SB 839_mgoldstein_fav 2022.pdf
Uploaded by: Mathew Goldstein
Position: FAV

Secular Maryland secularmaryland@tutanota.com

March 02, 2022

SB 839 - SUPPORT

Maryland Voluntary COVID-19 Vaccine Passport

Dear Chair Kelley, Vice-Chair Feldman, and Members of the Finance Committee,

Secular Maryland favors laws that push back against contagious diseases that injure and kill. Mobile vaccine passports protect us all by providing incentive to get vaccinated. They give businesses and service providers the confidence of knowing they are providing a safe setting for their clientele and employees. They give citizens more confidence that it is safe to be employed at indoor locations shared with others. They give customers more confidence to purchase goods and services at local indoor providers instead of purchasing online for delivery or postponing their purchases. They facilitate international travel.

Respectfully,
Mathew Goldstein
3838 Early Glow Ln
Bowie, MD

Testimony839.pdf
Uploaded by: Agne Pack
Position: UNF

Many concerned citizens like myself have likely been keeping track of Covid data via the Maryland Department of Health website. Visiting this MD Dept of health Immunet website even today shows that they are experiencing “a network security incident involving the MDH systems. The incident appears to have affected some of our partners, including local health departments”. On December 4th, 2021 events led to hearings held in January of this year defining these incidents as being ransomware attacks. Also in January, January 18th 2022 to be specific, the FBI released Alert Number I-011822-PSA “to raise awareness of malicious Quick Response (QR) codes. Cybercriminals are tampering with QR codes to redirect victims to malicious sites that steal login and financial information. A QR code is a square barcode that a smartphone camera can scan and read to provide quick access to a website, to prompt the download of an application, and to direct payment to an intended recipient. Businesses use QR codes legitimately to provide convenient contactless access and have used them more frequently during the COVID-19 pandemic. However, cybercriminals are taking advantage of this technology by directing QR code scans to malicious sites to steal victim data, embedding malware to gain access to the victim's device, and redirecting payment for cybercriminal use.” The 117th Congress of 2021-2022 has introduced H.R. 5936 Ransomware and Financial Stability Act of 2021 “to include requirements relating to ransomware attack deterrence for a covered U.S. financial institution in the consolidated Appropriations Act of 2021.” However, where are then the mobile ransomware deterrents for everyday people who may at first voluntarily and unknowingly give their information away but then by state mandate as have been ineffective vaccines and boosters? As Senator Paul G. Pinsky has mentioned in January as well, “the question is transparency and integrity - not system integrity, I’m talking about human integrity - who should we trust?” How can we secure our data into one centralized multi-state and even multi-nationally linked database with nonexistent security items with the government when the government is not able to secure our data for us under continued data security pressure as can be seen with the incidents that are ongoing with the MD department of health to this day? Vote no on this bill and S.B.840.

Page 1 Lines 21-22 “Access to the individual’s official state immunization records”

Pages1-2 Lines 23-2 “the ability to voluntarily and securely display on and transmit through a mobile device proof of the individual’s vaccination for Covid-19 using a smart health card QR code”.

Page 2 Line 4 “has a smart health card QR code that is verified as valid under commontrust network requirements for multistate functionality”

Page 2 Line 5 “is compatible with multinational vaccine passport platforms”

SB 839 A Phillips Oppose.pdf
Uploaded by: Amanda Phillips
Position: UNF

SB 839

Oppose

Dear Senators of the Finance committee,

I am writing to express my concerns about SB 839 *Maryland Voluntary COVID-19 Vaccine Passport.* I value medical privacy, and don't want the state to have access to an individual's vaccination records. The language in the bill says voluntary use, but it leaves the door open to be changed to required or mandatory in the future. There have been numerous data breaches, even as recent as December 2021, at the Maryland Department of Health.

I shop at small Maryland businesses for 50% of my family's needs, from meats, chicken feed, honey, building supplies, lumber and produce. We go to local farms and vendors as I want to support those in my direct community. If a vaccine passport is required, my support will end, which will hurt both my family and those I support.

If we've learned anything these last 2 years, it is how precious our freedom is. We don't want them taken away. I love this state and all that it has to offer. I'm a lifetime resident. However, my husband and I have been considering moving away due to the politics and covid restrictions we've endured.

I request unfavorable report for the bill to ensure continued freedoms for all Marylanders.

Respectively,

Amanda Phillips
St. Mary's County, district 29A

Andreas N. Mayr letter to MD.pdf
Uploaded by: ANDREAS MAYR
Position: UNF

March 1, 2022

TO whom it may concern -

As a lifelong resident of the state of Maryland I vote NO to the following two bills -

SB 0839 - MD Voluntary COVID -19 Vaccine Passport by Senator Rosapepe

SB 0840 - COVID - 19 Response Act of 2022

I, Andreas N. Mayr, a registered voter and tax payer of Maryland, **do not support** these two bills.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Andreas N. Mayr
8856 Horseshoe Lane
Potomac, MD 20854

SB839 - OPPOSE.pdf
Uploaded by: Angela Mogensen
Position: UNF

FROM: Angela Mogensen, Baltimore, MD

Dear Finance Committee Members -

Please accept this as my official request for opposing SB 839. Medical passports of any kind - voluntary or required - are unethical and discriminatory and create a second-class tier of citizen. We do not need any further division in this country and these passports only further divide us and allow discriminatory practices. There is also no scientific evidence that passports keep people "safe". In fact, it is clear that vaccines do not prevent transmission or contraction of COVID. In some of the most vaccinated countries, they are experiencing a record number of cases right now. And, according to Pfizer documents that were released yesterday, there are an alarming number of adverse event reactions documented – more than what was shared with the public.

Additionally, these passports do not take into account any natural immunity that has been acquired and which has been shown to be better and longer lasting than vaccine-induced immunity. https://www.medscape.com/viewarticle/969293

Members of the Finance Committee, I do not want my tax dollars supporting this discriminatory practice or financing the technology needed for these passports. Our elected officials are supposed to be working for us, making our lives better, not harder. But all I've seen over the past two years are officials making decisions out of fear and making things harder for us, and that is unacceptable.

Thank you for taking the time to read this.

Best regards,
Angela Mogensen
Democrat
Baltimore, MD

Testimony.pdf
Uploaded by: Ann Brown
Position: UNF

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion**; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.”

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Vote No for Covid Passport .pdf
Uploaded by: Anna Zambotti
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

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This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Medical or religious discrimination: People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.

Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may

live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

Right to bodily integrity: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are under debate, underpinned by a 'my body, my choice' argument. Persons who wish to decline COVID vaccines are not being offered the same respect for 'my body, my choice'! You can't have it both ways! (The correct way of looking at this is: A woman has the right to bodily integrity and autonomy over her own body. The developing baby in her womb is someone else's body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system

SB839_ Annette Nelson_UNFAV.pdf
Uploaded by: Annette Hibbert Nelson
Position: UNF

SB839 UNFAV Annette Nelson

March 1, 2022

Dear Members of the Senate Finance Committee,

Throughout the Covid-19 pandemic I have been incredibly impressed with how our state, and specifically Montgomery County where I live, have handled the crisis. We have responded with measured, calm, scientific approaches to the situation: shutting down to give us some time to learn about this new virus and support our hospitals, opening back up when things are more settled, requiring masks which clearly help to stop the spread, etc. Our leaders have done a wonderful job with these tough decisions and should be very proud of their efforts.

However, I strongly oppose a vaccine passport. A digital passport does not help us prevent the spread of Covid. The vaccines are a helpful tool people can choose to use, but they do not stop the spread of Covid. According to the CDC website:

The Omicron variant spreads more easily than the original virus that causes COVID-19 and the Delta variant. **CDC expects that anyone with Omicron infection can spread the virus to others, even if they are vaccinated or don't have symptoms.**

And

Scientists are still learning how effective COVID-19 vaccines are at preventing infection from Omicron. Current vaccines are expected to protect against severe illness, hospitalizations, and deaths due to infection with the Omicron variant. **However, breakthrough infections in people who are vaccinated are likely to occur.** People who are up to date with their COVID-19 vaccines and get COVID-19 are less likely to develop serious illness than those who are unvaccinated and get COVID-19.
Source:
https://www.cdc.gov/coronavirus/2019-ncov/variants/omicron-variant.html

Though it is anecdotal evidence, I have personally known about 47 people since November 2021 that have tested positive for Covid. Surprisingly, they were all vaccinated and most were recently boosted. And in every case, they caught it from another vaccinated person, not an unvaccinated person. Thanks to the vaccine they had a mild case, but they did still contract it and spread it to others around them.

If we spend the money to create a digital passport for the state of Maryland, we are wasting critical funds that could be used for other projects. Having a passport will not stop the spread of Covid. We will have sick, vaccinated people allowed to enter businesses, while healthy unvaccinated or those with natural immunity will not be able to.

While I understand the rationale behind this bill, it is simply not going to help stop the spread of Covid. Please oppose SB839.

Thank you for your time,
Annette Nelson, Silver Spring, MD

Export.pdf
Uploaded by: Brian Davies
Position: UNF

Dear sir or ma'am,
Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion**; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

I have taken the liberty of adding a few additional ideas you may consider using in your testimony below:

Medical or religious discrimination: People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/ religious belief.

Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

Right to bodily integrity: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are under debate, underpinned by a 'my body, my choice' argument. Persons who wish to decline COVID vaccines are not being offered the same respect for 'my body, my choice'! You can't have it both ways! (The correct way of looking at this is: A woman has the right to bodily integrity and autonomy over her own body. The developing baby in her womb is someone else's body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

With all sincerity,
Brian Davies

March 1-SB 839 testimony.pdf
Uploaded by: Brian Finglass
Position: UNF

March 1, 2022

To the Honerable Committee members:

Re: My testimony regarding SB 839

Dear Honorable Committee Members,

I am a 63 year old lifelong Maryland resident. I have never been involved politically in my life, but the events of the last 2 years have me very concerned with the loss of freedom, privacy and general rights in the name of public health. Therefore, I feel compelled to get involved and speak out.

I am opposed to any form of health document that will be utilized in any way to restrict participation in the full access to society. This is wrong in so many ways.

- It will serve to divide families, friends, communities and society as a whole. This should be rejected by our public leaders.
- Medical information should be 100% private. I do not want my personal medical information shared with anyone or any machine...only by myself to the doctor of my choosing.
- I feel that the push for digital tracking is the first step towards a society where all of our mobility and transactions are tracked with the associated complete loss of privacy. This has chilling implications and would lead to a society in which we would not have the freedom and privacy that I have enjoyed for my 63 years.

Please do not move forward with this legislation.

Respectfully submitted,

Brian Finglass

SB 839 letter - McDougall - Combined.pdf
Uploaded by: Clifford McDougall
Position: UNF

Senator Rosapepe

Senator King

Senate Finance Committee

Regarding: SB 839 – I Oppose this Bill

Finance Committee,

I am a concerned father and long-time MD resident. I work in Data Center technology and our personal medical data will not be safe with this proposed centralized vaccine passport. Numerous data breaches in recent years have proven that this private medical information at risk of being hacked or exposed.

We continue to learn from reports all over the world that these are not totally safe and effective, the drug companies fight to disclose study data while big pharma has no legal liability for damage they are causing. Please see attached chart showing increased death rates in 2020 correlating with the vaccine rollout. More deaths have been reported from the COVID vaccine rollout than have been reported in the last 30 years of the VAERS data.

The CDC has admitted that the vaccinated can get and spread the COVID virus. Many unvaccinated people have strong immunity and will not spread the virus. Why is this more robust protection not considered but only vaccines designed for the original virus are required?

The vaccine passport concept is flawed and not needed. The pandemic has passed. It would only serve to coerce people into getting vaccinated out of convenience and necessity for travel.

Please see the attached open letter to legislators outlining the risks of vax passports.

I strongly oppose this bill and ask you to vote no and prevent it from moving forward.

Thank you,

Cliff McDougall

For more information watch

https://stopvaxpassports.org/webinar-vaccine-passports-gateway-to-mass-surveillance/

STOP VAX PASSPORTS!

NEWS RELEASE: CPDC and WRWF Issue Letters to Congressional Leaders: Stop Vaccine Passports

For Immediate Release

August 26, 2021

CONTACTS:

For the *Committee on the Present Danger: China*
Hamilton Strategies,
Media@HamiltonStrategies.com,

For *Women's Rights Without Frontiers*
Reggie Littlejohn, 310.592.5722
reggielittlejohn@gmail.com

Beth Harrison, 610.584.1096, ext. 105,
or Deborah Hamilton, ext. 102

CPDC and WRWF Issue Letters to Congressional Leaders: Stop Vaccine Passports

Action Needed to Stop Vaccine Passports not only by the federal government, but also by any state or local government, or by businesses, schools, or commercial enterprises

WASHINGTON, D.C.—The *Committee on the Present Danger: China*, *(*CPDC*)* and *Women's Rights Without Frontiers* (WRWF) today issued letters to Republican members of the U.S. House and Senate calling on these leaders to take every opportunity to speak out against vaccine mandates and passport platforms used to track American's vaccine status to enable or deny access to public venues including grocery stores, restaurants, and even organ transplants, and to support legislation being introduced to defend the civil liberties of Americans who have already recovered from the Covid-19 virus, or those who for whatever reason have declined to get the shots.

A recent National Republican Senatorial Committee fundraising appeal sent August 8 promised Republican leaders would support efforts to stop vaccine mandates and passports now being pushed in New York City and being considered by additional states and cities.

Earlier in August, the Stop Vaccine Passports Task Force sponsored by the Committee on the Present Danger: China and Women's Rights Without Frontiers issued President Biden an Open Letter signed by human rights activists and defenders of the Constitution. President Biden has already mandated vaccines for federal workers, and a similar mandate is looming for the armed forces, as well.

NYC Mayor Bill de Blasio's discriminatory executive order denies unvaccinated citizens access to public facilities and businesses without proof of vaccination. With the advent of formal FDA approval of the Pfizer vaccine on Monday, Aug. 23, President Biden called on businesses and institutions to rapidly move to mandate vaccines for employees and consumers alike.

As we explained in our letter to President Biden and congressional leadership and in a webinar hosted in July, "***the digital platform used by vaccine passports can provide the same totalitarian functionality as that used by the Chinese "Social Credit System." The risks of such a system being abused to deprive the American people of their liberties, livelihoods and possibly even their lives are too great to allow it, or even its precursors, to be introduced here."***

China has instituted a "Social Credit System" that gives it totalitarian control over every person in the nation. This platform tracks and integrates the following aspects of every individual: medical history, social media posts, bank accounts, credit cards, shopping history, internet search history, residence, place of employment, criminal history, facial and gait recognition, network of relationships, religious activities, participation (or the lack thereof) in the "Xi-Jinping thought" app, and real-time physical location.

All this information is fed into a central database and used to issue a "social credit score." Citizens are rewarded or punished, based on these scores. Those with a high score are able to participate freely in society. Those with a low score cannot travel, borrow money, may be fired from their jobs, and may be unable to get their children into school. Those with very low scores, such as political dissidents, can be cut off from credit card use, a big problem in China's increasingly cashless society. Dissidents can be found (and potentially disappeared) in minutes, along with their networks of relationships.

While it may begin with only carrying digital information regarding whether an individual is vaccinated, the rest of the functionality of the Chinese Social Credit System can be integrated into the "Vaccine Passport" system in a matter of minutes. Whether such digital documentation is governmentally issued or produced by corporate sponsors, the practical effect will be to provide a platform that, in the wrong hands, could usher in totalitarianism in the United States.

Today's Stop Vax Passports Task Force letter to Republican members of the U.S. House and Senate calls on these elected leaders to:

- Translate that commitment into legislation by **co-sponsoring a bill that would stop vaccine passports** such as Senator Cruz's "No Vaccine Passports Act" and supporting House bills like Representative Clay Higgins' "Employee Rights and Freedom Act" and Representative Diana Harshbarger's "No Vaccine Passports for Americans Act."

- Utilize every available media platform to educate the public about your determination to stop these totalitarian measures. We fear that your constituents are not hearing about your leadership role in preserving their constitutional rights.

On Monday, former U.S. Secretary of Housing and Urban Development Ben Carson warned on Newsmax, ***"The mandating of vaccines could shape a terrible future. The really important thing here is for us to recognize that this is America that we're living in," Carson said. "This is a place where people came so that they could be free. And the whole concept of mandates, no matter how wonderful you think they are, are opening the door to something that could be pretty terrible in the future."***

* * *

To interview representatives of the Committee on the Present Danger: China, contact Media@HamiltonStrategies.com,
Beth Harrison, 610.584.1096, Ext. 105
or Deborah Hamilton, Ext 102.

To interview Reggie Littlejohn,
contact reggielittlejohn@gmail.com, 310.592.5722.

Share This:

‹ D.C. joins Maryland, Virginia in vaccine mandate for government workers
› Former Professor of Ethics Dr. Julie Ponesse provides essential lesson on courage and integrity

9739
signatures

CLICK HERE TO SIGN THE PETITION

STATE GOVERNMENT POLICIES ABOUT VACCINE REQUIREMENTS (VACCINE PASSPORTS)

Read The CDC Disclaimer

VAERS COVID Vaccine Adverse Event Reports

Reports from the Vaccine Adverse Events Reporting System. Our default data reflects all VAERS data including the "nondomestic" reports.

All VAERS COVID Reports **US/Territories/Unknown**

1,134,982 Reports
Through February 18, 2022

24,402
DEATHS

133,057
HOSPITALIZATIONS

120,552
URGENT CARE

175,921

DOCTOR OFFICE VISITS

9,262

ANAPHYLAXIS

14,157

BELL'S PALSY

4,142

Miscarriages

12,511

Heart Attacks

34,448

Myocarditis/Pericarditis

44,512
Permanently Disabled

5,725
Thrombocytopenia/
Low Platelet

27,811
Life Threatening

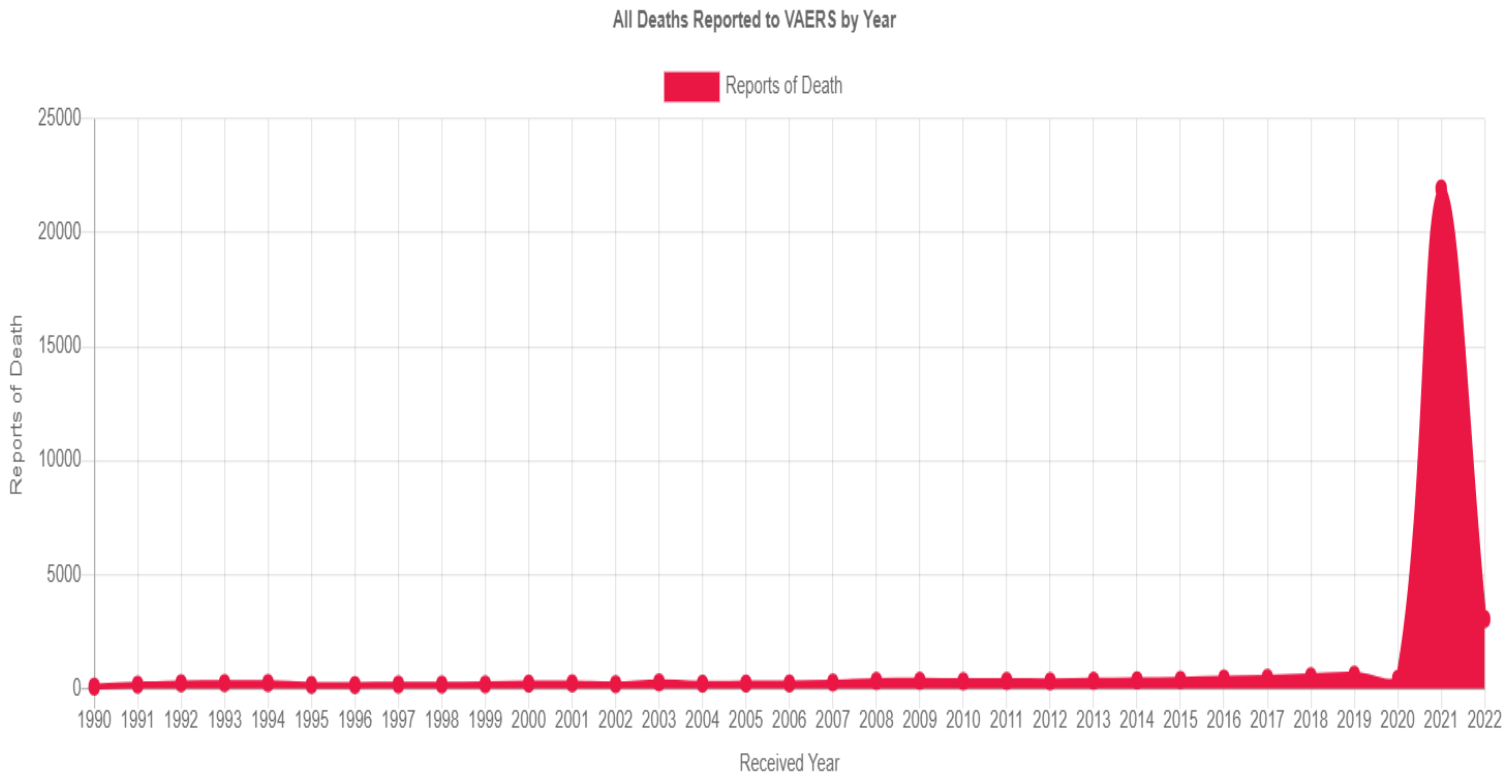
40,123
Severe Allergic Reaction

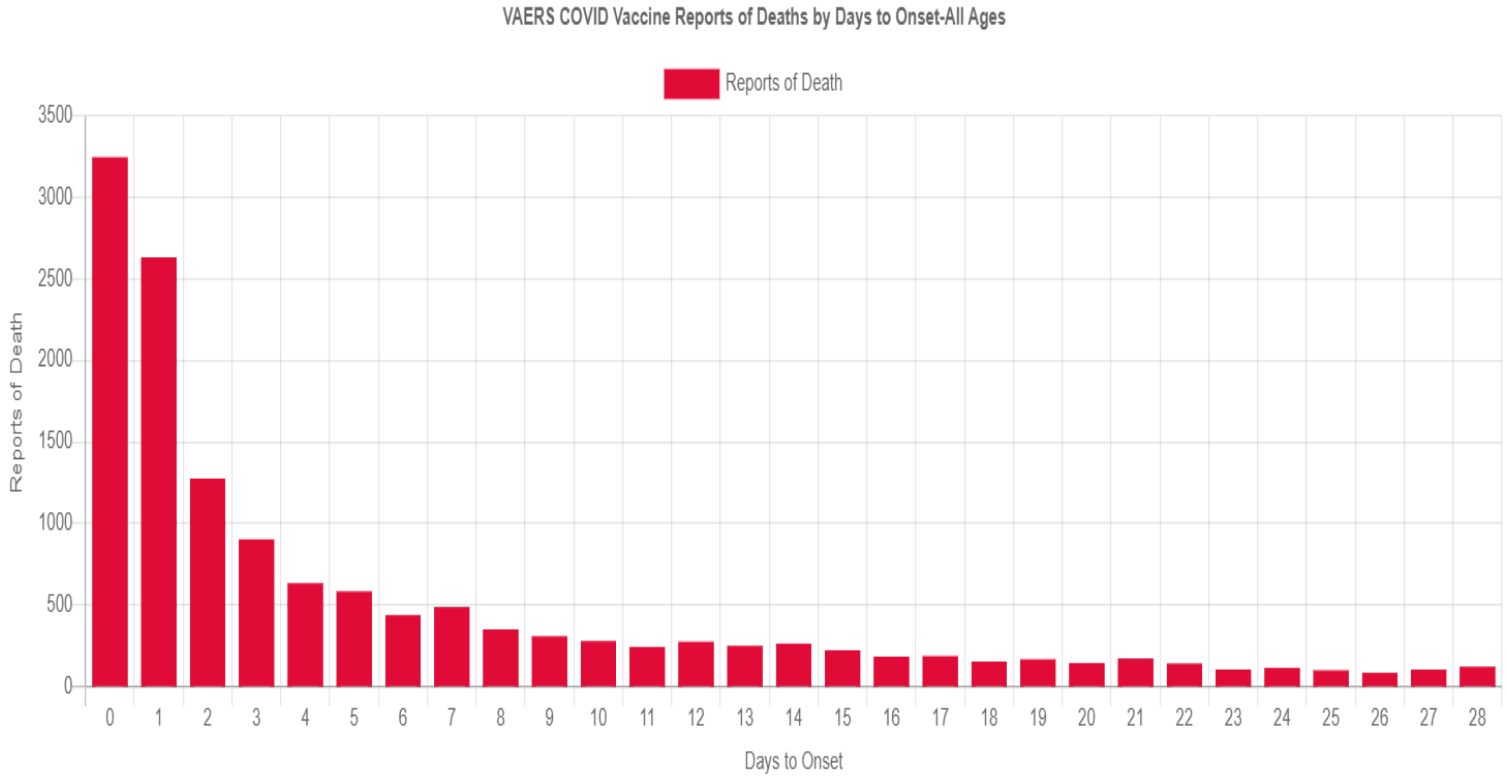
12,566
Shingles

Read COVID Child Reports

Read All VAERS COVID Reports

Read All VAERS Reports





Questions? Comments? Bugs?

info@openvaers.com

Due to the high volume of inquiries, please be patient with response times.

