to human health and safety;
 - e) That, at the initial stage, inflammatory changes consistent with myocarditis can be discovered using cardiac MRI imaging per recent peer reviewed studies;¹¹
 - f) That since there is no active vaccine adverse monitoring system within aviation medicine, no functional myocardial screening or risk stratification specifically being conducted for myocarditis, it is my personal professional opinion that substantial foreseen risks currently exist, and due to political pressure, are being handled in a manner that deviates from aeromedical safety standards and historic precedence;
 - g) That, by virtue of their occupations, said flight crews present extraordinary risks to themselves and others given the equipment they operate, munitions carried thereon and areas of operation in close proximity to populated areas;
 - h) That, without any current screening procedures in place, including any Aero Message (flight surgeon notice) relating to this demonstrable and identifiable risk, I cannot certify that COVID-19 vaccinated individuals on flight status will be free from sudden incapacitation as is required by the regulations;
 - i) That, having exhausted all means to rectify the above safety concern with the current tools available, the only option I am left with is to ground active flight personnel who received the vaccinations until such time as the causation of these serious systemic health risks can be more fully and adequately assessed;
 - j) I have collaborated with expert medical practitioners in this field, including the renowned Cardiologist Dr. Peter McCullough and a Senior Medical Examiner-Federal Air Surgeon's Cardiology Consultant for the Federal Aviation Administration (FAA), both of which are free from undue military and political influence. Both Cardiologist agree with my conclusions which are; 1) the combined risk of post-infectious and post-vaccination myocarditis is not trivial, in which both aviators and flight surgeons must be well educated and informed about; 2) the military aviation

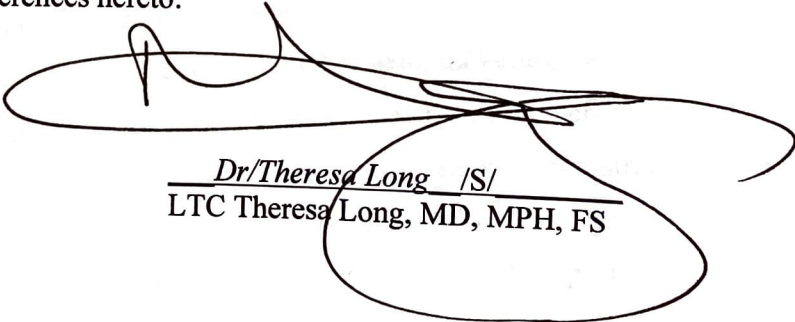
¹¹ <https://pubmed.ncbi.nlm.nih.gov/34042947/>

population is comprised of individuals with demographics that the CDC and FDA established (on June 25, 2021) was at the greatest risk for developing post-vaccination induced myocarditis; 3) the unpredictable nature and potential serious complications thereof, present an avoidable and unacceptable level of aeromedical risk in our military aviation population; 4) risk-stratification, screening and diagnostic testing (cardiac MRI) is necessary for continued safety of flight; and 5) immunizations with COVID-19 vaccinations should be immediately suspended until further aviation specific studies can be conducted regarding the risk of myocarditis on those whose risk factors include vaccination and COVID-19 independently and in combination;

That, in accordance with the foregoing, I am seriously concerned for all, but certainly those patients I have been responsible for, and hereby recommend that all pilots, air crew and flight personnel in the military service who have reported acute chest pain, shortness of breath or heart palpitations, after vaccination or required hospitalization from injection or received any COVID-19 vaccination be grounded similarly for further dispositive assessment;

- 1) Finally, recommend an immediate pause of vaccinations to military personnel who are some of the healthiest and most fit individuals in the nation, in order to protect the health and safety of our active duty, reservists, and National Guard troops due to what I have observed and researched as the high instance or possibility of myocarditis and other side effects or reactions.

41 I confirm and attest to the accuracy and truthfulness of my foregoing statements, analysis and attachments or references hereto:


Dr/Theresa Long /S/
 LTC Theresa Long, MD, MPH, FS

Washington DC

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§
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District of Columbia

The undersigned, being duly sworn, deposes and says:

I, Lieutenant Colonel Theresa M. Long, MD, MPH, FS, declare under the penalty of perjury of the laws of the United States of America, and state upon personal knowledge that:

I am an adult of sound mind, 47 years old, and declare that the information herein is true, correct, and complete and that I have voluntarily affirmed this Affidavit based upon my own personal knowledge, education, and experience, and under the penalty of perjury of the laws of the United States of America.

SUBSCRIBED AND SWORN TO BEFORE ME on the 2nd day of November 2021, to certify which witness my hand and official seal.

Louis A. Ruiz

Notary Public

(Name)

(State)

