**Notice of Conditional Acceptance**

Dear Dr/Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You are insisting that I receive the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccine. I will only agree to any such vaccines on the condition that you provide the following:

1. At least one double-blind, placebo-controlled study that proves the safety and effectiveness of vaccines
2. Scientific evidence on any study which confirms the long-term safety and effectiveness of vaccines
3. Scientific evidence which proves that any disease reduction at any point in history was directly attributable to the vaccination of a population
4. Scientific justification as to how injecting a human being with a confirmed neurotoxin is beneficial to human health and prevents disease
5. Scientific justification on how bypassing the respiratory tract or mucous membrane is advantageous and how directly injecting viruses into the bloodstream enhances immune functioning and prevents future infections
6. Scientific justification on how a vaccine would prevent viruses from mutation
7. Scientific justification as to how a vaccination can target a virus in an infected individual who does not have the exact viral configuration or strain the vaccine was developed for

It is my understanding that the vaccines actually place the recipient at risk of developing a wide range of diseases and conditions and so I also require you to complete, sign and return the enclosed Liability Statement in the presence of three witnesses.

Please respond with substance and the requested proofs of claim within seven (14) days, failure to do so will be deemed to mean that no such proofs exist and that it is your medical opinion that the proposed vaccination is not safe.

Yours sincerely

A long term double-blind placebo based study for vaccine safety: <https://www.rescuepost.com/files/mawson-et-al-2017-vax-unvax-jnl-translational-science.pdf>

Over 1400 published PubMed studies on vaccines: <https://www.wellnessdoc.com/1200studies/?fbclid=IwAR3gulQdIJbnTCqFou__Fe3iN7KjXB9_Gh8ssgewcTke_ZzDZmIhr511JKU>

**Liability Statement**

I, Dr/Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ as the physician administering the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ vaccine have thoroughly examined the patient Mr/Mrs/Miss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and have determined that the patient does not have any of the conditions listed below.

I therefore accept full responsibility and full commercial liability should the patient be subsequently diagnosed with any of the following conditions as a result of receiving this vaccine:

**[The disease that the vaccine was designed to inoculate against]**, allergic reactions, ADHD, autism, AIDS, cancer, dementia, Alzheimer’s disease, pneumonia, encephalitis, meningitis, hepatitis, Epstein-Barr disease, encephalopathy, febrile convulsions, non-febrile convulsions, paralytic poliomyelitis, Kawasaki disease and Guillain-Barre syndrome, sudden death.

Signed in the presence of three witnesses:

Dr./Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_