AND PLEASE read the FAQ first.

OpenVAERS is a private organization that posts publicly available CDC/FDA data of injuries reported post-vaccination.
Reports are not proof of causality.

SB839-UNFAVORABLE.pdf
Uploaded by: Crystal Kijesky
Position: UNF

SB839- **UNFAVORABLE**

March 1, 2022

Senators,

I write today to ask you to rule SB 839 **UNFAVORABLE**.

Vaccine passports not only are a waste of financial resources, vaccines have not curbed the spread of Covid-19 infections at all, and safeguarding personal medical information at the state level has recently failed.

Money can definitely be better spent on reducing costs for every day Marylanders trying to buy gas and groceries, or heat their homes. My grocery bill has doubled in the last month. Thankfully, we still have an income. For many that have very low incomes, are retired or disabled, or entry level jobs, this will absolutely break budgets where the choice will be made not just what to eat, but what to do – eat or keep the lights on?

I serve my community at my church's food pantry. We have even less funds to buy groceries to give to those in need. The quantity of families have in increased, and our budget has stayed the same. We do what we can as a church community by receiving donations, but families can only afford so much before they cut back on helping the poor.

Another aspect of this vaccine passport is "prevention of the spread of Covid-19." If you look at the infection curves and hospital visits, it seems as though those vaccinated have had negative outcomes during the Omicron surge this past December and January. The infection and hospitalization rates were highest amongst vaccinated individuals.

I myself became infected after both of my fully-vaccinated parents unknowingly shared the virus with my family. Thankfully we are recovered, but my parents are not and continue to fight to get better.

A vaccine passport would not have stopped this transmission.

My last concern is securing medical data. Back in December, the Maryland Department of Health was compromised. My mother-in-law passed away around this time so I was quite aware. Her medical data was unable to be verified for her death certificate. What happened during the breach? How will a vaccine passport, with so many access points, be able to be secured when we know recovering the information and seeing the damage done to personal information takes much time and financial resources. For as long as there are bad actors, there is risk to private data by unsecured means.

All around, the vaccine passport seems like an unwise decision with regard to resources and outcomes.

Respectfully, I ask that you **oppose** SB 839.

Crystal Kijesky

LaPlata, MD

Covid 19 testimony.pdf
Uploaded by: Cynthia Feldman
Position: UNF

To Whom It May Concern:

The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion**; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Furthermore, there are many religious and conscience objections to taking this kind of inoculation. I submit this testimony as part, but not the entire reason, to the numerous reasons that compel me to be wholly against it.

Cynthia Feldman

Cox.Unfavorable Testimony.SB839 Maryland Voluntary
Uploaded by: Dan Cox
Position: UNF

DANIEL L. COX
Legislative District 4
Frederick and Carroll Counties

Judiciary Committee

Subcommittees
Civil Law and Procedure
Family and Juvenile Law

Task Force to Study Crime Classification and Penalties

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

The Maryland House of Delegates
6 Bladen Street, Room 326
Annapolis, Maryland 21401
410-841-3288 · 301-858-3288
800-492-7122 *Ext.* 3288
Dan.Cox@house.state.md.us

March 2, 2022

Unfavorable Testimony, SB839 Maryland Voluntary COVID-19 Vaccine Passport

Chair Kelley, Vice Chair Feldman and committee members:

SB839 is setting up a wholly new passport system in the declining days of the covid outbreak. This action is contrary to the movement of the entire country.

New York Mayor Eric Adams is rolling back New York City's COVID-19 vaccine passport requirements on March 7th, and announced, "Yes. I can't wait to get it done," according to the New York Post.

The risks and problems with this proposal are so numerous they overwhelm.

Let's start with the idea that this is a voluntary thing. Why would it be necessary for such a vaccine passport to be set up by the state of Maryland if it's voluntary? Couldn't any app company develop and market it for those wanting to have one? People could sign up, put their medical information in it and show it to anyone who wants to see it. As long as it is voluntary it is in the realm of private business. But why make it available through the State?

There is only ONE REASON this would be done by the state of Maryland. Because when the state wants it to be involuntary, or MANDATED, only the State has the power to make that happen, and it will have the full structure already there and ready to go.

So, if this passes you can ***expect*** that either in this pandemic or the next, Maryland ***will mandate*** vaccine passports be used to participate in Maryland society. That means you will not have a choice of whether to be vaccinated or not. Whether you have religious, philosophical, health or legal issues with any part of the process, you will either be vaccinated or not be allowed to participate in society.

So, to all of the communities who hesitated to take the current vaccines, including our minority communities and our religious community, **this can only be seen as an attack on you.**

Even MSNBC shows concern over vaccine passport flaws. In Tiffini Li's column "The Risks of Covid 'Vaccine Passports' are Scarier than You Might Think" she cautioned "they don't solve the glaring problem of vaccination inequality, and, perhaps most dangerously, they risk reinforcing a system of haves and have-nots when our poor and marginalized communities are already suffering disproportionately in the pandemic."

Li's MSNBC column goes on to highlight other problems, "Vaccination verification systems can collect and store the sensitive personal and health information of potentially millions of people. At minimum, a vaccine passport app will have to include personal information such as your name and contact information, as well as at least enough medical information to confirm that you have been vaccinated. To verify that information, a vaccine passport app is likely to have to interface with state vaccination registration databases or with medical records from health care providers. Any app that collects this much information is ripe for abuse... Furthermore, there are no guarantees of how user privacy will be protected. There are few legal limits to what data a vaccine passport app could collect, *and things get complicated if people feel forced to use the apps to re-enter society*…. Even if a vaccine passport app suffered a major breach, consumers have legal rights in most states to be notified about data breaches only if leaks include financial information or Social Security numbers." (Emphasis added)

This nation felt strongly enough about the privacy of our individual health information that the federal government set up prohibitions via HIPPA laws that prevent those in medicine from sharing our health information. But, we are okay with handing this same information over to app companies who already abuse other personal information data collection privileges?

I am surprised that Sen. Rosapepe would bring a bill to this distinguished body that has the dangers this bill presents. Sen. Rosapepe isn't just a Senator and an investor, he was a United States Ambassador. Has it been so long ago that former Ambassador Rosapepe served in Romania and saw the destructive impact of population control? Has he forgotten how easily a population can be controlled by an oppressive government and how difficult it is to bring freedom back to that population? Sen. Rosapepe isn't just a Senator, an investor and a former Ambassador, he's also an author. Why would the man who co-wrote with his wife, **Dracula Is Dead: How Romanians Survived Communism, Ended It, and Emerged since 1989 as the New Italy**, be creating what could so easily be turned into a means to control the Maryland population and his own constituents?

Does SB839 have more to do with investments than supposed population protection? Companies that make covid testing and vaccinations are heavily benefitting from widespread government mandates and contracts. As the threat of covid fades into the background some companies may not want to see their hefty government contracts also fade. This app and its developers would certainly continue to benefit from covid and future health scares.

Who will benefit from the ongoing use of this app if the state passes its supposedly voluntary use? Investors and its corporate owners will. It won't be the general population that benefits. The

Maryland taxpayer will foot the bill, while its investors benefit financially. Maryland residents will bear the brunt of security and data breeches while investors and company developers will benefit from the personal information voluntarily, but unknowingly, handed over to them.

There is no upside to this bill, except for those who will make money from the app. For everyone else it is a slippery slope down.

I respectfully ask for an unfavorable report on SB839 Maryland Voluntary COVID-19 Vaccine Passport.

Respectfully,

Delegate Dan Cox, District 4
Frederick and Carroll Counties

Daniela DOrazio Testimony SB0839 0840 .pdf
Uploaded by: Daniela D’Orazio
Position: UNF

Unfavorable Testimony, SB839 Maryland Voluntary COVID-19 Vaccine Passport

Chair Kelley, Vice Chair Feldman and committee members:

My name is Daniela DOrazio and I am Romanian American citizen that loves freedom.

I strongly oppose SB 839 and SB 840 because both bills reflects **discrimination, government control, surveillance and an attack on one's physical and mental health.**

SB839 is setting up a wholly new passport system in the declining days of the covid outbreak. This action is contrary to the movement of the entire country and some European countries.

Bill sponsor Senator Rosapepe was the United States Ambassador of Romania. I am surprised that Sen. Rosapepe would bring a bill to this respected body that has the dangers this bill presents. Has he forgotten how easily a population can be controlled by an oppressive government and how difficult it is to bring freedom back to that population? I grew up in Communist Romania and was shot at twice during the Revolution, so I understand how valuable freedom is.

The risks and problems with this proposal are so numerous they overwhelm.

Let's say that COVID-19 vaccine passport is a voluntary thing **than why is the state involved? Is it because when the state wants it to be required, or MANDATED it will have the full structure already there and ready to go?**

As a survivor of Communism, **I ask you to mandate freedom and not vaccine passports**. **Our medical information should be private and not used to divide and segregate the population into vaccinated and unvaccinated.**

Moreover, Covid is NO longer a threat but we do have a pandemic of mental illness. Eight students in Montgomery County MD died to suicide, overdose and homicide in the last two months, yet thankfully no child died of Covid in two years. Please spend our tax dollars on mental health treatment and not useless passports and contact tracing for a now endemic virus.

My Covid recovered husband was forced to get vaccinated to keep his job. Hours after vaccination he spiked a 103 fever,crucial migraine and **was referred immediately to the emergency room with stroke symptoms**. **The next Covid shot could kill him.**

School children are in constant fear of getting traced and missing 5 to 10 days of school with no academic support and therefore add additional anxiety and depression that could lead to suicide.

Covid is NO longer a threat but WW3 is knocking in our doors so Please retract both bills right here right now and make history as a Senator that gave people freedom of choice over one's own body without external domination or duress in the last days on potential peace on earth.

This nation felt strongly enough about the privacy of our individual health information that the federal government set up prohibitions via HIPPA laws that prevent those in medicine from sharing our health information. But, we are okay with handing this same information over to app companies who already abuse other personal information data collection privileges?

Companies that make covid testing and vaccinations are heavily benefitting from widespread government mandates and contracts while people are dying from vaccine side effects or lost of jobs if chose to not bee part of this experimental injection.

SB 839 and SB 840 is an attack on our freedom and privacy I respectfully ask to oppose it.

Respectfully,

Daniela D'Orazio

vaccine passport objections.pdf
Uploaded by: Dean Harding
Position: UNF

Dear Legislators,

We don't trade essential liberty for temporary safety! This principle must be understood and enforced by all government officials or they will enslave the very people they are supposed to protect and serve.

All the recent covid policies failed, taking away peoples' rights. Let's admit our mistakes and learn from them. Let's not move forward down the same path. The people already distrust the government more than ever. Do you think they are asking you for more restrictions? Do you think they are asking for a system that can tell them where they can go and what they can do? Do you think they want to have to carry "papers please" or a mobile phone in order to get access to goods and services? Who is asking for this vaccine passport? It's not the citizens. It seems more in alignment with the World Economic Forum's Great Reset plan and the big players exploiting the CVID crisis.

The revolt is all around you. Can you not see it? Can you not see the people rising up and saying we're not going to take it anymore?

The vaccine mandates are being forced upon us to give vaccine passport systems a purpose. There is no need for a
vaccine passport system without vaccine mandates. Vaccine passport systems are nothing more than digital human
control systems. The US goverment has already asked Mitre corporation to build a vaccine passport system.
Since these systems take away freedom, the government needs some type of big scare (like a pandemic) to justify them.
Vaccine passport systems are simply another type of social credit score system in disguise (like the one China deployed).
This is all
part of the globalist World Econonic Forum's Great Reset plan, which defines the next version of how humans will live
(A New World Order, the next version of human slavery). If you want to keep your freedom, it is up to all of us to
speak out NOW against vaccine mandates and vaccine passports. Once vaccine passports are instituted, they will gradually
be adapted to enforce other mandates in society. There will be no way to stop it. Imagine having to own and carry a
mobile phone in public, having a digital tattoo or microchip in your skin so that you can show your vaccine passport
and get permission to do things! That's where we are heading unless we all do something to stop it. This is already
being implemented throughout other test countries. Mass protests and revolts are occurring (but the mainstream media
isn't showing that).

In order to sneak vaccine passports into public acceptance, we will call them "voluntary" to make them sound harmless. But this is just a trick because to take away peoples freedom. You need to build the core infrastructure behind the peoples back without them knowing it. Otherwise, they would never accept it. That's what

this bill will do. It will open the authoritarian doors wider. It will start the process. It will begin building the infrastructure. It will train the brainwashed people to comply because they don't know any better and blindly trust their government. It's your job to protect the people from these con games.

Besides the above, I also strongly believe in the principles below.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.”

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Medical or religious discrimination: People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.

Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

Right to bodily integrity: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are

under debate, underpinned by a ‘my body, my choice’ argument. Persons who wish to decline COVID vaccines are not being offered the same respect for ‘my body, my choice’! You can’t have it both ways! (The correct way of looking at this is: A woman has the right to bodily integrity and autonomy over her own body. The developing baby in her womb is someone else’s body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let’s use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

Sincerely,

Dean Harding

Petro_Testimony_SB0839_20220302.pdf
Uploaded by: Ed Petro
Position: UNF

Petro Testimony SB0839
02-March-2022

This testimony is to share my unfavorable views of SB0839: Maryland Voluntary COVID-19 Vaccine Passport and ask that the Senate vote to NOT pass this legislation.

Forcing or coercing someone in any way to take a vaccine or any medication is immoral and violates international statutes, specifically the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion;** and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and still are experimental. Each person should have the option to choose whether to take the vaccine or not. Regardless, each person must have the right to accept or refuse the vaccine without any coercion or penalty.

Medical or religious discrimination: People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it is not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.

Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

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womb is someone else's body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

Little Justification for Mandating Vaccinations: If the COVID-19 vaccinations are as effective as advertised, then everyone who has been vaccinated can be assured of protection against the virus. The virus has spread via both vaccinated and unvaccinated persons. Those who have chosen to be protected, have been vaccinated. Requiring a 'vaccination passport' will not add to the protection of vaccinated persons; it will only serve as a Yellow Star to single-out those who choose to follow their conscience about vaccinations. This singling-out will yield no value to society, but only make some individuals clear targets for discrimination and derision.

Thank you for considering my testimony. I ask that the Senate vote to NOT pass SB0839: Maryland Voluntary COVID-19 Vaccine Passport.

Sincerely,

Ed Petro
Ijamsville, Maryland

SB839_ElizabethStanford_unfav.pdf
Uploaded by: Elizabeth Kampororo
Position: UNF

SB839
UNFAV
Elizabeth Stanford

I am strongly opposed to SB839.

If the purpose of the vaccine passport is to corral COVID-19 and minimize the spread, the vaccine has proven ineffective with the latest variant. Given that the vaccine is not curbing the spread of COVID-19, proof of vaccination would be irrelevant.

Moreover, requiring businesses to check a passport would come with a higher cost of doing business while diminishing the potential pool of patrons. Why would a business open in Maryland if they could open in a state without these restrictions? Furthermore, businesses currently operating in Maryland would have a strong incentive to relocate outside of Maryland if SB839 were to take effect.

Now more than ever, we need to heal our state, economically and communally. We need to set aside legislative initiatives that no longer apply.

Please vote against SB839.

testimony opposing SB 839- 2022.pdf
Uploaded by: Emily Tarsel
Position: UNF

Emily Tarsell, LCPC, LCPA

2314 Benson Mill Road
Sparks, Maryland 21152
March 2, 2022

Oppose SB 839

Chairwoman Kelley and Committee Members, I am Emily Tarsell, founder of Health Choice Maryland, a grassroots non profit with hundreds of Members from all stripes and all walks of life across the state. We are united by our belief in our right to health choice, informed medical consent, parental rights and science based information for informed medical decisions. We care about health, both individual health and public health. But SB 839 is detrimental to both.

SB 839 conveys the illusion that those who received the Covid 19 vaccine are a special class who deserve admission to certain venues which should be denied to the unvaccinated. The false assumption is that the vaccinated present no public health risk while the unvaccinated do. But even the CDC has said that the vaccinated can both get and spread Covid virus whereas those unvaccinated with natural immunity do not reinfect or spread the virus. The CDC has also said that COVID 19 is long gone and the vaccine is not very effective against the dominant variant Omicron which is also almost gone. **Proof of vaccination is meaningless because COVID 19 is gone as is the efficacy of the vaccine.**

This bill is grossly misleading in terms of any individual or public health benefit. In fact, recent data from public health agencies attached below shows that one becomes **more vulnerable** to viral infection as the number of COVID jabs received increases. There are also known serious vaccine side effects such as blood clotting, neurological disorders and heart inflammation. I have family and friends who experienced serious adverse reactions to the still **experimental** COVID vaccines. **Therefore the right to chose to vaccinate or not must remain a free choice without stigmitization, discrimination or penalties.**

Finally there is the significant potential for cyber hacking of one's electronic health records and/ or invasive governmental overreach regarding private health information. We recall just recently a security breach in the public health department through hacking.

Vaccine passports have been withdrawn in other countries like the UK and other states for good reason. Vaccine passports are unnecessary and would be a total waste of public funds which could be used more productively elsewhere. **Please veto SB 839 - an unnecessary and divisive bill.**

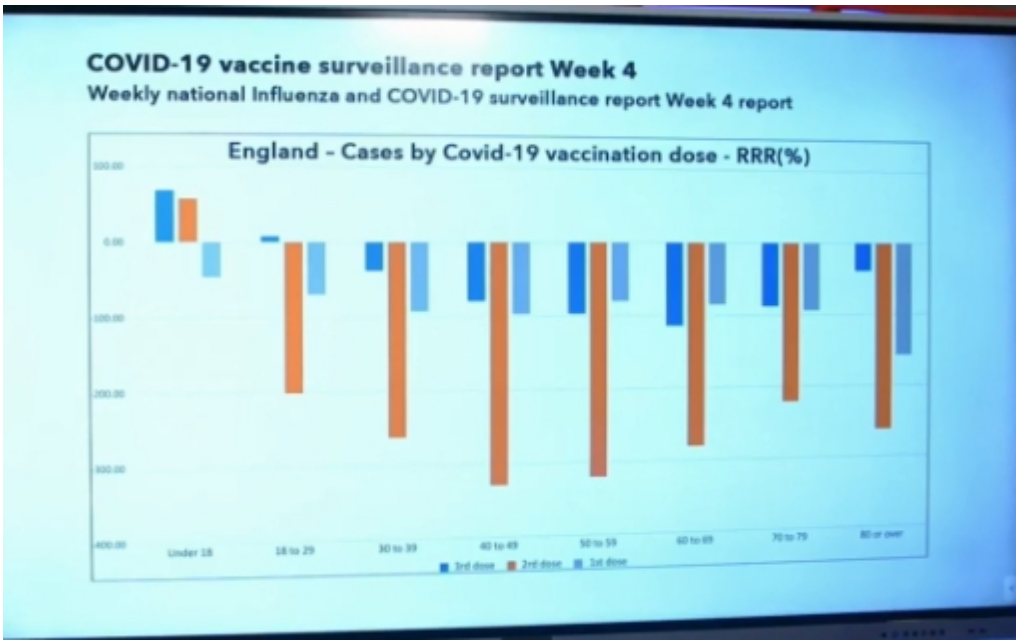
Thank you.

Emily Tarsell

Week	Unvaccinated			1 Dose		
	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals	No. tested positive by PCR	Population	Age-standardised case rate per 100,000 with 95% confidence intervals
18 December - 24 December 2021	5,594	1,006,025	**540.82** (518.55 - 563.08)	1,860	357,752	**780.31** (733.17 - 827.45)
25 December - 31 December 2021	9,496	998,045	**958.52** (926.37 - 990.68)	3,387	348,727	**1,409.70** (1,347.89 - 1,471.51)
01 January - 07 January 2022	9,105	988,033	**923.27** (893.85 - 952.70)	3,066	341,481	**1,393.46** (1,325.60 - 1,461.32)
08 January - 14 January 2022	3,601	979,617	**412.77** (390.36 - 435.18)	1,093	340,151	**543.98** (497.93 - 590.03)

The above table is taken from that recently published by Public Health Scotland. It compares positive cases of Omicron per 100,000 among those who are Unvaccinated and those who were Vaccinated. It clearly shows that the vaccinated have a higher rate of Omicron infection than the unvaccinated.

The chart below is from recent data from the UK. It shows the rate by age category of Omicron cases in the vaccinated depending on the number of COVID vaccine shots received. The bar graphs show sequential doses in the order 3rd dose, 2nd dose, 1st dose. It clearly shows not only waning efficacy but actual NEGATIVE efficacy. That means that one is more likely to get Omicron if one is vaccinated and vulnerability greatly increases after the second dose. There is some benefit initially in the under 18 group because they just got it. But that benefit will also likely wane and actually make the recipient more vulnerable to the variant as suggested by the other data.



Opposing SB839.pdf
Uploaded by: Eszter Szabo
Position: UNF

OPPOSE Senate Bill 839

Eszter Szabo
7608 Cayuga Avenue, Bethesda, MD 20817
March 1, 2022

I would like to talk about my personal experience growing up in Hungary with respect to the proposed MyIR digital vaccine passport for displaying COVID-19 EUA vaccination information in this bill. As you know till 1990 Hungary was a socialist country. Citizens there had only limited access to products, services, information, technology as well as travel outside of the former Soviet Bloc. We could only apply for a visa to the West once every three years.

Most people know that in 1990 the Berlin Wall separating East and West Europe fell down which ended a system that brought limitations to half of Europe's citizens. Few however know that in 1989 Hungarians were on the streets peacefully protesting for more freedom and ending a socio-political system that limited people's individual rights as well as freedom to travel. I first came to the USA in 1990 after travel opened up for the citizens in the Eastern Bloc.

In the USA and in Western Europe I found a system much freer and with a wide variety of choices and I would have never imagined that in 2022 we would be talking about a digital system that keeps track of, and allows just about anyone to see an individual's health record which is a personal private information, and that based on such record, some would be limited to access certain services in Maryland. Establishing such a vaccine passport de-facto starts segregation of people in society and limits access to services. It invites discrimination based on one's health choices as well as possible disabilities, turns vaccinated and unvaccinated against each other, and turns a door-keeper at a business against its potential customers. This should never take place. Would we want to create violence in society via such pass? One only needs to look at Canada to know that is a bad idea.

Moreover, vaccine passports have failed all over the world. Washington, D.C. gave up on vaccine requirements to access businesses after 2 weeks and New York just scrapped its vaccine pass system as well. There are many reasons why these passes failed. First, Covid 19 is over. Second, the Covid 19 vaccine is not stopping transmission of Sars-COV 2 thus there is no scientific reason to institute such passport and segregate people based on that vaccine. Third such system allows for unprecedented surveillance, privacy breach, data collection, censorship, discrimination and control over people. Little tyrants, as many of us experienced such practices during the last two years, base hiring or employment decisions on such vaccine record. This is unconstitutional and creates such havoc in the economy and in one's life which shouldn't be even thought of. Lastly, creation of this platform would need to be financed out of taxpayers' money which could be used much better somewhere else. There is no reason to fund such platform.

I respectfully ask that you vote against this Bill.

SB 839 Against.pdf
Uploaded by: Gwenn Murray
Position: UNF

SB 839 Against

Gwenn Murray

706 Cypress Road

Severna Park, MD 21146

While the title of this bill is Maryland Voluntary Covid–19 Vaccine Passport, make no mistake that once this technology is approved for use in Maryland, it will enable Maryland to become a Covid passport state. This technology, promoted by Big Tech and Big Pharma, will facilitate government overreach which is inappropriate in a free society. This technology also has the very real potential to impact many aspects of life for all citizens in Maryland. With the implementation and utilization of vaccine passports, individual privacy will be compromised. Additionally, it is a precursor to digital identity which will facilitate a digital surveillance apparatus for the government. As a result, vaccine passports and digital id's can force compliance in any area of life.

If you accept vaccine passports, you are essentially giving consent to what may come as a result of its implementation. As a country that was founded on freedom and individual rights, should we NOT be legislating tools that can very easily be used to take away the very rights and freedoms that we cherish as American citizens.

Opposing Bills SB0839 and SB0840.docx.pdf
Uploaded by: Hind Walker
Position: UNF

Good day to all,

I am writing as a Maryland resident of Carroll County to request these two bill be withdrawn as soon as possible because they infringe upon my individual liberties and those of my family.
To Everyone,

SB 839- The bill proposes using mobile technology to implement an immunization record "service" called MyIR. This vaccine passport would display COVID 19 vaccination status allegedly for admission to certain venues.
It would furthermore use tax payer money to develop and promote this outrageous and unnecessary "service".

https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0839

Why I oppose this bill:

1.One's medical information is one's own business and should not be used to discriminate and segregate citizens based on vaccine status.
2. No business should be discriminating who can or cannot use their service based on COVID or other vaccination status especially vaccines that are still only Emergency Use Approved.
3.The CDC itself has said that the vaccinated can both get and spread COVID virus. Many unvaccinated people have natural immunity which is cross protective, enduring and a benefit to the public.
4.One's medical information should be protected information but we have seen repeatedly that "protected" information can be hacked.
5.Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy and health choice.
6.Public funding would be used to develop and market an unecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness and control.

SB 840-
This bill was originally passed last year as Emergency Use Authorization that was supposed to expire at the end of this year. This bill extends to 2024 emergency use authorizations that are no longer required! Furthermore it expands the authority and reach of administrators regarding testing, contact tracing and protocols in multiple settings to "control" COVID 19, a virus that no longer exists! The bill is allegedly to be able to reopen schools, colleges and workplaces which are already open.

But there are even more egregious things in this sweeping bill which talks about the vaccine passport structure mentioned in SB839 as though it were already law. The bill talks about incentivizing vaccine uptake of ANY CDC recommended vaccine now or in the future. How can

we possibly know if that is a good idea when we don't know what the risks and benefits might be? And every parent should be outraged that the bill wants to allow a PHARMACIST (or his delegated assistant) to have the authority to ORDER and ADMINISTER a vaccine to a child 3 or older and does not even require parental informed consent!

There is more in this egregious bill that is way too broad and includes everything from qualifications for an apprentice geriatric nurse assistant to rates for an Urgent Care Center. What have these things got to do with each other?
https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0840

Why I oppose this bill:

1. We oppose any vaccine passport as our medical information should be private and not used to divide and segregate the population into vaccinated and unvaccinated.
2. Vaccine passports have been withdrawn globally
3. Pharmacies are not doctor's offices and pharmacists (and their assistants) are not doctors. They should not have the authority to ORDER and vaccinate our children even more so without parental or guardian informed consent.
4. This bill was originally intended to expire by the end of 2022 and it should expire. It was an emergency use bill intended for a pandemic which has passed. The authorizations given in the original bill should expire as intended.
5. The bill is a mishmash of all kinds of unrelated things from listing the qualifications for certain practictioners to rates for an urgent care center to tracking, testing and funding for a virus that no longer exists. Each of these things should be considered separately with thoughtful debate, not thrown together in a bill that is too far reaching.

I came to this country for freedom and equality. I am saddened and worried about the government over-reach that has been taking place over the past 2 years. This started our because of Covid and is now continuing for no valid reason. This has to stop

testimony_against_SB0839.pdf
Uploaded by: J Laird
Position: UNF

Whether you are in favor of vaccinations or not, people should not be required to have a foreign substance injected into their body to live normal lives. If the vaccines are very effective, then those vaccinated have nothing to fear from the unvaccinated.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

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Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

Right to bodily integrity: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are under debate, underpinned by a 'my body, my choice' argument. Persons who wish to decline COVID vaccines are not being offered the same respect for 'my body, my choice'! You can't have it both ways! (The correct way of looking at this is: A woman has the right to bodily integrity and autonomy over her own body. The developing baby in her womb is someone else's body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give

informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

Maryland-OPPOSE SB839 Maryland Voluntary COVID-19
Uploaded by: Jacquelin Zubko-Cunha
Position: UNF

OPPOSE

SB839-Maryland Voluntary COVID-19 Vaccine Passport

Jacquelin Zubko-Cunha, Gaithersburg, MD

I urge you to oppose SB839. Vaccine passports are unscientific and not supported by the current scientific evidence. The studies below in relation to the COVID vaccinations should make decision makers question their assumptions that the vaccinated can be excluded as a source of transmission. It is also negligent to ignore the vaccinated as a source of transmission when deciding about public health control measures.

-An article in Lancet Regional Health EU highlights that high COVID-19 vaccination rates have not reduced transmission of SARS-CoV-2 in populations by reducing the number of possible sources for transmission and thereby reduced the burden of COVID-19 disease. Recent data indicates that the epidemiological relevance of COVID-19 vaccinated individuals as a source of transmission is increasing, as there are fewer unvaccinated and more people are naturally immune. (The epidemiological relevance of the COVID-19-vaccinated population is increasing. Günter Kampf, LETTER| VOLUME 11, 100272, DECEMBER 01, 2021.)

-Another paper out of the UK shows that fully vaccinated individuals with breakthrough infections have peak viral loads similar to the unvaccinated, and that fully vaccinated individuals can efficiently transmit infection in household settings. (Community transmission and viral load kinetics of the SARS-CoV-2 delta (B.1.617.2) variant in vaccinated and unvaccinated individuals in the UK: a prospective, longitudinal, cohort study. Lancet Infect Dis. 2021.)

-In yet another report by the Robert Koch Institute, it was shown that In Germany, the rate of symptomatic COVID-19 cases among the fully vaccinated ("breakthrough infections", reported weekly since 21, July 2021) was 16.9% at that time among patients of 60 years and older. This proportion has increased weekly and was 58.9% on October 27, 2021. This provides clear evidence of the increasing relevance of the fully vaccinated as a possible source of transmission (Robert Koch-Institut. Wöchentlicher Lagebericht des RKI zur Coronavirus-Krankheit-2019 (COVID-19). AKTUALISIERTER STAND FÜR DEUTSCHLAND July 22, 2021.)

-In the UK, a similar situation shows among citizens of 60 years or older, the fully vaccinated accounted for 89.7% of the SARS-CoV-2 cases versus 3.4% among the unvaccinated (UK Health Security Agency. COVID-19 vaccine surveillance report. Week 4328. October 2021.)

-A report out of Israel reports a nosocomial outbreak involving 16 healthcare workers, 23 exposed patients and two family members. The source was a fully vaccinated COVID-19 patient. The vaccination rate was 96.2% among all 248 exposed individuals (151 healthcare workers and 97 patients). Our of the 248 people, fourteen fully vaccinated patients became severely ill or died, and two unvaccinated patients developed mild disease (Nosocomial outbreak caused by the SARS-CoV-2 Delta variant in a highly vaccinated population, Israel, July 2021. Euro Surveill. 2021; 262100822.)

Vaccine passports are also unethical and not supported by the public. Allowing businesses and organizations to VERIFY status for entry is DISCRIMINATION, both religious and medical, as well as to those that are socioeconomically disadvantaged. Such a move will have real and lasting social and

economic consequences to any state, county, down to individual families. There are real privacy concerns as well with Maryland's health data recently compromised. Creating an internationally compatible system of this kind would only make Marylanders' private health information more vulnerable.

Furthermore, endorsing the discriminatory practice of vaccine passports and financing the needed technology is unacceptable and fiscally irresponsible. This legislation will have a huge financial burden on the state and may cut into funding that could be used for critical health initiatives.

Thank you for your time and consideration. Jacquelin Zubko-Cunha

Copy of Written testimony for HB0839. .pdf
Uploaded by: Jaime Brooke
Position: UNF

Written testimony for HB0839.
Jaime Brooke

I am a registered democrat living in West Laurel (20707), and I oppose HB0839.

I am strongly opposed to this bill for many reasons, but mainly the fact that it deals with starting a digital V passport for the state of Maryland. This is not only a violation of privacy, but a huge expense that I feel is not necessary. There are so many other areas where this money could be going: keeping our children safer and well prepared in schools, environmental initiatives, housing/community initiatives for impoverished neighborhoods (especially for youth and young mothers). Also, the Maryland Health Department had a breach/data was compromised just recently this year. I do not feel comfortable with my health information (and especially my vaccination status) on my phone. I know it says "optional", but we know that this can open doors that shouldn't be opened. A passport will do nothing to stop the spread of Covid (we know this now). This will lead to healthy unvaccinated individuals who are not carrying the virus, or have natural immunity from a previous infection will be discriminated against like they have been over the last year. New York, who has a passport system is now dropping the passport. We need to follow the science and protect the privacy and health decisions of Marylanders.

Medical decisions have always been private, and respected. This should remain. Please VOTE NO on HB0840.

Thank you,

Jaime Brooke
6605 Weaver Court
Laurel, MD 20707

OPPOSE SB0839.pdf
Uploaded by: James Elbourn
Position: UNF

SB839 – WITHDRAW!

Hello, please withdraw this bill. It is hard to believe we have come to this in our country. This is un-American. My medical status is my business and should not have any relevance to serve as an access card to services, as I can already see happening in certain states. We DO NOT WANT THIS HERE!

Thank you.

Sincerely,

James Elbourn
D33

SB0839 OPPOSE Helms, James Jr.pdf
Uploaded by: James Helms Jr
Position: UNF

UNFAVORABLE/OPPOSE

SB0839

James Helms Jr

Capitol Heights, MD

I oppose the passing of SB0839. Many individuals choose not to be vaccinated for religious reasons. While I assume that the majority of this bill's supporters are innocent of any malicious motives, a passport system for vaccines posses a serious threat to those who declined the vaccine. It could potentially become a form of "Jewish Star" to point out the "others" or those who are noncompliant with the dominant worldview of the times. In fact, many who declined vaccination are members of devout Jewish sects and practices. Given the metrics, I do not see an emergency that justifies the risks involved with this bill.

SB839.pdf
Uploaded by: Janet Stann
Position: UNF

Vaccine passports are a waste of financial resources and do not curb the spread of infection. I am opposed.

testimony_against_SB0839.pdf
Uploaded by: jasraj joglekar
Position: UNF

Whether you are in favor of vaccinations or not, people should not be required to have a foreign substance injected into their body to live normal lives. If the vaccines are very effective, then those vaccinated have nothing to fear from the unvaccinated.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Medical or religious discrimination: People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.

Weakening of medical privacy: Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

Future implications: COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

Right to bodily integrity: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are under debate, underpinned by a 'my body, my choice' argument. Persons who wish to decline COVID vaccines are not being offered the same respect for 'my body, my choice'! You can't have it both ways! (The correct way of looking at this is: A woman has the right to bodily integrity and autonomy over her own body. The developing baby in her womb is someone else's body. Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give

informed consent apart from coercion.)

Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

MD Bills.pdf
Uploaded by: Jeff Wall
Position: UNF

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Potential for Misuse of the MyIR Mobile app: Like any app, this one is subject to technological failure and hacking. Let's use caution before mandating it. Additionally, while it is currently being used and proposed to track vaccination records, its use could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government and the development of a Communist-style social credit system. Please review the work of Reggie Littlejohn to learn more about this.

Jeff Wall

SB 839- OPPOSE.pdf
Uploaded by: Jenna Butler
Position: UNF

SB 839
OPPOSE

Updating the MyIR Mobile platform to expand its usefulness as a "voluntary vaccine passport" is an outrageous proposition. According to the fiscal and policy note, this would cost MDH close to 3 million dollars, and it would take 12-18 months for the work contract to even be awarded. As we are even now seeing the rollback of vaccine passports- because they are not useful, they are burdensome for businesses, and extremely unpopular with the public- committing the state to such a large expense is not sound policy. Further, especially given the recent situation with Maryland's health data and systems being compromised, this concept is a huge privacy and security risk.

Respectfully,

Jenna Butler
Annapolis, MD

SB839_Jennifer-Rauhofer_Unfavorable.pdf
Uploaded by: Jennifer Rauhofer
Position: UNF

SB839
Maryland Voluntary COVID-19 Vaccine Passport
Jennifer Rauhofer
Unfavorable

Since the inception of the COVID-19 vaccine, we have learned a lot. We have learned that having a vaccine does not stop transmission of the virus or prevent the person from getting the virus. Additionally, we know that vaccines have waning effects. So why would we waste our precious state fund on a system that is meaningless. These funds should be spent on our future, our children, our school systems. Not something that has already been proven to be meaningless.

A passport will do nothing to stop the spread. In fact, it can actually do the opposite because vaccinated people who are positive for the virus can gain entry to establishments, while healthy unvaccinated people with natural antibodies and immunity may be discriminated against.

The data has shown that the actual risk of COVID-19 varies greatly for different sectors of the population. I am grateful for the availability of the vaccination for more vulnerable portions of the population. However, to encourage a passport that may lead to a blanket use by establishment for everyone based on one risk segment is misguided.

I urge you to consider the long-term ramifications of encouraging a program, even if it is voluntary, that can discriminate against a portion of the population which can cause real social and economic consequences. Please follow the science like you have been saying throughout the pandemic and don't get lost in the one size fits all category for vaccinations and requiring proof.

SB0839 Jessica Helms OPPOSE.pdf
Uploaded by: Jessica Helms
Position: UNF

OPPOSE SB0839

I OPPOSE SB0839. This bill is unnecessary, costly, and discriminatory. DC, Montgomery County, and other places nearby have tried to implement something similar only to rescind it later. The use of a vaccine passport discriminates against minorities, religious peoples, and those with medical issues. It also hurts small businesses. While it might be “optional” now, what’s the prevent it from becoming mandatory later? I OPPOSE SB0839.

Thank you,

Jessica Helms

623 Elfin Ave

Capitol Heights, MD 20743

585-610-6119

SB 839 new.pdf
Uploaded by: Jill Kapper
Position: UNF

Hello,

I’m writing in regards to SB 839. I strongly oppose this bill because no business should be discriminating who can or cannot use their service based on COVID or other vaccination status especially vaccines that are still only Emergency Use Approved. I also oppose this bill because one’s medical information is one's own business and should not be used to discriminate and segregate citizens based on vaccine status. One's medical information should be protected information but we have seen repeatedly that "protected" information can be hacked. Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy and health choice. Public funding would be used to develop and market an unecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness and control. For what may be the most obvious reason, I oppose this bill because the vaccine doesn’t even work! We can’t implement a vaccine passport for a vaccine that doesn’t prevent transmission or infection. The CDC itself has said that the vaccinated can both get and spread the COVID virus. Many unvaccinated people have natural immunity which is cross protective, enduring and a benefit to the public. This makes no sense. Common sense and logic must be used by those in positions to protect American citizens and their rights. I urge you to do just that by voting NO!

I appreciate you hearing my concerns and feel free to reach out with any questions.

-Jill

MGA_FNL_2mar22.pdf
Uploaded by: John Kelly
Position: UNF

Oppose Senate Bill 839

Before the Senate Finance Committee
of the
Maryland General Assembly
Hearing on SB 839
March 2, 2022

Written Testimony in Opposition to Senate Bill 839

John M. Kelly
Bethesda, Maryland

Thank you for the opportunity to submit testimony on Maryland Senate Bill 839 (SB 839). There are practical concerns about the bill that are important such as cost, security and related matters. But assumptions underlying the bill and their implications are of greater concern and need to be addressed. I will focus my comments on them.

The bill proposes to facilitate the use of COVID-19 vaccine passports and by doing so it implicitly accepts, takes for granted, that the Federal and the state's COVID-19 policies of the past two years were prudent and successful. It effectively sanctions them and proposes a way to further implement them. It provides mortar for the bricks of the policies. However, if there are serious flaws in the policies, facilitating their implementation will have serious negative effects for civil liberties and public health.

To help understand the bill's deeper implications the terms used in its title need to be clarified. The terms "voluntary" and "passports" are largely contradictory and distract attention from questionable aspects of the bill. Something voluntarily is freely chosen or undertaken whereas a passport entails a requirement that an individual may or may not have agreed to in the absence the requirement.

The *voluntary* aspect of the bill is that a person can choose between a mobile device or a paper document to verify that he or she received the COVID-19 vaccine. However, allowing a person access to a public venue based on her or his vaccination status is an entirely different matter. The choice is no longer voluntary, based on the simple desire of the person to enter or not enter a public venue solely on her or his own volition. The *voluntary choice* comes down to how a person wants her or his civil liberties infringed upon, by way of a mobile application or by a paper document.

Under the guises of being voluntary and convenient, the bill implicitly sanctions and explicitly facilitates invasions of personal privacy, in general, and discrimination against the un-vaccinated, in particular. Never before in the United States have persons been required to show proof of her or his vaccination status before entering a grocery store, restaurant, theater or other public venues. The seemingly innocuous proposal for a mobile application for COVID-19 passports implicitly says that it is acceptable to have such passports as a permanent feature of daily life in America.

Further, the mobile application for proof of COVID-19 vaccination is being proposed at a time when other other states and nations around the world are dropping vaccination and masking requirements. New York City, the first major city to impose vaccination and masking requirements, is planning to soon rescind them. Vaccinations, vaccination passports and masking have failed to prevent vaccinated persons from COVID-19 infections and transmission of the virus. So while most jurisdictions are eliminating restrictions, SB 839 is "swimming against the current in the wrong destination."

In addition, by facilitating the use of vaccine passports SB 839 implicitly endorses a vaccine that has a highly questionable, even alarming, safety record. The evidence that has emerged in the past year on the safety of COVID-19 vaccines is sufficient to oppose any

measure that directly or indirectly encourages its use absent open, uncensored scientific investigation and debate.

For the United States, the Center for Disease Control's (CDC) vaccine injury reporting system (Vaccine Adverse Event Reporting System) provides evidence that COVID-19 injuries and deaths are neither anecdotal nor rare. For the year 2021, it reported less than three (3) thousand non-COVID-19 vaccine adverse events compared to almost 800 thousand for COVID-19 vaccines. Thirty-six (36) deaths from non-COVID-19 vaccines were reported compared to 12,635 deaths from COVID-19 vaccines.

From 2011 through 2020 reported vaccine adverse events ranged between 25 thousand and 49 thousand per year. However, in 2021 when COVID-19 vaccines were introduced, reported adverse effects soared to 798 thousand. Reported vaccine deaths ranged between 120 and 183 for the ten-year period, but in 2021 after COVID-19 vaccines were introduced deaths shot up to 12,635.

It is widely acknowledged that vaccine adverse events are vastly under-reported. The most conservative estimate concludes they are under-reported by thirty times. Consequently, the number of adverse events for the COVID-19 vaccine in the year 2021 is closer to 24 million, and for deaths closer to 380 thousand.

The magnitudes of adverse events for COVID-19 vaccines compared to adverse events for non-COVID-19 vaccines in the official data are clear warnings that something is seriously wrong that *cries out* for investigation. Even seemingly innocuous proposals like SB 839 that facilitate COVID-19 vaccine requirements should be opposed, especially now that the pandemic is over.

Rather than the General Assembly spending time and resources promoting vaccine passports, it would be better to initiate a thorough review and investigation of the

effectiveness of the state's response to the pandemic and of federal policies that the state felt compelled to follow.

One of the most important functions of legislative bodies is oversight of the executive branches of government to assure they do not overstep their authority. During the past two years the Congress has not exercised rigorous oversight of Federal executive agencies' COVID-19 policies. Nor have most state legislatures made their respective executive agencies accountable for the unprecedented restrictions imposed.

I respectively request that the members and committees of the General Assembly vigorously exercise their oversight responsibilities and have Maryland state executive agencies explain and justify the COVID policies it implemented which infringed upon basic civil liberties and may have had severe and long-lasting effects on public and economic health.

It is time for the legislature to *find out for itself.* Fundamental questions that need to be asked and which can start us down the correct investigatory road are: Were the restrictions implemented needed?; Did we need a vaccine? Did we need to attempt to vaccinate everybody?; What were the costs to our civil liberties, physical and mental health, our communal sense as a nation, and our economic welfare?; Did the risk justify the cost?; Did the risk justify the economic wreckage?; Why COVID-19 patients *not* allowed to make their own decisions about treatment in consultation with their personal physicians?; Why was there blatant censorship of scientific debate about public health policies to respond to the pandemic?; and Why were lifesaving effective treatments for persons with COVID-19 suppressed?

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Document 2 (3).pdf
Uploaded by: John Roswell
Position: UNF

John C. Roswell

6357 Old Washington Road

Elkridge, MD. 21075

3/01/2022

SB0839

This proposed law if passed will be a bureaucratic waste of time. The vaccines do not prevent the spread of covid. As examples Governor Hogan's wife caught it and even though Prime Minister Trudeau of Canada was vaccinated 3 times he also caught it. Eventually herd immunity may happen which will more likely happen from the omicron strain after effect than from vaccines and all this unnecessary fear of covid 19 will go away.

IMG_2548.pdf
Uploaded by: John Wells
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

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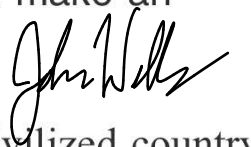

This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

SB839_SHARPE_UNfav.pdf
Uploaded by: Julie Sharpe
Position: UNF

SB839_Sharpe_UNfav

There are few things that belong to a person. Fundamental to everyone's humanity is their bodily autonomy. What I do with my body should be my choice. But this bill wants to take a little bit of that autonomy away. It's not obvious. It is voluntary. I can choose to do something to my body, get a vaccine. Then I can choose to carry proof of that having done that. It seems like a convenience really. I don't have to worry about losing my vaccine card. It's easier that way.

But there is a tradeoff that I don't want to make. The passport enables my freely given, happily willing, uncoerced medical compliance to be linked with social freedoms like going to a restaurant, or financial freedoms, like whether I can have a certain job.

And what for the person who chooses not to get the vaccine. What for the person who now will be unable to access places that require the vaccine.

Of course it is a business's prerogative to discriminate against that choice. Businesses should be able to make their own rules. But it is not right for the state of Maryland to enable that discrimination and for taxpayers to fund the system that facilitates that discrimination, which is exactly what this bill is created to do.

We aren't in an emergency any more. It is not urgent any longer that we shut down and take away. Thank goodness we have arrived at opening and freeing.

But instituting a passport system locks us into to a solution whose need has passed. That actually, has been tried in other places and rejected. Montgomery County tried, and the business community balked. NYC is nixing passports as of March 7. They see that financial harm passports did, and really, the need has passed; covid metrics are on the decline, as they are in most of the United States.

Please vote no for this bill. We do not want vaccine passports.

Vaccine Bills Testimony.pdf
Uploaded by: Justin Foster
Position: UNF

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Signed,
Justin J. Foster

Justin Foster

Type text here

Opposition to SB 839.pdf
Uploaded by: Justin Kuk
Position: UNF

To Finance Committee Members:

I am writing to urge you to reject SB 839. The bill requires the Maryland MyIR Mobile immunization record service to meet certain standards which will enable it to be used for COVID-19 vaccine passports. The bill also requires the Maryland Department of Health to implement a campaign to raise awareness of the usage of Maryland MyIR Mobile as a COVID-19 vaccine passport. While it is currently a voluntary system, it is an inappropriate function of the government to contribute to regulating access to venues, events, and services based on vaccination status. Standardizing a COVID-19 vaccine passport system is a state-sponsored endorsement of COVID-19 vaccine mandates and discrimination.

Many states have already prohibited such vaccine passports and I believe that Maryland would be wise to oppose this bill. Cities that implemented vaccine passport systems, such as New York City, were not able to slow the spread of COVID during the Omicron wave. Even if implemented with good intentions, the vaccine passport systems are not an effective mitigation measure.

Beyond that, they will segregate our society based on vaccination status, which will have the unintended consequence of segregating our society based on race and class. Even if it is not its intention, this bill will have a disparate impact on black, brown, and lower-class Marylanders and prevent them from fully participating in community life. That is a step backward that our state cannot support.

Finally, I believe that this bill is a violation of the principles of medical freedom laid out established in the Nuremberg Code in 1947 after the terrible acts that took place at the hands of the Nazi regime in the name of science. The first of ten points begins as follows: “The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.”

Even if the MyIR Mobile App is a voluntary program, it is still a form of state-sponsored coercion that is attempting to make it more difficult for individuals to make a free choice regarding vaccination. Many people have legitimate religious, philosophical, medical, scientific, and logical reasons why they do not want to participate in a mass vaccination experiment in which the potential long-term side effects are unknown.

I urge you to reject SB 839 and to protect the medical freedom of all Marylanders. A freer Maryland is a stronger Maryland for the sake of all Marylanders.

Sincerely,

Justin Kuk
Baltimore, Maryland

SB839_Fisher_UNF.pdf
Uploaded by: Kara Fisher
Position: UNF

SB839: Maryland Voluntary COVID-19 Vaccine Passport

UNFAV

Kara Fisher

Dear Chair, Vice Chair and Senate Finance Committee:

I ask you to oppose SB 839.

A system like this is **unnecessary**. It will be an expensive proposition to design, test and implement a digital system and marketing plan. There is no need for any business or organization to see a mobile vaccine record.

A system like this is **discriminatory** against those who will not have the means to acquire a mobile phone or share this data via a mobile device.

A system like this is **risky** as it puts aggregated confidential medical information in one place where it could be vulnerable to hackers.

Thank you.

Kara Fisher

District #19

Rockville, MD

Please oppose SB839 and SB840.pdf
Uploaded by: Karen McCullough
Position: UNF

3/1/2022

RE: Please oppose SB839 and SB840

Hello, please oppose SB839 and SB840. The idea of a vaccine passport is discriminatory and a waste of money. The concept that our government would spend money on a passport when 70% of high school students in Baltimore can't read above a 5th grade level is ridiculous. This really shows the priority of the government in Maryland. The passport won't stop the spread of the virus and could potentially allow vaccinated people who have the virus to spread a virus while health unvaccinated and those who have natural immunity would be discriminated against similar to what black people fought and died to overcome in this country. I guess we will soon see "Vaccinated" and "Unvaccinated" bathrooms soon.

Furthermore, how on earth is a pharmacy technician qualified after 6 weeks of training to know the contraindications of administering vaccines to my child without knowing their health history. Pediatricians are trained to properly access risk factors and pharmacist are not. It is absolutely unbelievable that government officials feel they should be making laws like this that they hold no one liable when something goes wrong, and EVERYTHING falls on the parent. The pharmaceutical company isn't held liable do the 1986 National Childhood Vaccine Injury Act, the doctors, pharmacist, government will all have immunity when something goes wrong and a child is serious harmed and/or dies.

I am a Maryland citizen and will be watching this bill closely and voting accordingly in the next election. I will also be deciding if I want to live in a state (where I contribute my taxes to) where its government believes that carrying around a passport to prove that I have injected drugs in my system is synonymous with living in the "land of the FREE".

Regard

Karen

MD vaccine passport bill SB0839 letter.pdf
Uploaded by: Kathleen Shoemaker
Position: UNF

3/1/2022

Dear Maryland General Assembly,

I oppose the MD Senate bill SB0839. I oppose vaccine passports. It is not right when a bill:

1) **will REMOVE a citizen's right to body integrity:**
   [Everyone has the right to maintain bodily integrity by declining medical interventions to which they do not give informed consent apart from coercion.]

2) **will UNDERMINE medical or religious exemptions:**
   [Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.]

3) **will establish a SEPERATIST PRECEDENT:**
   [COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights.]

4) **will WEAKEN each citizen's medical privacy:**
   [First, the websites/apps used to hold these passports will be easy prey for hackers to steal medical and personal information. Second, Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.]

For these reasons (and more), I implore you to not pass this bill. Sincerely,

Kathleen Shoemaker
8308 Painted Rock Road, Columbia MD 21045

SB 839.pdf
Uploaded by: Kathy Jaggers
Position: UNF

Senate Bill 839

Forcing someone in any way to take any medication violates the Nuremburg Code established in 1947. It emphasizes voluntary consent and the free power of choice without any **constraint or coercion.**

The ethical and legal traditions of Maryland have long countered discrimination based on medical condition and religious belief. They must continue to do so. We must not violate doctor/patient confidentiality and medical privacy. These would be seriously eroded with any kind of covid passport or other requirements.

Everyone has the right to bodily integrity. Those who are willing to destroy an unborn child which is its own person are on the other hand saying that persons must accept, under pain of joining an underclass, a medical procedure for which he or she does not give informed consent.

A vaccine passport is a further step in the direction of Communist style surveillance and the Chinese social credit system. Why protest the invasion of Ukraine when Maryland government proposes its own invasion of privacy and bodily integrity?

Anti Vax Mandate (1).pdf
Uploaded by: Kristin Treacy
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

This code of ethics must be upheld ion any civilized country.

SB0839.pdf
Uploaded by: Laura Gallo
Position: UNF

SB0839

UNFAV

Laura Gallo

I strongly oppose mobile technology to track COVID immunization records as it discriminates against those who can not get immunized.

SB839 Written Testimony.pdf
Uploaded by: Laura Hartman
Position: UNF

SB839 Written Testimony

I am a lifelong resident of Baltimore County and writing to you today out of sheer terror as it relates to SB839. Maryland has been my home and a place up until recently, I have been proud to call my home. My family has been here for many generations and we have worked hard to build a life for our family.

MyIR is a for profit company taking advantage of innocent citizens and their privacy. Why would anyone need to have their medical records in digital format? What systems do they have in place to ensure that my private information will be kept private? Why all of the sudden do we not trust our doctors to hold our HIPPA regulated private information private?

This bill is also taking away our religious, medical and personal freedoms in a way that opens the door for many future grand-scale issues. What happens next? Do I need a digital code to decide what school my children should attend? Do I need a digital code to find a job? Do I need a digital code to decide what foods to buy at the grocery store?

I ask you to vote NO on this bill so that we can ensure that we still have our God given rights to privacy, democracy, and personal freedoms. I also implore you to vote no so that the free citizens of Maryland are not discriminated against for their medical decisions.

Dear Finance Committee-1.pdf
Uploaded by: Lelane Schmitt
Position: UNF

Greetings Finance Committee,

I have been a Maryland resident for over 20 years, and I am greatly concerned about proposed Bill SB839. I do not want my tax money, nor any other Marylander's tax money, to be spent supporting vaccine passports. Given that the numbers of covid cases in Maryland has dropped significantly and continues to do so, and given that the CDC has made it publicly known that covid vaccines do not stop transmission, mandating these vaccines for admission to certain venues is absolutely unnecessary. Furthermore, it makes personal medical information public. Our country has worked very hard in recent years to implement HIPAA practices, to protect personal health records, yet this bill would do the very opposite. There are so many important issues that need our tax money. Please don't use it to fund such a ridiculous measure. Many of my friends and family have contracted covid from vaccinated individuals, and yet this bill sends the erroneous message that covid vaccination is effective enough to be mandated. This is simply wrong. Please do the right thing and oppose this bill. Use our money for something that will benefit all of us rather than create even more segregation and fear.

Thank you.

Lelane Schmitt
March 1, 2022

sb0839.pdf
Uploaded by: Linda Adlum
Position: UNF

I oppose bill SB0839 for the following reasons:

I firmly oppose mandatory COVID vaccines, Vaccine Passports and tracking and tracing apps.

I should have the free choice to determine if I want a COVID shot. Neither government nor private corporations have the right to force me to have a so-called “Vaccine Passport.” Nor should an app that contains my private medical information and that tracks and traces my movement be permitted.

Vaccine passports and other COVID requirements erode or remove legal protections of doctor-patient confidentiality and privacy and protection of medical records. Business should not discriminate who can or cannot use their service using an individual's private medical record. Digital vaccine passport information can be "hacked".

Vaccine passports discriminate and segregate citizens based on vaccine status. Persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights - even medical treatment!

The Covid vaccines are experimental and have not been tested for long term effects. Mandating vaccines to force or coerce someone in any way to take a vaccine or any medication violates the 1947 Nuremberg Code. Everyone has the right to bodily integrity and autonomy, which includes the right to decline medical interventions.

Mandating vaccines ignores natural immunity which is enduring and a benefit to the public.

Vaccine passports have been withdrawn globally. They are unnecessary and represent a violation of personal freedom, privacy and medical choice.

Misuse of digital vaccine passports could easily be expanded to illegal and unjust overreaching surveillance of American citizens by the government, tracking, surveillance, divisiveness and control, and the development of a Communist-style social credit system. Digital vaccine passports presents a serious threat to freedom. My private medical decisions regarding a COVID shot or other vaccine should not determine whether I can leave my home, work, shop, dine or worship.

SB839VAXPassport3:2.pdf
Uploaded by: Linda Diefenbach
Position: UNF

SB 839- UNFAVORABLE! The bill proposes using mobile technology to implement an immunization record "service" called MyIR. This vaccine passport would display COVID 19 vaccination status allegedly for admission to certain venues.
It would furthermore use tax payer money to develop and promote this outrageous and unnecessary "service". The bill claims the MyIR is VOLUNTARY, but when does voluntary become MANDATORY?

This wording from the bill is very concerning and frankly anything that has SMART in it sets off alarm bells:
HAS A SMART HEALTH CARD QR CODE THAT IS VERIFIED AS VALID UNDER COMMONTRUST NETWORK REQUIREMENTS FOR MULTISTATE FUNCTIONALITY;
(5) IS COMPATIBLE WITH MULTINATIONAL VACCINE PASSPORT PLATFORMS;
With all this connectivity to other platforms, there are serious privacy concerns as when the Maryland data base was hacked late last year.
Standardizing a COVID-19 vaccine passport format is essentially a state sponsored endorsement of COVID-19 vaccine and is discrimination. Any form of discrimination against individuals unvaccinated against COVID-19 is essentially a form of coercion to try and get them vaccinated by implementing barriers to navigate life. It also reduces the focus from health to mere vaccine status.
Multiple states have prohibited vaccine passports including Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Montana, North Dakota, Oklahoma (for students) South Carolina, South Dakota, Texas, Utah (government ban only), and Wyoming. Maryland should too. THIS WRETCHED BILL MUST BE STOPPED!

Linda Diefenbach
6742 Deer Spring Ln.
Middletown, MD 21769

Against Vaccine Passports.pdf
Uploaded by: Lourdes Corso
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

Very truly yours,

Lourdes Corso
12601 Orchard Brook Terrace
Potomac, MD 20854
(301) 251-6318
Corsojohn@aol.com

testimony regarding SB0839 and SB0840.pdf
Uploaded by: Marco Colombini
Position: UNF

Date: 3/1/2022

Citizen: Professor Marco Colombini

I am very much against vaccine passports. Although one can call them voluntary, in fact, they are a mechanism of coercion. The first of the ten points of the Nuremberg Code begins as follows: "The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion…"** No matter how one spins it, these proposed bills SB0839 and SB0840, facilitate and encourage the use of vaccine passports to limit the normal activities of unvaccinated individuals.

As a Biophysicist, I read the peer reviewed literature. There is no question that the current vaccines being urged on Marylanders are experimental. They use technology never before used in vaccines. There has not been time for long-term testing, for obvious reasons. There are serious problems with these vaccines as demonstrated by clinical research in many labs all over the world and by reports collected by VAERS . Thus, not only is it unethical to coerce anyone to inject a foreign substance into their body but that substance could be harmful making the coercion even more unethical.

Finally, when a person has taken a vaccine that is effective at reducing morbidity and mortality, that person should feel safe enough not to expect others to also be vaccinated. Vaccine passports seriously erode the basic freedoms of those who choose not to be vaccinated.

SB 839 Unfavorable.pdf
Uploaded by: Margaret Montuori
Position: UNF

SB 839
UNFAVORABLE
Margaret Montuori
7901 Deepwell Dr.
Bethesda, MD 20817

Once again Maryland state senators are proposing a bill that is deceptively vague and therefore should be withdrawn. What is “certain design requirements”? That tells the taxpayer/citizen/resident ABSOLUTELY NOTHING.

The only reason why people are being asked about their vaccine status is because the federal health emergency was recently renewed. Otherwise HEPA prohibits such health inquiries because health status is no one’s concern other than that of the individual, their family and their physician. Why the health emergency was extended is nonsensical. Nationwide the blue states have almost simultaneously withdrawn their mask and vaccine mandates. Red states stopped buying into these protocols last year with tremendous socioeconomic success! Globally, nations around the world are withdrawing their mask and vaccine mandates and passport schemes. WHY? Not because of science, because governments including the U.S. federal agencies and the federal, state and local governments never truly investigated the science, but because citizens, parents, healthcare professionals and businesses are standing up for the truth. Covid-19 was a hoax except for the elderly and those with comorbidities. Covid-19 was created with the purpose of negatively affecting western societies, including the United States, by decimating their economies, crippling child development and education, eradicating small businesses, increasing crime, fragmenting families, neighborhoods and churches. The money that the U.S. government has spent for Covid is staggering and has turned out to be an unfathomable waste.

Why would Maryland legislators want to continue to travel down this road? Because, they are not going to relinquish power. After watching the bills and testimonials this legislative session, I have witnessed the constant begging for money from the taxpayer for the most inconsequential and ludicrous schemes. At this point in time ANYTHING for Covid is a waste of tax dollars. Omicron, zenacron, larry moe and curlycron are attenuated derivatives of the original flu. The public can survive them. The number of people who passed from the regular flu in 2021 is similar to the number that passed from Covid. People, unfortunately pass from the flu. We don’t need to invest in a medical fact of life. The state of Maryland does not need mobile units, vaccine mandates, vaccine passports or lists regarding the public’s immunization status. The CDC’s information on Covid, which should have been a reliable source, has either been all over the map or simply published lies. They couldn’t be trusted, Maryland legislators can’t be trusted. Stop all Covid related legislative schemes!

SB0839 Testimony - Stoklosa.pdf
Uploaded by: Margaret Stoklosa
Position: UNF

Dear Committee Members,

Please OPPOSE SB0839 for the following reasons:

1. On the last estimate, 3 out of 4 Americans either had COVID overtly or are vaccinated and did not contract it (or maybe did but it did not present overtly). The other ¼, probably made up mostly of children, already had a COVID infection but it was mild enough to not even present. There is no need to micromanage SARS-CoV-2 at this point.
2. Vaccine passports would funnel money away from other programs that are more vital, such as early treatment. Collectively, there is an abundance of research that supports various therapeutic agents. Let's put money towards this.
3. Vaccine passports are onerous for businesses to implement. This is precisely the reason they have been voted down in many jurisdictions. Small business, especially, are still trying to recover from the shutdowns – let's funnel money to support them.

There is no need for a vaccine passport system in Maryland and as a taxpayer, I oppose this bill.

Thank you,
Margaret Stoklosa
803 Main St
Gaithersburg, MD 20878

Testimony ‘passports’.pdf
Uploaded by: Marianne Sibal
Position: UNF

I totally reject any medical “passport” for Covid and all other medical reasons because they are easily manipulated, forged, and are potentially vehicles of private data abuse, either nefarious or politically misguided. It will increase the desire of people to try to circumvent it leading to unproductive legal actions.
There is no need for this action. It would be onerous and a hardship for many. The lack of nimbleness of such cumbersome legislation would restrict honest citizens from exercising Constitutional Freedoms as the ability to keep ahead of public health is unattainable when it comes to the unpredictable, as is quite evident looking at the past two years of events in New York City for example. It is shameful that so many people suffered the loss of freedoms and jobs because an illegal mandate that has now been lifted. Who will make up the financial and psychological losses caused by the shortsighted rush to control a virus which has mutated beyond its initial concern?
No, to any health “passport”. No, to this bill.
Sincerely,
Marianne Sibal

2020 Baltimore County Schools Hacked.pdf

Uploaded by: Mark Meyerovich
Position: UNF

Baltimore County Schools Hacked, Expert Predicts Months to Fix

by Chris Papst
Wednesday, November 25th 2020

A person working on a laptop. Baltimore County Schools announced that its network was hit with a ransomware attack on November 25, 2020 (WBFF)

County Public Schools were closed Wednesday
ails of the attack are being investigated, but it could
have a major impact on virtual learning.

What happened to Baltimore County Schools is not uncommon. In September, Virginia's largest school system, Fairfax County, was hacked. Earlier this year, Nevada's largest school system, Clark County, was hacked. Now, America's 24th largest school system, Baltimore County, is the latest target.

ALSO READ |Baltimore County Public Schools closed - ransomware attack on network

Project Baltimore spoke with Brian Dykstra, the CEO of Atlantic Data Forensics in Elkridge, which specializes in defending against ransomware. He says ransomware attacks are on the rise during the COVID pandemic. He tells FOX45 News it's a criminal business and it's thriving.

Dykstra told Project Baltimore the hackers who attacked Baltimore County Schools have likely been in the system for weeks, finding out where everything is and planning when to send out the ransomware to encrypt the district's data. There are several ways the system could have been hacked, but Dykstra says remote learning may have made the school system an easier target.

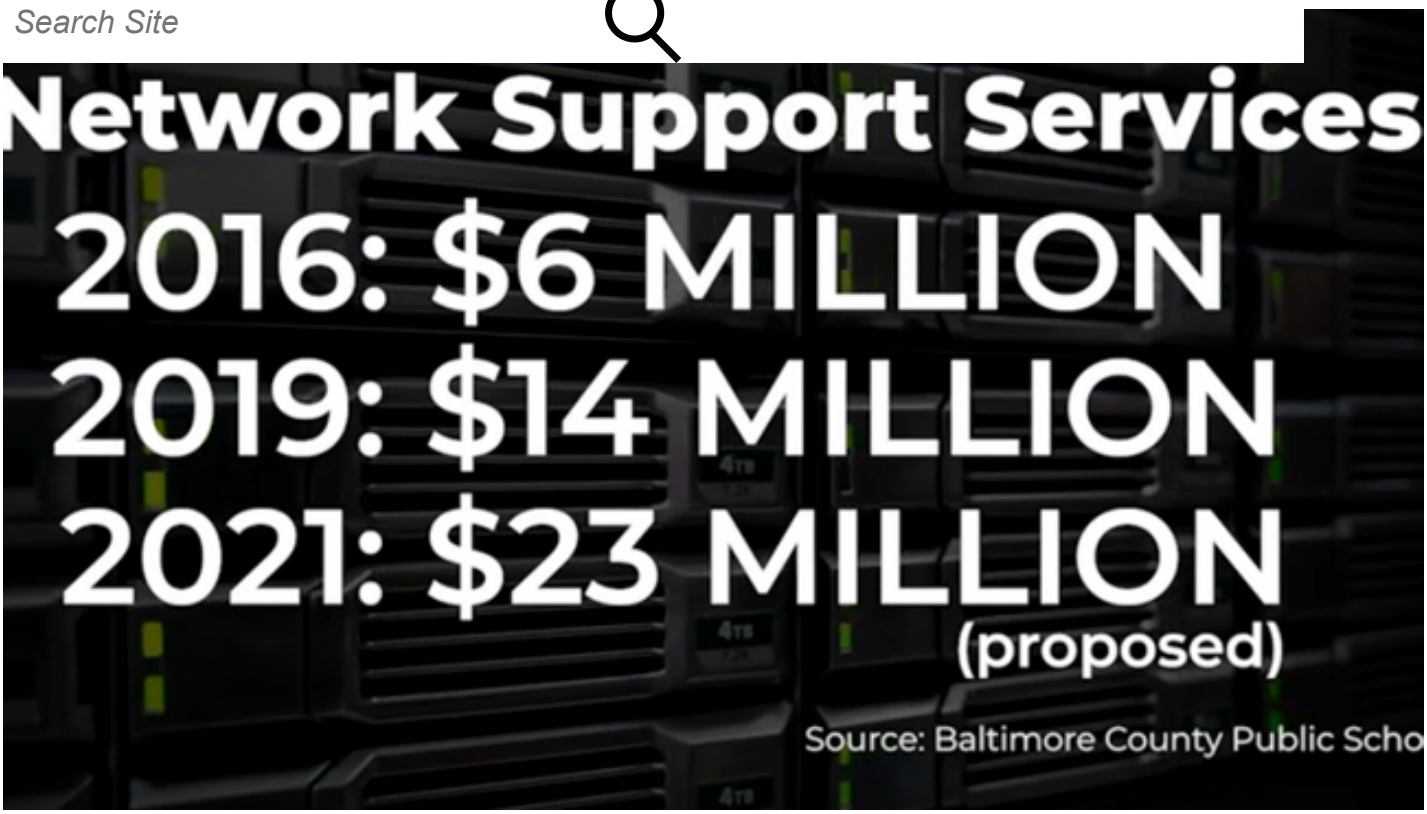
"They pushed out remote access to everybody really quickly with the goal being get everybody covered as quickly as possible, right?" explained Dykstra. "Did they do it in the most secure way possible? Unfortunately, the answer for a lot of organizations is that they didn't. They did whatever was most expedient but not most secure."

Dykstra says organizations should be spending roughly four to six percent of their budget on IT security. But, in his experience, organizations tend to underfund their IT departments.

"It's really a management problem, right?" said Dykstra. "It's usually because there has been a decision made of not funding IT."

Project Baltimore looked at the Baltimore County Schools budget and found, since 2016, the amount of money BCPS put toward Network Support Services has more than tripled from $6

ks out to about on percent of the school system's
ng has increased the system's network needs.



BCPS has more than tripled spending on Network Support Services over the last five years (WBFF)

We don't know the full extent of this attack and what will be affected. The hackers could have emails, payroll, or student records. The best hope, Dykstra says, is the school system has good backups. Dykstra believes this will determine whether the system should just pay the ransom. But either way, he says, there's no quick fix.

ALSO READ | Ransomware attack has cost Baltimore $18M so far. Can it be recouped?

"My general experience with an organization as big as the public school system," explained Dykstra, "it's going to take them weeks, months to get back to anything that looks like normal."

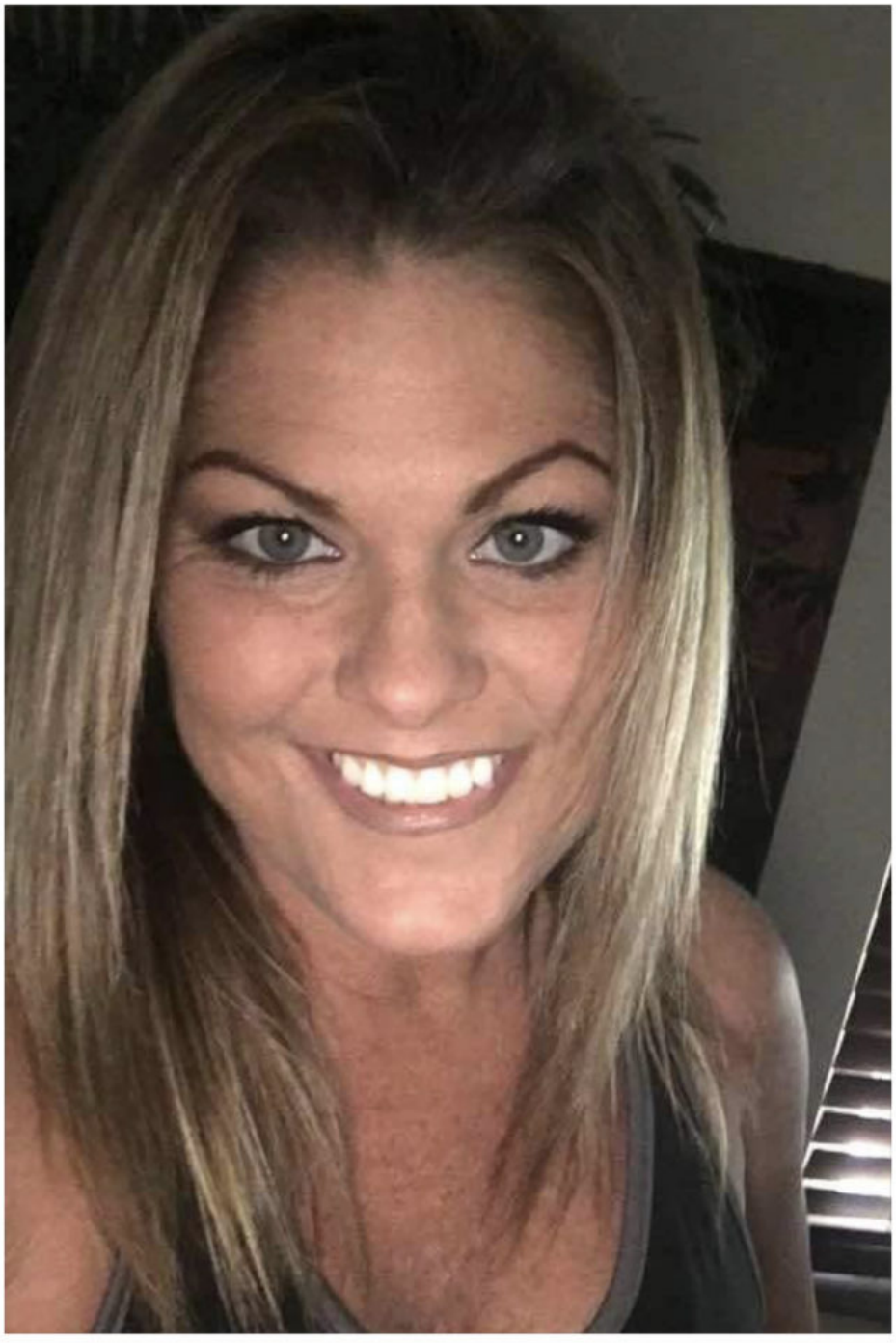
2021 John Hopkins Hospital Employee Dies After Man

Uploaded by: Mark Meyerovich

Position: UNF

45 Year Old John Hopkins Hospital Employee Dies After Mandatory Covid Shot This June

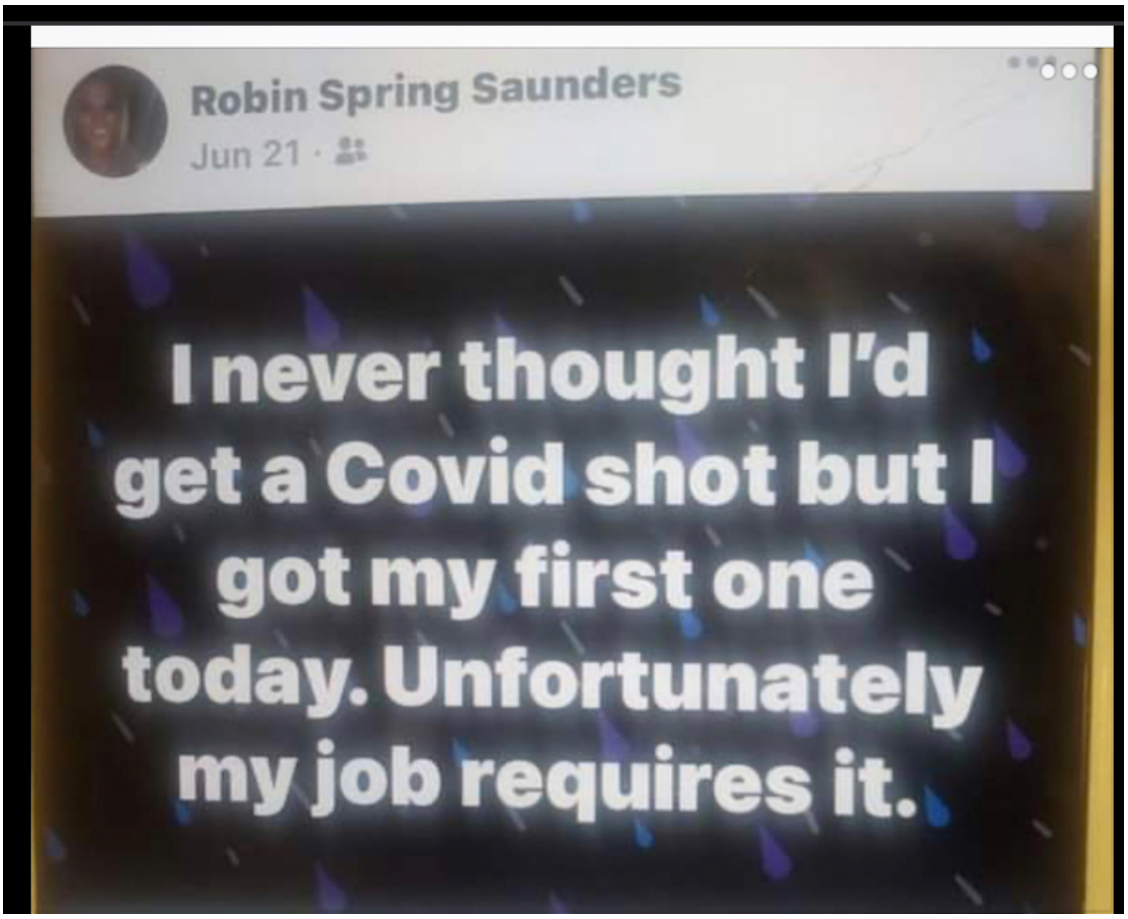
By **NewsRescue** - July 10, 2021



Another tragic story and this time it involves a 45 year old woman from the state of Maryland.

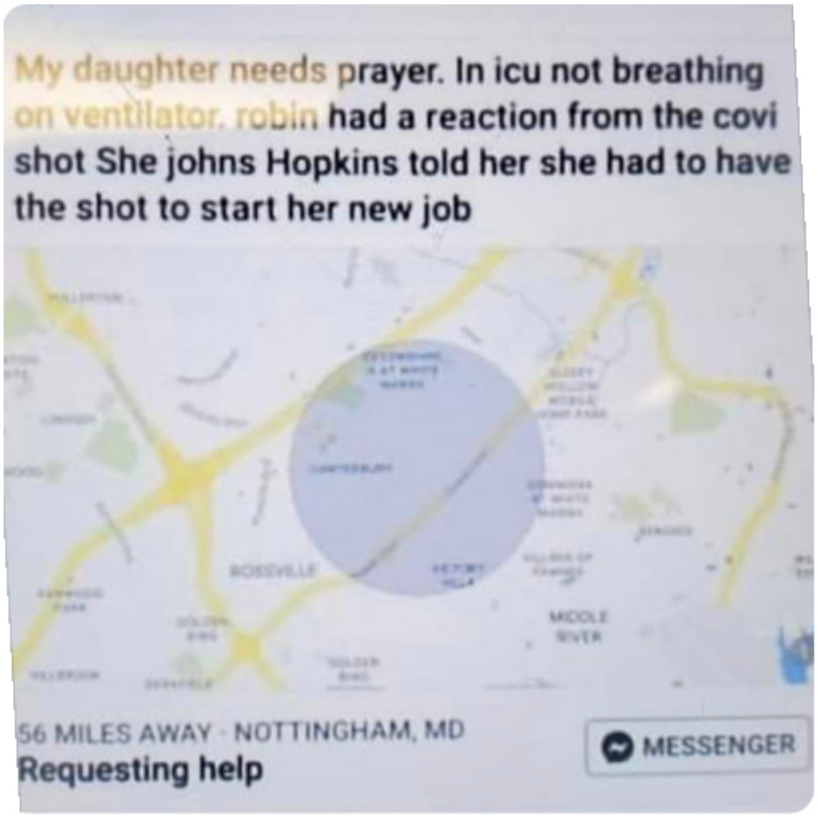
Robin Spring Saunders had accepted an employment position with John Hopkins Hospital. She was a certified medic and was looking forward to working with autistic children at the hospital. Part of the hiring process for Robin however, included a mandatory covid shot.

Robin announced on social media that she had received her first dose on June 21, 2021. She also mentioned in the post that her job required it. Judging by her post, she did not seem enthused that it was a requirement but she did comply.



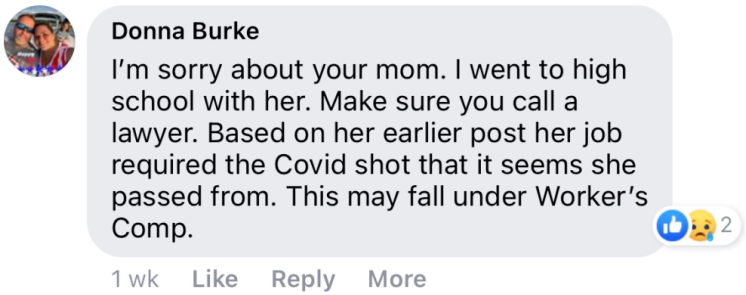
Not long after the shot Iona Sellers, Robin's mother, had requested prayers for Robin online and stated "Robin had a reaction from the covid shot". Robin was not breathing and was on a ventilator in ICU according to her mother.

Iona also made mention in her post that Robin needed the shot to start her new job.



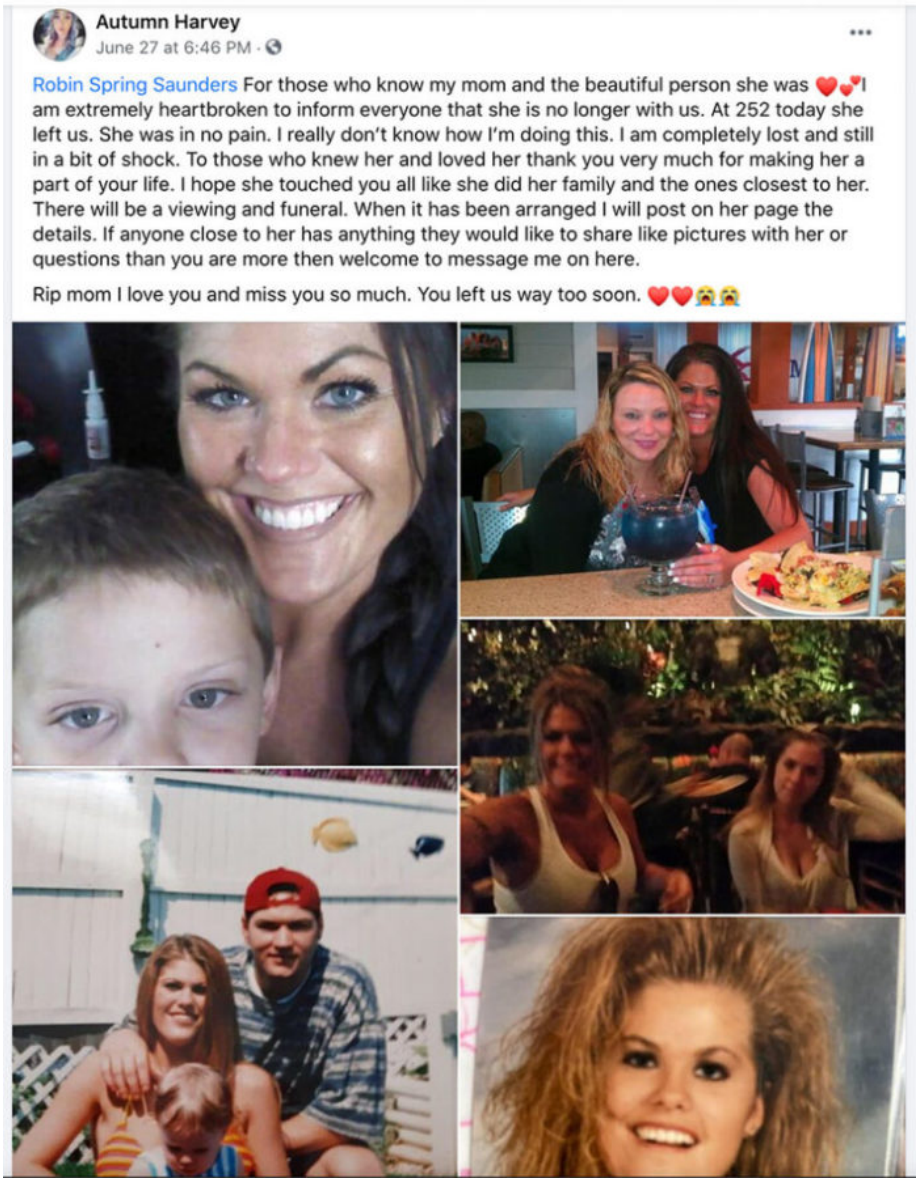
Unfortunately due to heart issues and brain swelling from the reaction, Robin did not recover. On June 27, 2021 Robin Spring Saunders passed away. She leaves behind two children.

Robin's funeral will be held on July 5, 2021. May she rest in peace and her loved ones be comforted during such a difficult time.



Posts did not note whether Robin received either the Pfizer or Moderna vaccine.

According to a post later that day from Saunders' daughter, however, her condition took a turn for the worst and she died in the ICU.



An obituary at the Connelly Funeral Home of Essex in Baltimore shows a memorial for Robin.

If you or a loved one have had a reaction to a covid shot, please contact me. There are many stories that deserve to be heard.

45 Year Old John Hopkins Hospital Employee Dies After Reaction To Mandatory Covid Shot

2021 Vaccine Passports May Backfire.pdf

Uploaded by: Mark Meyerovich
Position: UNF

vaccines

MDPI

Article

"Vaccine Passports" May Backfire: Findings from a Cross-Sectional Study in the UK and Israel on Willingness to Get Vaccinated against COVID-19

Talya Porat [1,*], Ryan Burnell [1], Rafael A. Calvo [1], Elizabeth Ford [2], Priya Paudyal [2], Weston L. Baxter [1] and Avi Parush [3]

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[2] Department of Primary Care and Public Health, Brighton and Sussex Medical School, Brighton BN1 9PH, UK; E.M.Ford@bsms.ac.uk (E.F.); P.Paudyal@bsms.ac.uk (P.P.)
[3] The Faculty of Industrial Engineering & Management, Technion Israel Institute of Technology, Haifa 3200003, Israel; aparush@technion.ac.il
* Correspondence: t.porat@imperial.ac.uk

Abstract: Domestic "vaccine passports" are being implemented across the world as a way of increasing vaccinated people's freedom of movement and to encourage vaccination. However, these vaccine passports may affect people's vaccination decisions in unintended and undesirable ways. This cross-sectional study investigated whether people's willingness and motivation to get vaccinated relate to their psychological needs (autonomy, competence and relatedness), and how vaccine passports might affect these needs. Across two countries and 1358 participants, we found that need frustration—particularly autonomy frustration—was associated with lower willingness to get vaccinated and with a shift from self-determined to external motivation. In Israel (a country with vaccine passports), people reported greater autonomy frustration than in the UK (a country without vaccine passports). Our findings suggest that control measures, such as domestic vaccine passports, may have detrimental effects on people's autonomy, motivation, and willingness to get vaccinated. Policies should strive to achieve a highly vaccinated population by supporting individuals' autonomous motivation to get vaccinated and using messages of autonomy and relatedness, rather than applying pressure and external controls.

Keywords: COVID-19; public health; self-determination theory; vaccine passports; vaccination

Citation: Porat, T.; Burnell, R.; Calvo, R.A.; Ford, E.; Paudyal, P.; Baxter, W.L.; Parush, A. "Vaccine Passports" May Backfire: Findings from a Cross-Sectional Study in the UK and Israel on Willingness to Get Vaccinated against COVID-19. *Vaccines* **2021**, *9*, 902. https://doi.org/10.3390/vaccines9080902

Academic Editors: Efrat Neter and Karen Morgan

Received: 6 July 2021
Accepted: 12 August 2021
Published: 14 August 2021

1. Introduction

Since the start of the COVID-19 pandemic, the world's hopes have been pinned on vaccines that have the potential to allow people to return to "life as normal" [1]. The rollout of these vaccines is now well underway, with 2.3 billion people (29.6% of the world's population) having received at least one dose at the time of writing. Some countries have already vaccinated the majority of their populations—for instance, 62.3% of Israel's population are fully vaccinated, as is 57.3% of the UK's population [2].

These high proportions demonstrate that people in most countries, on the whole, have accepted the need for vaccines and are eager to get vaccinated [3,4]. However, there remain some individuals who are reluctant to take the vaccine. In Israel, for example, 15% of the eligible adult population have not taken up the opportunity to get vaccinated [5]. Likewise, 11% of eligible adults in the UK have not yet chosen to get vaccinated [6]. Although these reluctant groups are relatively small, they are not insignificant—some estimates suggest that any vaccine refusal rate greater than 10% could significantly hinder herd immunity [1]. Therefore, if we want to ensure enough people choose to get vaccinated to control the spread of the virus, it is vital that we understand the factors that affect people's willingness to get vaccinated.

One important policy that might affect willingness to get vaccinated is vaccine passports. In order to allow vaccinated individuals to move freely and return to daily activities, several countries have introduced or considered measures that would restrict access to public spaces for people who are unvaccinated [7]. The first country to implement such a policy was Israel. "Green passes" were provided from January 2021 onwards to fully vaccinated residents or people who had recovered from COVID-19, permitting entry to otherwise restricted sites such as gyms, restaurants, hotels, theatres, and music venues. In the US, New York required vaccine certification in order to access certain social activities, and many other states have also expressed interest in the idea [8]. In Europe, Denmark launched its "coronapas" system in March to be used domestically [9].

The goal of vaccine passports is to pave the way for economic recovery and restore people's freedoms [10]. However, these passports also raise concerns about potential violations of people's autonomy and freedom of choice [7,11,12]. For example, in the UK, more than 375,000 people signed a petition against the rollout of COVID-19 vaccine passports because they "could be used to restrict the rights of people who have refused a COVID-19 vaccine" (https://petition.parliament.uk/petitions/569957, accessed on 8 August 2021). Even putting aside these ethical issues, it remains unclear how these passports might affect people's vaccination decisions and well-being. On the one hand, vaccine passports could incentivize people to get vaccinated so they are able to move freely in society [11]. However, on the other hand, there are reasons to think that measures such as vaccine passports might actually increase some people's resistance to vaccination or alter the motivation behind their decision to get vaccinated in ways that might have detrimental long-term consequences.

Decades of research shows that societies and individuals can only flourish in environments that foster basic psychological needs [13]. According to self-determination theory (SDT), there are three of these needs: a need for autonomy (a sense of meaning, volition, choice over one's life), a need for competence (the feeling of being capable of achieving one's goals and overcoming challenges), and a need for relatedness (feeling cared for by others, trusted and understood). Satisfaction of these three psychological needs is critical for self-regulating and sustaining behaviours that improve health and well-being, such as exercising, smoking cessation and adherence to prescribed medications [14,15]. Recent evidence also suggests that the satisfaction of these needs is important for adherence to preventative COVID-19 measures [16,17]. In contrast, the frustration of these needs may elicit ill-being, a lack of motivation to act, or in some cases might even provoke defensiveness (doing the opposite of what is requested) [18,19]. People with frustrated needs are also more drawn to conspiracy theories, which could feed into vaccine hesitancy [20,21].

Together, these data provide reasons to expect that people's willingness and motivation to get vaccinated will depend on their psychological needs—more specifically, the extent to which they feel a sense of autonomy over the decision to get vaccinated, the extent to which they feel competent in their ability to get vaccinated, and the extent to which they feel a sense of relatedness to local and health authorities. If this hypothesis is correct, then if vaccine passports frustrate people's psychological needs—for example by making people feel a lack of autonomy over their decision—then these passports might paradoxically reduce people's willingness to get vaccinated.

Furthermore, behaviours are more likely to be sustained over time if people's motivation for engaging in those behaviours is self-determined and autonomous (performed for internal reasons) than if their motivation is controlled (performed due to external pressures) [18,22]. In addition, there is evidence that the frustration of psychological needs can shift people's motivation from autonomous to controlled [23,24].

A common form of autonomous motivation is *identified regulation*—when one identifies and understands the value and importance of a behaviour. This is facilitated when local authorities provide meaningful rationales for a behaviour, and do not apply pressure and external controls [14]. In contrast, common forms of controlled motivation are *external regulation*, in which one only acts to avoid punishment, receive a reward or be in accordance

with social pressure and *introjected regulation*, in which one acts to receive approval or avoid feelings of guilt [14]. According to SDT, in contrast to autonomous motivation, these forms of controlled regulations are not sustainable and may improve adherence only for a short period of time [25]. In the context of vaccination, measures such as vaccine passports may increase vaccination uptake in the short term, but might also shift people's motivation to external or introjected, making them less likely to sign-up for a second dose of the vaccine, less willing to take up the opportunity to receive a "booster" shot, or less willing to take a yearly vaccine against new variants.

Given these potential detrimental effects of vaccine passports, the aim of this study was to investigate whether people's willingness and motivation to get vaccinated depends on their psychological needs, and how vaccine passports might affect these needs. Recent studies have called to evaluate the unintended secondary negative effects of vaccine passports, in addition to their effectiveness and impact [7]. This is the first study to our knowledge to investigate the unintended consequences of domestic vaccine passports using self-determination theory. The results have implications for policy decisions regarding vaccine passports and will help in understanding the importance of autonomy, competence and relatedness in people's vaccination decisions. We collected data from two countries, one that has implemented vaccine passports and one that has not—Israel and the UK, respectively. We asked participants to report the extent to which their psychological needs were satisfied and frustrated in relation to getting vaccinated. Then, we asked them to report whether they were vaccinated, how willing they would be to get vaccinated and what their attitudes were towards vaccine passports.

2. Materials and Methods

2.1. Design and Setting

The pre-registration for the study is available at: osf.io/vtz7h. The study was an online survey disseminated online via Prolific in the UK [26] and via PanelView in Israel [27]. Data collection began on the 10 May 2021 and ended on the 14 May 2021. Israel and the UK were selected for this study because at the time of the study (10 May, 2021), they were the two leading countries in terms of vaccination rate (Israel was leading with 62.7% of its population having received at least one dose, followed by the UK with 52.4% [2]). The fact that many people in these countries would have had the opportunity to get vaccinated allowed us to examine predictors of actual vaccination decisions in addition to intentions.

2.2. Participants

In line with our pre-registration, 1411 participants completed the study (701 from the UK and 710 from Israel). Among them, we excluded 20 participants from the UK and 33 from Israel who failed the attention check, leaving us with our final sample of 1358 participants (681 from the UK and 677 from Israel). Both samples were representative of the country's demographics. All participants were aged 18 or older. Participants received GBP 1.4–GBP 1.6 for their participation.

2.3. Main Outcome Measures

2.3.1. Psychological Need Satisfaction and Frustration

We adapted 12 items from the Basic Psychological Need Satisfaction and Frustration Scale (BPNSNF) [28] to the context of getting vaccinated, with two items assessing each of the six constructs—autonomy satisfaction; autonomy frustration; relatedness satisfaction; relatedness frustration; competence satisfaction; and competence frustration (See Table 1). Each item was rated from 1 (strongly disagree) to 5 (strongly agree). The Hebrew translation was based on Benita et al. [29].

Table 1. The items for the 6 basic psychological needs, including their Cronbach's alpha coefficient of reliability.

Psychological Need Satisfaction and Frustration	Cronbach's Alpha
Autonomy satisfaction	$\alpha = 0.76$
I feel [felt] a sense of choice and freedom in the decision to get vaccinated	
I feel [felt] that my decision to get vaccinated reflects what I really want	
Autonomy frustration	$\alpha = 0.81$
I feel [felt] forced to get vaccinated	
I feel [felt] that I will [would] be 'punished' if I didn't get vaccinated	
Competence satisfaction	$\alpha = 0.79$
I feel [felt] confident that I could get vaccinated if I wanted to	
I feel [felt] capable of getting vaccinated if I wanted to	
Competence frustration	$\alpha = 0.71$
I have [had] serious doubts about whether I could get vaccinated if I wanted to	
I feel [felt] that it would be difficult for me to get vaccinated if I wanted to	
Relatedness satisfaction	$\alpha = 0.85$
I feel [felt] that the official authorities care about me	
I feel [felt] that the official authorities understand [understood] my needs	
Relatedness frustration ($\alpha = 0.76$)	$\alpha = 0.76$
I feel [felt] excluded by the official authorities	
I feel [felt] that the official authorities are [were] cold and distant	

2.3.2. Vaccination Behaviour

We asked participants whether they were vaccinated, and if so, how many doses they received.

2.3.3. Willingness to Get vaccinated

Our main dependent measure was participants' willingness to get vaccinated, which we measured in two ways. First, we asked people how willing they are (or were, if they have already been vaccinated) to get vaccinated from 1 (not at all willing) to 5 (extremely willing). Then, we asked people who were not yet vaccinated whether they would choose to get vaccinated (yes/no).

2.3.4. Attitudes towards "COVID Passports"

Attitudes towards COVID passports were measured by asking participants the extent to which they support three scenarios: A "COVID passport" enabling only people who got *fully vaccinated* to perform some activities (e.g., stay in hotels, participate in large events, etc.); A "COVID passport" enabling people who got *fully vaccinated or recently tested* to perform some activities (e.g., stay in hotels, participate in large events, etc.); and mandatory vaccination for all residents.

2.3.5. Motivations to Get Vaccinated/Not to Get Vaccinated

We measured different motivations to get vaccinated/not to get vaccinated using the Treatment Self-Regulation Questionnaire (TSRQ) [30,31], with two items for each kind of motivation, measured from 1 (Not at all true) to 7 (Very true), as can be seen in Table 2.

Table 2. The items for the 4 types of motivation, including their Cronbach's alpha coefficient of reliability.

Motivations to Get Vaccinated/Not Get Vaccinated	Cronbach's Alpha
Identified motivation	$\alpha = 0.72$
Because I feel that I want to take responsibility for my own health	
Because I have carefully thought about it and believe this decision is very important for many aspects of my life	
Introjected motivation	$\alpha = 0.73$
Because I would feel bad about myself if I did [didn't] get vaccinated	
Because I would feel guilty or ashamed of myself if I did [didn't] get vaccinated	
External motivation	$\alpha = 0.70$
Because I feel under pressure from others [not] to get vaccinated	
Because other people would be upset if I do [don't] get vaccinated	
Amotivation	$\alpha = 0.58$
I really don't think about it	
I don't really care	

2.3.6. Demographics

We asked participants to report their age, gender, religion, education, employment status, whether they have children, marital status, ethnicity and county, as can be seen in Table 3.

Table 3. Demographics and vaccine status of participants from the UK and Israel.

Characteristics	UK	Israel
n	681	677
Age		
18–29	18%	29%
30–59	53%	56%
60+	29%	15%
Gender		
Man	48.5%	48.5%
Woman	51%	51.5%
Non-binary	0.5%	0%
Education (Highest Level)		
No formal education	1%	1%
Primary school	0%	1%
Secondary school	34%	41%
Undergraduate degree	43%	38%
Postgraduate degree	22%	19%
Vaccination Status		
Unvaccinated	34%	14%
Single dose	41%	4%
Two doses	25%	82%

2.4. Power Calculation

This sample size provides us with greater than 99% power to detect small effects ($f^2 = 0.05$) in the regression investigating the relationship between the six psychological need variables and people's willingness to get vaccinated against COVID-19.

2.5. Statistical Analysis

In line with our pre-registration, for our primary analysis, we conducted a linear regression with the six psychological needs (autonomy satisfaction, autonomy frustration, competence satisfaction, competence frustration, relatedness satisfaction, and relatedness frustration) as predictors and people's willingness to get vaccinated as the dependent measure. We also conducted a logistic regression with the same predictors, with the di-

chotomous intention to get vaccinated measure as the dependent measure. We investigated the possible effects of vaccine passports on willingness to get vaccinated by calculating the mean difference in need frustration between Israeli and UK participants and the 95% confidence interval around that difference.

2.6. Pilot Studies

Two pilot studies, one with 100 participants (50 from each country on April 29) and one with 60 participants (30 from each country on May 5) were performed through Prolific to receive feedback from members of the public about the survey. Based on the feedback, changes to the questionnaire (improving clarity of the questions, removing and adding questions) were made after each pilot.

3. Results

3.1. Demographics, Vaccination Status and Willingness to Get Vaccinated

Demographics and vaccination status of participants from the UK and Israel is displayed in Table 3. Among the 229 participants in the UK who were unvaccinated, 69% (or 23.05% of the full UK sample) said they intended to get vaccinated, while 31% (or 10.57% of the full UK sample) said they did not intend to get vaccinated. Less than 0.5% reported they could not get vaccinated due to medical reasons. Of the 97 participants in Israel who were unvaccinated, 19% (or 2.66% of the full Israel sample) said they intended to get vaccinated, while 81% (or 11.67% of the full Israel sample) said they did not. Only 1% reported they could not get vaccinated due to medical reasons.

In terms of willingness to get vaccinated (rated from 1—not at all willing to 5—extremely willing), participants in the UK who had already received at least one dose of the vaccine reported being highly willing to get vaccinated (Mdn = 5, M = 4.71, SD = 0.63). Participants in Israel who had received at least one dose were also relatively willing, although less so than people in the UK (Mdn = 4, M = 4.06, SD = 1.14). Among the participants who had not yet been vaccinated, participants in the UK were relatively willing to do so (Mdn = 4, M = 3.72, SD = 1.49), but participants in Israel tended to be reluctant (Mdn = 2, M = 2.15, SD = 1.24).

3.2. Psychological Needs

Our primary research aim was to investigate the relationships between people's psychological needs and their willingness to get vaccinated. To do so, we conducted a linear regression with the six need ratings predicting people's willingness to get vaccinated. As Table 4 shows, autonomy frustration was the strongest predictor of people's willingness to get vaccinated, such that the more people felt autonomy frustrated (forced to get vaccinated or "punished" if not), the less willing they were to get vaccinated. In addition, autonomy satisfaction and relatedness satisfaction also predicted people's willingness to get vaccinated such that the more people felt volition and choice and that the authorities care about and understand their needs, the more willing they were to get vaccinated.

Table 4. Linear regression of the three psychological needs and willingness to get vaccinated.

Coefficients from Linear Regression			
Term	β	**t-Statistic**	p
autonomy_satisfaction	0.17	5.35	<0.001
autonomy_frustration	−0.47	−15.79	<0.001
competence_satisfaction	0.05	1.52	0.128
competence_frustration	0.07	2.66	0.008
relatedness_satisfaction	0.24	7.94	<0.001
relatedness_frustration	0.09	2.88	0.004

Ultimately, however, people have to make a decision one way or the other about whether to get vaccinated, so it is useful to consider whether psychological needs are

related to these dichotomous decisions. To do so, we conducted a logistic regression using a dichotomous "decision to get vaccinated" variable we created, with anyone who has had at least one dose of the vaccine or who said that they would choose to get vaccinated coded as a 1, and anyone who said they would not choose to get vaccinated coded as a 0. This regression (see Table 5) showed a very similar pattern—once again, autonomy frustration, autonomy satisfaction and relatedness satisfaction were by far the strongest predictors of intentions to get vaccinated. Together, these relationships are consistent with the hypothesis that psychological needs affect people's willingness to get vaccinated.

Table 5. Logistic regression of the three psychological needs and "decision to get vaccinated".

Coefficients from Logistic Regression			
Term	**Odds Ratio**	**Statistic**	***p***
(Intercept)	−2.83	−3.28	<0.001
autonomy_satisfaction	0.84	5.62	<0.001
autonomy_frustration	1.21	9.08	<0.001
competence_satisfaction	−0.36	−2.19	0.03
competence_frustration	−0.09	−0.68	0.49
relatedness_satisfaction	−1.13	−7.74	<0.001
relatedness_frustration	−0.37	−2.44	0.01

Of course, vaccination intentions do not necessarily reflect people's vaccination behaviour. Therefore, we next examined how psychological needs relate to whether people had received at least one dose of the vaccine. The results were similar to those of the vaccination intention analyses—we found that autonomy frustration ($\beta = -0.19$, $p = 0.022$), and relatedness satisfaction ($\beta = 0.58$, $p = <0.001$) predicted people's vaccination status, as did competence satisfaction ($\beta = 0.34$, $p = 0.004$).

Then, we sought to investigate the possibility that need frustration around vaccination might affect people's motivation to get vaccinated. To do so, we investigated the relationships between need frustration and four types of motivation: identified, introjected, external, and amotivation.

Across all three needs, we found that need frustration was negatively correlated with identified motivation (i.e., understanding the value and importance of getting vaccinated). In addition, autonomy and relatedness frustration were negatively correlated with introjected motivation (acting to receive approval or avoid feelings of guilt). These findings suggest that people who feel that their autonomy, competence, or relatedness are frustrated are less likely to have self-determined motivation to get vaccinated. Frustration of each need was also positively correlated with amotivation, and frustration of autonomy and competence were positively correlated with external motivation (acting only to avoid punishment or conform to social pressure). Together, these findings suggest that people whose psychological needs are frustrated tend to be more externally motivated to get vaccinated and care less about getting vaccinated. These correlations are displayed in Table 6.

Table 6. Correlations between need frustration and motivation.

Motivation	Autonomy Frustration	Competence Frustration	Relatedness Frustration
External	0.32 **	0.17 **	0.09 *
Amotivation	0.24 **	0.17 **	0.21 **
Identified	−0.46 **	−0.24 **	−0.34 **
Introjected	−0.19 **	−0.05	−0.19 **

* $p < 0.05$, ** $p < 0.001$.

The findings we described thus far suggest that need frustration is related to both an unwillingness to get vaccinated and a shift from self-determined to external motivation. Therefore, to the extent that vaccine passports frustrate people's psychological needs, these passports might have undesirable effects on people's vaccination behaviour and motivation.

However, do vaccine passports frustrate psychological needs? To address this question, we compared the experience of psychological needs in a country with vaccine passports (Israel) to a country without them (United Kingdom). We found that autonomy frustration was markedly higher in Israel than in the UK, Mdiff = 0.62, 95% CI [0.50, 0.74]). Both competence and relatedness frustration were also higher in Israel, although the difference between the countries was smaller than for autonomy, Mdiff(competence) = 0.24, 95% CI [0.15, 0.33]; Mdiff(relatedness) = 0.39, 95% CI [0.29, 0.50] (see Figure 1). This hypothesis is further supported by the relationships between support for vaccine passports and need frustration. For example, the more participants were against vaccine passports, the more autonomy frustration they reported: r(1356) = −0.37, 95% CI [−0.32, −0.41].

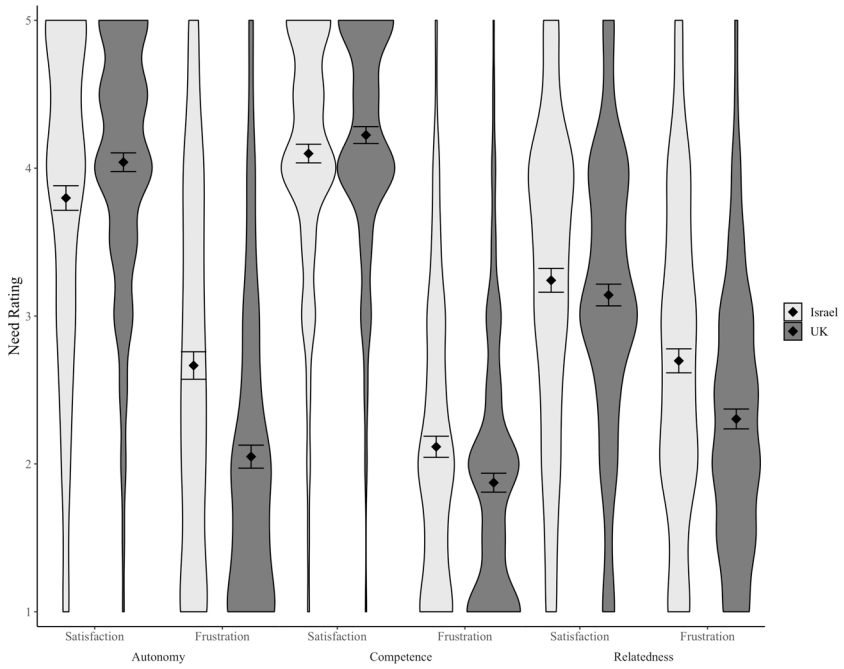

Figure 1. Violin plot displaying the distributions of participants' need satisfaction and frustration ratings in Israel and the UK. Diamonds represent the cell means and error bars represent the 95% confidence intervals around those means.

4. Discussion

Across two countries and 1358 participants, we investigated the relationship between psychological needs and people's motivation and willingness to take the COVID-19 vaccine. In both the UK and Israel, we found that need frustration—particularly autonomy frustration—predicted unwillingness to get vaccinated and a shift from self-determined to external motivation. Need satisfaction—particularly autonomy and relatedness satisfaction—predicted people's willingness to get vaccinated. In Israel, autonomy frustration was markedly higher than in the UK, suggesting that people in Israel felt more pressure to get vaccinated.

There could be several reasons as to why people in Israel are more need-frustrated than people in the UK. Differences in health communication messages, social pressure and other circumstantial, social, and cultural differences between the two countries could all contribute. However, the vaccine passports in Israel, called "green passes", received considerable backlash and criticism, including several appeals to the Israeli supreme court, with citizens and healthcare experts seeing them as coercion and against individual autonomy and freedom of choice [32]. It seems reasonable to expect, therefore, that vaccine passports would frustrate psychological needs—particularly people's sense of autonomy—and our data are consistent with this hypothesis. Moreover, we found that the more people felt autonomy frustrated, the more they were against vaccine passports.

To the extent that vaccine passports do increase psychological need frustration, our data suggest that they might reduce people's willingness to get vaccinated. A vast body of research showed that the satisfaction of the three psychological needs (autonomy, competence and relatedness) is critical for internalising and maintaining behaviours that improve health and well-being [14,15]. Moreover, frustration of these needs may elicit undesired responses, including disengagement from the activity or doing the opposite of what is requested (oppositional defiance) [19]. Our study extends these findings to vaccination behaviour, showing that people's willingness to get vaccinated against COVID-19 is related to the satisfaction and frustration of psychological needs around getting vaccinated—particularly their sense of autonomy. For this reason, control measures such as vaccine passports that frustrate psychological needs may have detrimental effects on people's motivation and willingness to get vaccinated.

Furthermore, if people with frustrated needs do succumb to the pressure to get vaccinated, they are more likely to do so due to external motivation (feeling pressure from others or to satisfy others) rather than due to autonomous identified motivation (wanting to take responsibility over one's health and understanding the importance of the decision). Although such a possibility would provide some immediate benefits in the form of vaccination rates, it might also produce unintended side effects. For example, as previously mentioned, people might be less willing to receive a "booster" shot or to take a yearly vaccine against new variants. In contrast, if people are autonomously motivated to get vaccinated, sustained adherence to vaccine guidance will be more likely [13,14].

Autonomy-frustrating policies such as vaccine passports may also have long-term public health implications in terms of trust in the health system. People who are amotivated, or who feel pressured are unlikely to build good and trusting relationships with local governments and health authorities—relationships that are crucial for public health adherence and behaviour change to occur [16,33]. Moreover, need frustration can damage people's well-being, so need-frustrating policies might add to the already heavy burden of the pandemic on people's mental health [19,34,35]. It is therefore important for governments and policy makers to apply health and risk communication that enhances basic psychological needs, such as creating an autonomy-supportive health care climate and building a caring and trusting relationship with the public (see [16] for full guidelines).

Strengths and Limitations

It is important to note that, in Israel, domestic vaccine passports are given only to fully vaccinated residents or people who have recovered from COVID-19; this may be more restricted than other passports' initiatives, such as the "coronapas" in Denmark, where the requirements for a valid coronavirus passport are full vaccination or two weeks since first dose; a negative test taken within the last 72 h; or recent recovery from COVID-19 [9]. This may influence the level of perceived autonomy, and hence the motivation and decision to get vaccinated. In this study, we evaluated attitudes towards domestic vaccine passports for everyday use (e.g., going to restaurants, social events), not for facilitating international travel, which may have different implications and should be examined.

In addition, this study only analysed data from two developed and democratic countries. Although previous research has shown that the satisfaction of basic needs for autonomy, relatedness and competence are essential for optimal functioning across cultures and across individual differences in need strength [28], it is still important to investigate whether our findings are applicable to other countries and cultures.

Furthermore, our study is quantitative in nature, also eliciting qualitative data about attitudes towards vaccine passports, could enhance our understanding of the reasons behind the satisfaction and frustration of needs.

One key strength of this study is that it includes large, representative samples from two different countries (the UK and Israel). Because these countries have advanced vaccination programmes, we were able to investigate the relationships between psychological needs and actual vaccination behaviour in addition to vaccination intentions. A key limitation of

this study is the observational design. Although we demonstrated robust relationships between psychological needs and people's willingness to get vaccinated, we cannot establish causal links between the two. Although it is possible need frustration reduces willingness to get vaccinated, it is also possible that people first decide whether to get vaccinated, and that decision ultimately leads to more or less need frustration. Such a pattern would still be of interest, however. For example, authorities in the US are going to great lengths to encourage people who have chosen not to get vaccinated to change their minds. If people are experiencing need frustration (for example, because of vaccine passports), it is likely to be even more difficult to change their minds [17,34].

5. Conclusions

Control measures, such as domestic vaccine passports, may have detrimental effects on people's autonomy, motivation and willingness to get vaccinated. We should strive to achieve a highly sustainable vaccinated population by supporting individuals' autonomous motivation to get vaccinated and using messages of autonomy and relatedness. Thus, providing a caring culture and meaningful rationales for a behaviour, rather than applying pressure and external controls.

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

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Summary

Background The SARS-CoV-2 delta (B.1.617.2) variant is highly transmissible and spreading globally, including in populations with high vaccination rates. We aimed to investigate transmission and viral load kinetics in vaccinated and unvaccinated individuals with mild delta variant infection in the community.

Methods Between Sept 13, 2020, and Sept 15, 2021, 602 community contacts (identified via the UK contract-tracing system) of 471 UK COVID-19 index cases were recruited to the Assessment of Transmission and Contagiousness of COVID-19 in Contacts cohort study and contributed 8145 upper respiratory tract samples from daily sampling for up to 20 days. Household and non-household exposed contacts aged 5 years or older were eligible for recruitment if they could provide informed consent and agree to self-swabbing of the upper respiratory tract. We analysed transmission risk by vaccination status for 231 contacts exposed to 162 epidemiologically linked delta variant-infected index cases. We compared viral load trajectories from fully vaccinated individuals with delta infection (n=29) with unvaccinated individuals with delta (n=16), alpha (B.1.1.7; n=39), and pre-alpha (n=49) infections. Primary outcomes for the epidemiological analysis were to assess the secondary attack rate (SAR) in household contacts stratified by contact vaccination status and the index cases' vaccination status. Primary outcomes for the viral load kinetics analysis were to detect differences in the peak viral load, viral growth rate, and viral decline rate between participants according to SARS-CoV-2 variant and vaccination status.

Findings The SAR in household contacts exposed to the delta variant was 25% (95% CI 18–33) for fully vaccinated individuals compared with 38% (24–53) in unvaccinated individuals. The median time between second vaccine dose and study recruitment in fully vaccinated contacts was longer for infected individuals (median 101 days [IQR 74–120]) than for uninfected individuals (64 days [32–97], p=0·001). SAR among household contacts exposed to fully vaccinated index cases was similar to household contacts exposed to unvaccinated index cases (25% [95% CI 15–35] for vaccinated *vs* 23% [15–31] for unvaccinated). 12 (39%) of 31 infections in fully vaccinated household contacts arose from fully vaccinated epidemiologically linked index cases, further confirmed by genomic and virological analysis in three index case–contact pairs. Although peak viral load did not differ by vaccination status or variant type, it increased modestly with age (difference of 0·39 [95% credible interval –0·03 to 0·79] in peak $\log_{10}$ viral load per mL between those aged 10 years and 50 years). Fully vaccinated individuals with delta variant infection had a faster (posterior probability >0·84) mean rate of viral load decline (0·95 $\log_{10}$ copies per mL per day) than did unvaccinated individuals with pre-alpha (0·69), alpha (0·82), or delta (0·79) variant infections. Within individuals, faster viral load growth was correlated with higher peak viral load (correlation 0·42 [95% credible interval 0·13 to 0·65]) and slower decline (–0·44 [–0·67 to –0·18]).

Interpretation Vaccination reduces the risk of delta variant infection and accelerates viral clearance. Nonetheless, fully vaccinated individuals with breakthrough infections have peak viral load similar to unvaccinated cases and can efficiently transmit infection in household settings, including to fully vaccinated contacts. Host–virus interactions early in infection may shape the entire viral trajectory.

Funding National Institute for Health Research.

Introduction

While the primary aim of vaccination is to protect individuals against severe COVID-19 disease and its consequences, the extent to which vaccines reduce onward transmission of SARS-CoV-2 is key to containing the pandemic. This outcome depends on the ability of

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Research in context

Evidence before this study

The SARS-CoV-2 delta variant is spreading globally, including in populations with high vaccination coverage. While vaccination remains highly effective at attenuating disease severity and preventing death, vaccine effectiveness against infection is reduced for delta. Determining the extent of transmission from vaccinated delta-infected individuals to their vaccinated contacts is a public health priority. Comparing the upper respiratory tract (URT) viral load kinetics of delta infections with those of other variants gives insight into potential mechanisms for its increased transmissibility. We searched PubMed and *medRxiv* for articles published between database inception and Sept 20, 2021, using search terms describing "SARS-CoV-2, delta variant, viral load, and transmission". Two studies longitudinally sampled the URT in vaccinated and unvaccinated delta variant-infected individuals to compare viral load kinetics. In a retrospective study of a cohort of hospitalised patients in Singapore, more rapid viral load decline was found in vaccinated individuals than unvaccinated cases. However, the unvaccinated cases in this study had moderate-to-severe infection, which is known to be associated with prolonged shedding. The second study longitudinally sampled professional USA sports players. Again, clearance of delta viral RNA in vaccinated cases was faster than in unvaccinated cases, but only 8% of unvaccinated cases had delta variant infection, complicating interpretation. Lastly, a report of a single-source nosocomial outbreak of a distinct delta sub-lineage in Vietnamese health-care workers plotted viral load kinetics (without comparison with unvaccinated delta infections) and demonstrated transmission between fully vaccinated health-care workers in the nosocomial setting. The findings might therefore not be generalisable beyond the particular setting and distinct viral sub-lineage investigated.

Added value of this study

The majority of SARS-CoV-2 transmission occurs in households, but transmission between fully vaccinated individuals in this setting has not been shown to date. To ascertain secondary transmission with high sensitivity, we longitudinally followed index cases and their contacts (regardless of symptoms) in the community early after exposure to the delta variant of SARS-CoV-2, performing daily quantitative RT-PCR on URT samples for 14–20 days. We found that the secondary attack rate in fully vaccinated household contacts was high at 25%, but this value was lower than that of unvaccinated contacts (38%). Risk of infection increased with time in the 2–3 months since the second dose of vaccine. The proportion of infected contacts was similar regardless of the index cases' vaccination status. We observed transmission of the delta variant between fully vaccinated index cases and their fully vaccinated contacts in several households, confirmed by whole-genome sequencing. Peak viral load did not differ by vaccination status or variant type but did increase modestly with age. Vaccinated delta cases experienced faster viral load decline than did unvaccinated alpha or delta cases. Across study participants, faster viral load growth was correlated with higher peak viral load and slower decline, suggesting that host–virus interactions early in infection shape the entire viral trajectory. Since our findings are derived from community household contacts in a real-life setting, they are probably generalisable to the general population.

Implications of all the available evidence

Although vaccines remain highly effective at preventing severe disease and deaths from COVID-19, our findings suggest that vaccination is not sufficient to prevent transmission of the delta variant in household settings with prolonged exposures. Our findings highlight the importance of community studies to characterise the epidemiological phenotype of new SARS-CoV-2 variants in increasingly highly vaccinated populations. Continued public health and social measures to curb transmission of the delta variant remain important, even in vaccinated individuals.

vaccines to protect against infection and the extent to which vaccination reduces the infectiousness of breakthrough infections.

Vaccination was found to be effective in reducing household transmission of the alpha variant (B.1.1.7) by 40–50%,[1] and infected, vaccinated individuals had lower viral load in the upper respiratory tract (URT) than infections in unvaccinated individuals,[2] which is indicative of reduced infectiousness.[3,4] However, the delta variant (B.1.617.2), which is more transmissible than the alpha variant,[5,6] is now the dominant strain worldwide. After a large outbreak in India, the UK was one of the first countries to report a sharp rise in delta variant infection. Current vaccines remain highly effective at preventing admission to hospital and death from delta infection.[7] However, vaccine effectiveness against infection is reduced for delta, compared with alpha,[8,9] and the delta variant continues to cause a high burden of cases even in countries with high vaccination coverage. Data are scarce on the risk of community transmission of delta from vaccinated individuals with mild infections.

Here, we report data from a UK community-based study, the Assessment of Transmission and Contagiousness of COVID-19 in Contacts (ATACCC) study, in which ambulatory close contacts of confirmed COVID-19 cases underwent daily, longitudinal URT sampling, with collection of associated clinical and epidemiological data. We aimed to quantify household transmission of the delta variant and assess the effect of vaccination status on contacts' risk of infection and index cases' infectiousness, including (1) households with unvaccinated contacts and index cases and (2) households with fully vaccinated contacts and fully vaccinated index cases. We also compared sequentially sampled

URT viral RNA trajectories from individuals with non-severe delta, alpha, and pre-alpha SARS-CoV-2 infections to infer the effects of SARS-CoV-2 variant status—and, for delta infections, vaccination status—on transmission potential.

Methods

Study design and participants

ATACCC is an observational longitudinal cohort study of community contacts of SARS-CoV-2 cases. Contacts of symptomatic PCR-confirmed index cases notified to the UK contact-tracing system (National Health Service Test and Trace) were asked if they would be willing to be contacted by Public Health England to discuss participation in the study. All contacts notified within 5 days of index case symptom onset were selected to be contacted within our recruitment capacity. Household and non-household contacts aged 5 years or older were eligible for recruitment if they could provide written informed consent and agree to self-swabbing of the URT. Further details on URT sampling are given in the appendix (p 13).

The ATACCC study is separated into two study arms, ATACCC1 and ATACCC2, which were designed to capture different waves of the SARS-CoV-2 pandemic. In ATACCC1, which investigated alpha variant and pre-alpha cases in Greater London, only contacts were recruited between Sept 13, 2020, and March 13, 2021. ATACCC1 included a pre-alpha wave (September to November, 2020) and an alpha wave (December, 2020, to March, 2021). In ATACCC2, the study was relaunched specifically to investigate delta variant cases in Greater London and Bolton, and both index cases and contacts were recruited between May 25, and Sept 15, 2021. Early recruitment was focused in West London and Bolton because UK incidence of the delta variant was highest in these areas.[10] Based on national and regional surveillance data, community transmission was moderate-to-high throughout most of our recruitment period.

This study was approved by the Health Research Authority. Written informed consent was obtained from all participants before enrolment. Parents and caregivers gave consent for children.

Data collection

Demographic information was collected by the study team on enrolment. The date of exposure for non-household contacts was obtained from Public Health England. COVID-19 vaccination history was determined from the UK National Immunisation Management System, general practitioner records, and self-reporting by study participants. We defined a participant as unvaccinated if they had not received a single dose of a COVID-19 vaccine at least 7 days before enrolment, partially vaccinated if they had received one vaccine dose at least 7 days before study enrolment, and fully vaccinated if they had received two doses of a COVID-19 vaccine at least 7 days before study enrolment. Previous literature was used to determine the 7-day threshold for defining vaccination status.[11–13] We also did sensitivity analyses using a 14-day threshold. The time interval between vaccination and study recruitment was calculated. We used WHO criteria[14] to define symptomatic status up to the day of study recruitment. Symptomatic status for incident cases—participants who were PCR-negative at enrolment and subsequently tested positive—was defined from the day of the first PCR-positive result.

Laboratory procedures

SARS-CoV-2 quantitative RT-PCR, conversion of ORF1ab and envelope (E-gene) cycle threshold values to viral genome copies, whole-genome sequencing, and lineage assignments are described in the appendix (pp 13–14).

Outcomes

Primary outcomes for the epidemiological analysis were to assess the secondary attack rate (SAR) in household contacts stratified by contact vaccination status and the index cases' vaccination status. Primary outcomes for the viral load kinetics analysis were to detect differences in the peak viral load, viral growth rate, and viral decline rate between participants infected with pre-alpha versus alpha versus delta variants and between unvaccinated delta-infected participants and vaccinated delta-infected participants.

See Online for appendix

We assessed vaccine effectiveness and susceptibility to SARS-CoV-2 infection stratified by time elapsed since receipt of second vaccination as exploratory analyses.

Statistical analysis

To model viral kinetics, we used a simple phenomenological model of viral titre[15] during disease pathogenesis. Viral kinetic parameters were estimated on a participant-specific basis using a Bayesian hierarchical model to fit this model to the entire dataset of sequential cycle threshold values measured for all participants. For the 19 participants who were non-household contacts of index cases and had a unique date of exposure, the cycle threshold data were supplemented by a pseudo-absence data point (ie, undetectable virus) on the date of exposure. Test accuracy and model misspecification were modelled with a mixture model by assuming there was a probability p of a test giving an observation drawn from a (normal) error distribution and probability $1-p$ of it being drawn from the true distribution.

The hierarchical structure was represented by grouping participants based on the infecting variant and their vaccination status. A single-group model was fitted, which implicitly assumes that viral kinetic parameters vary by individual but not by variant or vaccination status. A four-group model was also explored, where groups 1, 2, 3, and 4 represent pre-alpha, alpha, unvaccinated delta, and fully vaccinated delta, respectively. We fitted a correlation matrix between

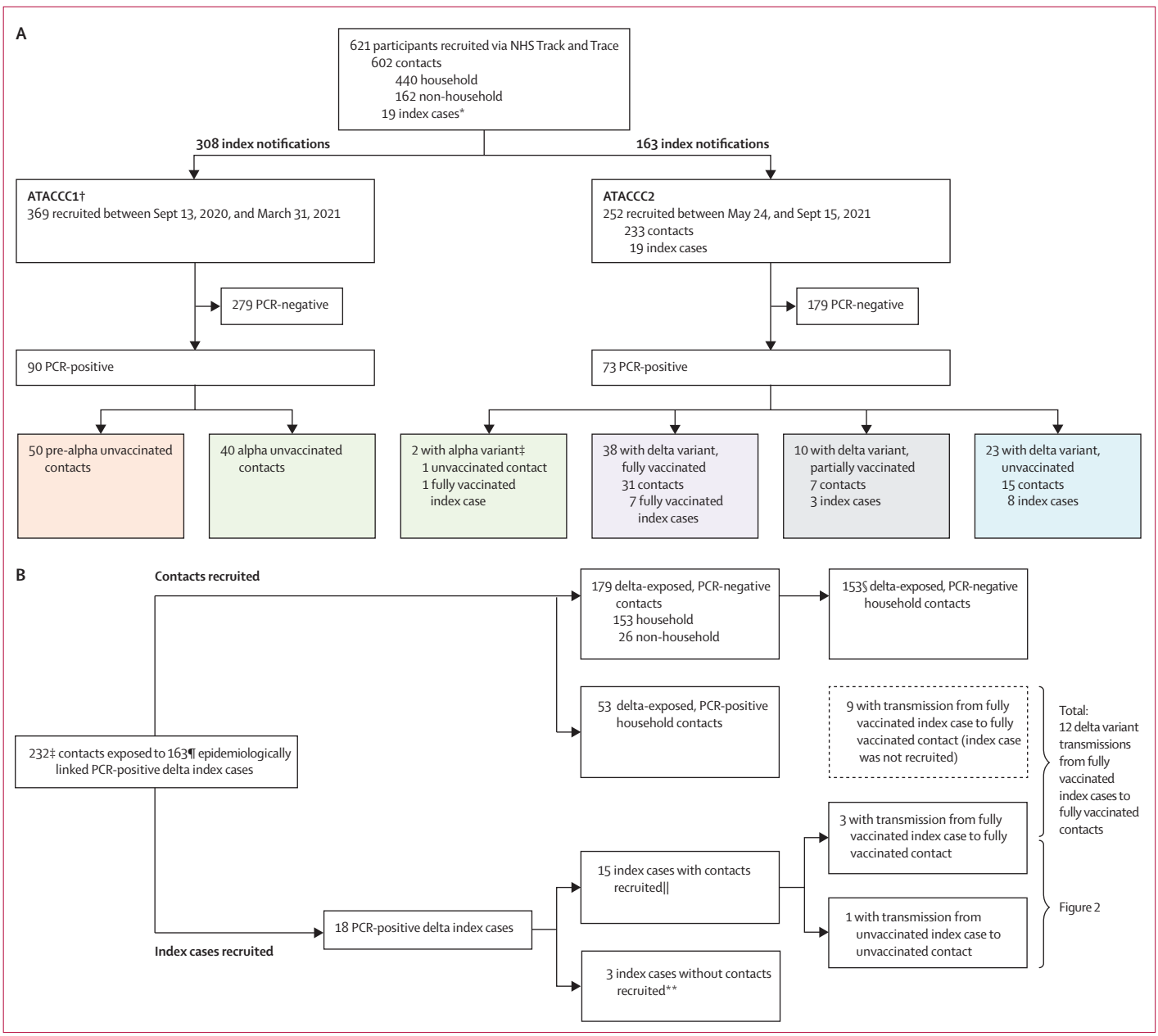


Figure 1: **Recruitment, SARS-CoV-2 infection, variant status, and vaccination history for ATACCC study participants**
(A) Study recruitment and variant status confirmed by whole-genome sequencing (ATACCC1 and ATACCC2 combined). (B) ATACCC2: delta-exposed contacts included in secondary attack rate calculation (table 1) and transmission assessment (table 2). NHS=National Health Service. *All index cases were from ATACCC2. †All contacts. ‡The two earliest PCR-positive cases from the ATACCC2 cohort (one index case and one contact) were confirmed as having the alpha variant on whole-genome sequencing (recruited on May 28, 2021). This alpha variant-exposed, PCR-positive contact is excluded from figure 1B. §One PCR-negative contact had no vaccination status data available and one PCR-negative contact's index case had no vaccination data available. ¶Vaccination data were available for 138 index cases of 163. ||The contacts of these 15 index cases are included within the 232 total contacts. **These three index cases without contacts are only included in the viral load kinetics analysis (figure 3) and are not included in tables 1 and 2.

participant-specific kinetic parameters to allow us to examine whether there is within-group correlation between peak viral titre, viral growth rate, and viral decline rate. Our initial model selection, using leave-one-out cross-validation, selected a four-group hierarchical model with fitted correlation coefficients between individual-level parameters determining peak viral load and viral load growth and decline rates (appendix p 5). However, resulting participant-specific estimates of peak viral load (but not growth and decline rates) showed a marked and significant correlation with age in the exploratory analysis, which motivated examination of models where mean peak viral load could vary with age. The most predictive model overall allowed mean viral

load growth and decline rates to vary across the four groups, with mean peak viral load common to all groups but assumed to vary linearly with the logarithm of age (appendix p 5). We present peak viral loads for the reference age of 50 years with 95% credible intervals (95% CrIs). 50 years was chosen as the reference age as it is typical of the ages of the cases in the whole dataset and the choice of reference age made no difference in the model fits or judgment of differences between the groups.

We computed group-level population means and within-sample group means of log peak viral titre, viral growth rate, and viral decline rate. Since posterior estimates of each of these variables are correlated across groups, overlap in the credible intervals of an estimate for one group with that for another group does not necessarily indicate no significant difference between those groups. We, therefore, computed posterior probabilities, *pp*, that these variables were larger for one group than another. For our model, Bayes factors can be computed as *pp*/(1–*pp*). We only report population (group-level) posterior probabilities greater than 0·75 (corresponding to Bayes factors >3) as indicating at least moderate evidence of a difference.

For vaccine effectiveness, we defined the estimated effectiveness at preventing infection, regardless of symptoms, with delta in the household setting as 1 – SAR (fully vaccinated) / SAR (unvaccinated).

Role of the funding source

The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.

Results

Between Sept 13, 2020, and Sept 15, 2021, 621 community-based participants (602 contacts and 19 index cases) from 471 index notifications were prospectively enrolled in the ATACCC1 and ATACCC2 studies, and contributed 8145 URT samples. Of these, ATACCC1 enrolled 369 contacts (arising from 308 index notifications), and ATACCC2 enrolled 233 contacts (arising from 163 index notifications) and 19 index cases. SARS-CoV-2 RNA was detected in 163 (26%) of the 621 participants. Whole-genome sequencing of PCR-positive cases confirmed that 71 participants had delta variant infection (18 index cases and 53 contacts), 42 had alpha variant infection (one index case and 41 contacts), and 50 had pre-alpha variant infection (all contacts; figure 1A).

Of 163 PCR-positive participants, 89 (55%) were female and 133 (82%) were White. Median age was 36 years (IQR 26–50). Sex, age, ethnicity, body-mass index (BMI) distribution, and the frequency of comorbidities were similar among those with delta, alpha, and pre-alpha infection, and for vaccinated and unvaccinated delta-infected participants, except for age and sex (appendix pp 2–3). There were fewer unvaccinated females than males (p=0·04) and, as expected from the age-prioritisation of the UK vaccine roll-out, unvaccinated participants infected with the delta variant were significantly younger (p<0·001; appendix p 3). Median time between exposure to the index case and study enrolment was 4 days (IQR 4–5). All participants had non-severe ambulatory illness or were asymptomatic. The proportion of asymptomatic cases did not differ among fully vaccinated, partially vaccinated, and unvaccinated delta groups (appendix p 3).

No pre-alpha-infected and only one alpha-infected participant had received a COVID-19 vaccine before study enrolment. Of 71 delta-infected participants (of whom 18 were index cases), 23 (32%) were unvaccinated, ten (14%) were partially vaccinated, and 38 (54%) were fully vaccinated (figure 1A; appendix p 3). Of the 38 fully vaccinated delta-infected participants, 14 had received the BNT162b2 mRNA vaccine (Pfizer–BioNTech), 23 the ChAdOx1 nCoV-19 adenovirus vector vaccine (Oxford–AstraZeneca), and one the CoronaVac inactivated whole-virion vaccine (Sinovac).

It is highly probable that all but one of the 233 ATACCC2 contacts were exposed to the delta variant because they were recruited when the regional prevalence of delta was at least 90%, and mostly 95–99% (figure 1B).[10] Of these, 206 (89%) were household contacts (in 127 households), and 26 (11%) were non-household contacts. Distributions of age, ethnicity, BMI, smoking status, and comorbidities were similar between PCR-positive and PCR-negative contacts (appendix p 4). The median time between second vaccine dose and study recruitment in fully vaccinated contacts with delta variant infection was 74 days (IQR 35–105; range 16–201), and this was significantly longer in PCR-positive contacts than in PCR-negative contacts (101 days [IQR 74–120] *vs* 64 days [32–97], respectively, p=0·001; appendix p 4). All 53 PCR-positive contacts were exposed in household settings and the SAR for all delta variant-exposed household contacts was 26% (95% CI 20–32). SAR was

	Total	PCR positive	PCR negative	SAR (95% CI)	p value
Contacts					
All	231	53	178	23 (18–29)	NA
Fully vaccinated	140	31	109	22 (16–30)	0·16
Unvaccinated	44	15	29	34 (22–49)	..
Partially vaccinated	47	7	40	15 (7–28)	NA
Household contacts					
All	205	53	152	26 (20–32)	NA
Fully vaccinated	126	31	95	25 (18–33)	0·17
Unvaccinated	40	15	25	38 (24–53)	..
Partially vaccinated	39	7	32	18 (9–33)	NA

χ^2 test was performed to calculate p values for differences in SAR between fully vaccinated and unvaccinated cases. One PCR-negative contact who withdrew from the study without vaccination status information was excluded. NA=not applicable. SAR=secondary attack rate.

Table 1: **SAR in contacts of delta-exposed index cases recruited to the ATACCC2 study**

	All household contacts (n=204)*	Fully vaccinated contacts (n=125)		Partially vaccinated contacts (n=39)		Unvaccinated contacts (n=40)	
		PCR positive (n=31)	PCR negative (n=94)	PCR positive (n=7)	PCR negative (n=32)	PCR positive (n=15)	PCR negative (n=25)
Fully vaccinated index cases (n=50)	69	12	31	1	8	4	13
Partially vaccinated index cases (n=25)	35	7	12	3	10	3	0
Unvaccinated index cases (n=63)	100	12	51	3	14	8	12

Non-household exposed contacts (n=24, all PCR negative) were excluded. One PCR-negative household contact who withdrew from the study without vaccination status information was excluded. One PCR-negative household contact who could not be linked to their index case was also excluded. *The rows below show the number of contacts exposed to each category of index case.

Table 2: **Comparison of vaccination status of the 138 epidemiologically linked PCR-positive index cases for 204 delta variant-exposed household contacts**

not significantly higher in unvaccinated (38%, 95% CI 24–53) than fully vaccinated (25%, 18–33) household contacts (table 1). We estimated vaccine effectiveness at preventing infection (regardless of symptoms) with delta in the household setting to be 34% (bootstrap 95% CI –15 to 60). Sensitivity analyses using a 14 day threshold for time since second vaccination to study recruitment to denote fully vaccinated did not materially affect our estimates of vaccine effectiveness or SAR (data not shown). Although precision is restricted by the small sample size, this estimate is broadly consistent with vaccine effectiveness estimates for delta variant infection based on larger datasets.[9,16,17]

The vaccination status of 138 epidemiologically linked index cases of 204 delta variant-exposed household contacts was available (figure 1B, table 2). The SAR in household contacts exposed to fully vaccinated index cases was 25% (95% CI 15–35; 17 of 69), which is similar to the SAR in household contacts exposed to unvaccinated index cases (23% [15–31]; 23 of 100; table 2). The 53 PCR-positive contacts arose from household exposure to 39 PCR-positive index cases. Of these index cases who gave rise to secondary transmission, the proportion who were fully vaccinated (15 [38%] of 39) was similar to the proportion who were unvaccinated (16 [41%] of 39). The median number of days from the index cases' second vaccination to the day of recruitment for their respective contacts was 73 days (IQR 38–116). Time interval did not differ between index cases who transmitted infection to their contacts and those who did not (94 days [IQR 62–112] and 63 days [35–117], respectively; p=0·43).

18 of the 163 delta variant-infected index cases that led to contact enrolment were themselves recruited to ATACCC2 and serial URT samples were collected from them, allowing for more detailed virology and genome analyses. For 15 of these, their contacts were also recruited (13 household contacts and two non-household contacts). A corresponding PCR-positive household contact was identified for four of these 15 index cases (figure 1B). Genomic analysis showed that index–contact pairs were infected with the same delta variant sub-lineage in these instances, with one exception (figure 2A). In one household (number 4), an unvaccinated index case transmitted the delta variant to an unvaccinated contact, while another partially vaccinated contact was infected with a different delta sub-lineage (which was probably acquired outside the household). In the other three households (numbers 1–3), fully vaccinated index cases transmitted the delta variant to fully vaccinated household contacts, with high viral load in all cases, and temporal relationships between the viral load kinetics that were consistent with transmission from the index cases to their respective contacts (figure 2B).

Inclusion criteria for the modelling analysis selected 133 participant's viral load RNA trajectories from 163 PCR-positive participants (49 with the pre-alpha variant, 39 alpha, and 45 delta; appendix p 14). Of the 45 delta cases, 29 were fully vaccinated and 16 were unvaccinated; partially vaccinated cases were excluded. Of the 133 included cases, 29 (22%) were incident (ie, PCR negative at enrolment converting to PCR positive subsequently) and 104 (78%) were prevalent (ie, already PCR positive at enrolment). 15 of the prevalent cases had a clearly resolvable peak viral load. Figure 3 shows modelled viral RNA (ORF1ab) trajectories together with the viral RNA copy numbers measured for individual participants. The E-gene equivalent is shown in the appendix (p 2). Estimates derived from E-gene cycle threshold value data (appendix pp 5, 7, 9, 11) were similar to those for ORF1ab.

Although viral kinetics appear visually similar for all four groups of cases, we found quantitative differences in estimated viral growth rates and decline rates (tables 3, 4). Population (group-level) estimates of mean viral load decline rates based on ORF1ab cycle threshold value data varied in the range of 0·69–0·95 $\log_{10}$ units per mL per daxes 4; appendix p 10), indicating that a typical 10-day period was required for viral load to decline from peak to undetectable. A faster decline was seen in the alpha (*pp*=0·93), unvaccinated delta (*pp*=0·79), and fully vaccinated delta (*pp*=0·99) groups than in the pre-alpha group. The mean viral load decline rate of the fully vaccinated delta group was also faster than those of the alpha group (*pp*=0·84) and the unvaccinated delta group (*pp*=0·85). The differences in decline rates translate into a difference of about 3 days in the mean duration of the decline phase between the pre-alpha and delta vaccinated groups.

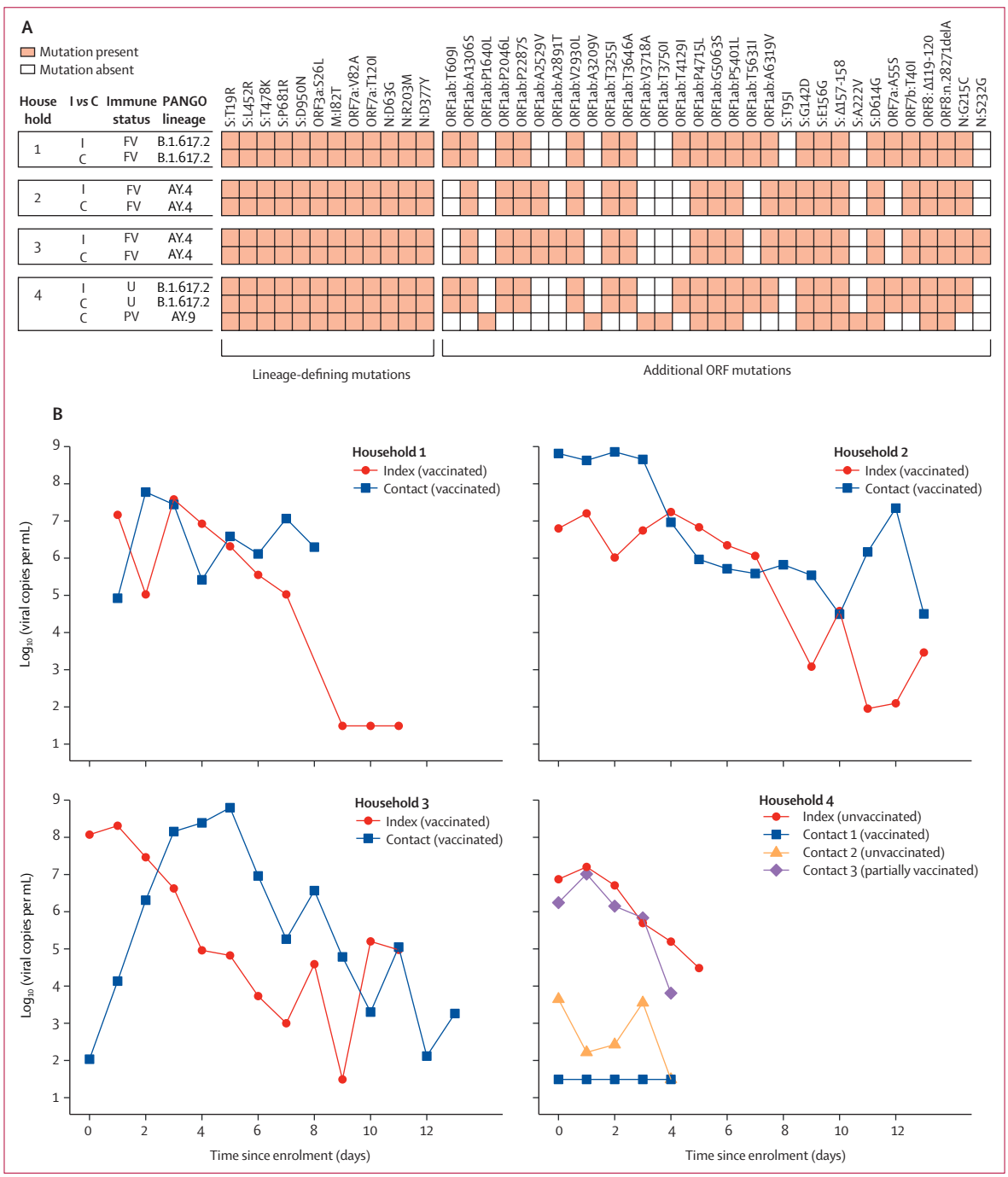
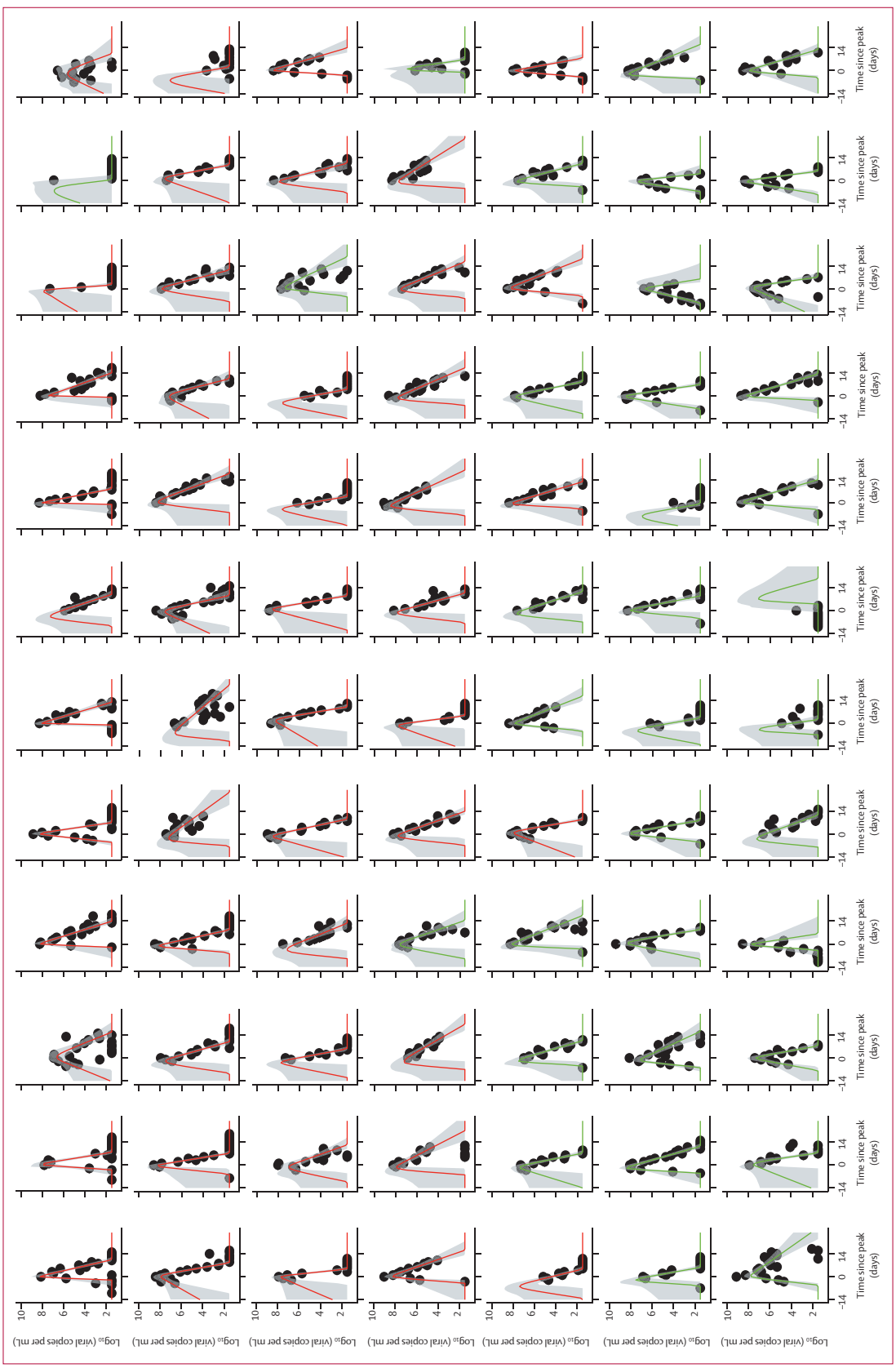


Figure 2: **Virological, epidemiological, and genomic evidence for transmission of the SARS-CoV-2 delta variant (B.1.617.2) in households**
(A) Genomic analysis of the four households with lineage-defining mutations for delta[18] and additional mutations within ORFs displayed to give insight into whether strains from individuals within the household are closely related. Lineages AY.4 and AY.9 are sub-lineages of delta. (B) Viral trajectories and vaccination status of the four index cases infected with the delta variant for whom infection was detected in their epidemiologically linked household contacts. All individuals had non-severe disease. Each plot shows an index case and their household contacts. Undetectable viral load measurements are plotted at the limit of detection ($10^{1\cdot49}$). C=contact. I=index case. FV=fully vaccinated. ORF=open reading frame. PV=partially vaccinated. U=unvaccinated.

Viral load growth rates were substantially faster than decline rates, varying in the range of 2·69–3·24 $\log_{10}$ units per mL per day between groups, indicating that a typical 3-day period was required for viral load to grow from undetectable to peak. Our power to infer differences in growth rates between groups was more restricted than for viral decline, but there was moderate evidence (*pp*=0·79) that growth rates were lower for



(Figure 3 continues on next page)

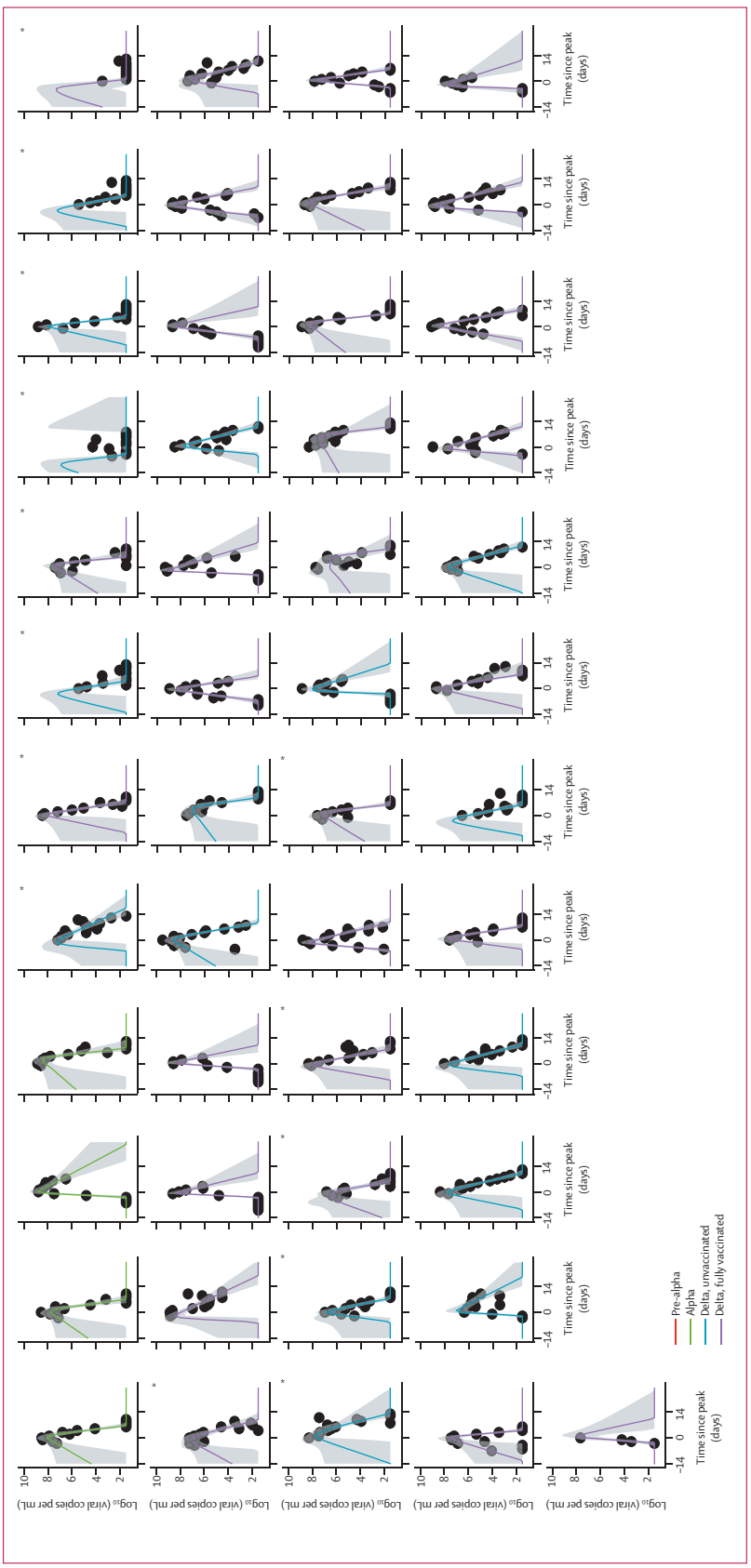


Figure 3: **ORF1ab viral load trajectories from 14 days before to 28 days after peak for 133 participants infected with pre-alpha or alpha variants (uncaccinated), or the delta variant (vaccinated and unvaccinated) variants**
Black circles are measured values, with the first datapoint for each participant being taken to the day of enrolment. Plots are rooted on the day of peak viral load for each participant, denoted as day 0 on the x-axis. Curves show the model posterior median estimate, with a 95% credible interval shading. 133 infected participants, comprising 114 contacts and 19 index cases. *Index cases.

	VL growth rate (95% CrI), log_{10} units per day	Posterior probability estimate is less than pre-alpha	Posterior probability estimate is less than alpha	Posterior probability estimate is less than delta (unvaccinated)	Posterior probability estimate is less than delta (fully vaccinated)
Pre-alpha (n=49)	3·24 (1·78–6·14)	..	0·44	0·27	0·21
Alpha (n=39)	3·13 (1·76–5·94)	0·56	..	0·32	0·25
Delta, unvaccinated (n=16)	2·81 (1·47–5·47)	0·73	0·68	..	0·44
Delta, fully vaccinated (n=29)	2·69 (1·51–5·17)	0·79	0·75	0·56	..

VL growth rates are shown as within-sample posterior mean estimates. Remaining columns show population (group-level) posterior probabilities that the estimate on that row is less than an estimate for a different group. Posterior probabilities are derived from 20 000 posterior samples and have sampling errors of <0·01. VL=viral load. CrI=credible interval.

Table 3: **Estimates of VL growth rates for pre-alpha, alpha, and delta (unvaccinated and fully vaccinated) cases, derived from ORF1ab cycle threshold data**

	VL decline rate (95% CrI), log_{10} units per day	Posterior probability estimate is larger than pre-alpha	Posterior probability estimate is larger than alpha	Posterior probability estimate is larger than delta (unvaccinated)	Posterior probability estimate is larger than delta (fully vaccinated)
Pre-alpha (n=49)	0·69 (0·58–0·81)	..	0·07	0·21	0·01
Alpha (n=39)	0·82 (0·67–1·01)	0·93	..	0·60	0·16
Delta, unvaccinated (n=16)	0·79 (0·59–1·04)	0·79	0·40	..	0·15
Delta, fully vaccinated (n=29)	0·95 (0·76–1·18)	0·99	0·84	0·85	..

VL decline rates are shown as within-sample posterior mean estimates. Remaining columns show population (group-level) posterior probabilities that the estimate on that row is less than an estimate for a different group. Posterior probabilities are derived from 20 000 posterior samples and have sampling errors of <0·01. VL=viral load. CrI=credible interval.

Table 4: **Estimates of VL decline rates for pre-alpha, alpha, and delta (unvaccinated and fully vaccinated) cases, derived from ORF1ab cycle threshold data**

those in the vaccinated delta group than in the pre-alpha group.

We estimated mean peak viral load for 50-year-old adults to be 8·14 (95% CrI 7·95 to 8·32) log_{10} copies per mL, but peak viral load did not differ by variant or vaccination status. However, we estimated that peak viral load increases with age (*pp*=0·96 that the slope of peak viral load with log[age] was >0), with an estimated slope of 0·24 (95% CrI –0·02 to 0·49) log_{10} copies per mL per unit change in log(age). This estimate translates to a difference of 0·39 (–0·03 to 0·79) in mean peak log_{10} copies per mL between those aged 10 years and 50 years.

Within-group individual participant estimates of viral load growth rate were positively correlated with peak viral load, with a correlation coefficient estimate of 0·42 (95% CrI 0·13 to 0·65; appendix p 8). Hence, individuals with faster viral load growth tend to have higher peak viral load. The decline rate of viral load was also negatively correlated with viral load growth rate, with a correlation coefficient estimate of –0·44 (95% CrI –0·67 to –0·18), illustrating that individuals with faster viral load growth tend to experience slower viral load decline.

Discussion

Households are the site of most SARS-CoV-2 transmission globally.[19] In our cohort of densely sampled household contacts exposed to the delta variant, SAR was 38% in unvaccinated contacts and 25% in fully vaccinated contacts. This finding is consistent with the known protective effect of COVID-19 vaccination against infection.[8,9] Notwithstanding, these findings indicate continued risk of infection in household contacts despite vaccination. Our estimate of SAR is higher than that reported in fully vaccinated household contacts exposed before the emergence of the delta variant.[1,20,21] The time interval between vaccination and study recruitment was significantly higher in fully vaccinated PCR-positive contacts than fully vaccinated PCR-negative contacts, suggesting that susceptibility to infection increases with time as soon as 2–3 months after vaccination—consistent with waning protective immunity. This potentially important observation is consistent with recent large-scale data and requires further investigation.[17] Household SAR for delta infection, regardless of vaccination status, was 26% (95% CI 20–32), which is higher than estimates of UK national surveillance data (10·8% [10·7–10·9]).[10] However, we sampled contacts daily, regardless of symptomatology, to actively identify infection with high sensitivity. By contrast, symptom-based, single-timepoint surveillance testing probably underestimates the true SAR, and potentially also overestimates vaccine effectiveness against infection.

We identified similar SAR (25%) in household contacts exposed to fully vaccinated index cases as in those exposed to unvaccinated index cases (23%). This finding indicates that breakthrough infections in fully vaccinated people can efficiently transmit infection in the household setting. We identified 12 household transmission events between fully vaccinated index case–contact pairs; for three of these, genomic sequencing confirmed that the index case and

contact were infected by the same delta variant sub-lineage, thus substantiating epidemiological data and temporal relationships of viral load kinetics to provide definitive evidence for secondary transmission. To our knowledge, one other study has reported that transmission of the delta variant between fully vaccinated people was a point-source nosocomial outbreak—a single health-care worker with a particular delta variant sub-lineage in Vietnam.[22]

Daily longitudinal sampling of cases from early (median 4 days) after exposure for up to 20 days allowed us to generate high-resolution trajectories of URT viral load over the course of infection. To date, two studies have sequentially sampled community cases of mild SARS-CoV-2 infection, and these were from highly specific population groups identified through asymptomatic screening programmes (eg, for university staff and students[23] and for professional athletes[24]).

Our most predictive model of viral load kinetics estimated mean peak $\log_{10}$ viral load per mL of 8·14 (95% CrI 7·95–8·32) for adults aged 50 years, which is very similar to the estimate from a 2021 study using routine surveillance data.[25] We found no evidence of variation in peak viral load by variant or vaccination status, but we report some evidence of modest but significant (pp=0·95) increases in peak viral load with age. Previous studies of viral load in children and adults[4,25,26] have not used such dense sequential sampling of viral load and have, therefore, been restricted in their power to resolve age-related differences; the largest such study[25] reported a similar difference between children and adults to the one we estimated. We found the rate of viral load decline was faster for vaccinated individuals with delta infection than all other groups, and was faster for individuals in the alpha and unvaccinated delta groups than those with pre-alpha infection.

For all variant vaccination groups, the variation between participants seen in viral load kinetic parameter estimates was substantially larger than the variation in mean parameters estimated between groups. The modest scale of differences in viral kinetics between fully vaccinated and unvaccinated individuals with delta infection might explain the relatively high rates of transmission seen from vaccinated delta index cases in our study. We found no evidence of lower SARs from fully vaccinated delta index cases than from unvaccinated ones. However, given that index cases were identified through routine symptomatic surveillance, there might have been a selection bias towards identifying untypically symptomatic vaccine breakthrough index cases.

The differences in viral kinetics we found between the pre-alpha, alpha, and delta variant groups suggest some incremental, but potentially adaptive, changes in viral dynamics associated with the evolution of SARS-CoV-2 towards more rapid viral clearance. Our study provides the first evidence that, within each variant or vaccination group, viral growth rate is positively correlated with peak viral load, but is negatively correlated with viral decline rate. This finding suggests that individual infections during which viral replication is initially fastest generate the highest peak viral load and see the slowest viral clearance, with the latter not just being due to the higher peak. Mechanistically, these data suggest that the host and viral factors determining the initial growth rate of SARS-CoV-2 have a fundamental effect on the trajectory throughout infection, with faster replication being more difficult (in terms of both peak viral load and the subsequent decline of viral load) for the immune response to control. Analysis of sequentially sampled immune markers during infection might give insight into the immune correlates of these early differences in infection kinetics. It is also possible that individuals with the fastest viral load growth and highest peaks contribute disproportionately to community transmission, a hypothesis that should be tested in future studies.

Several population-level, single-timepoint sampling studies using routinely available data have found no major differences in cycle threshold values between vaccinated and unvaccinated individuals with delta variant infection.[10,27,28] However, as the timepoint of sampling in the viral trajectory is unknown, this restricts the interpretation of such results. Two other studies longitudinally sampled vaccinated and unvaccinated individuals with delta variant infection.[23,29] A retrospective cohort of hospitalised patients in Singapore[29] also described a faster rate of viral decline in vaccinated versus unvaccinated individuals with delta variant, reporting somewhat larger differences in decline rates than we estimated here. However, this disparity might be accounted for by the higher severity of illness in unvaccinated individuals in the Singaporean study (almost two-thirds having pneumonia, one-third requiring COVID-19 treatment, and a fifth needing oxygen) than in our study, given that longer viral shedding has been reported in patients with more severe illness.[30] A longitudinal sampling study in the USA reported that pre-alpha, alpha, and delta variant infections had similar viral trajectories.[24] The study also compared trajectories in vaccinated and unvaccinated individuals, reporting similar proliferation phases and peak cycle threshold values, but more rapid clearance of virus in vaccinated individuals. However, this study in the USA stratified by vaccination status and variant separately, rather than jointly, meaning vaccinated individuals with delta infection were being compared with, predominantly, unvaccinated individuals with pre-alpha and alpha infection. Moreover, sampling was done as part of a professional sports player occupational health screening programme, making the results not necessarily representative of typical community infections.

Our study has limitations. First, we recruited only contacts of symptomatic index cases as our study recruitment is derived from routine contact-tracing notifications. Second, index cases were defined as the first household member to have a PCR-positive swab, but we cannot exclude the possibility that another household member might already have been infected and transmitted

to the index case. Third, recording of viral load trajectories is subject to left censoring, where the growth phase in prevalent contacts (already PCR-positive at enrolment) was missed for a proportion of participants. However, we captured 29 incident cases and 15 additional cases on the upslope of the viral trajectory, providing valuable, informative data on viral growth rates and peak viral load in a subset of participants. Fourth, owing to the age-stratified rollout of the UK vaccination programme, the age of the unvaccinated, delta variant-infected participants was lower than that of vaccinated participants. Thus, age might be a confounding factor in our results and, as discussed, peak viral load was associated with age. However, it is unlikely that the higher SAR observed in the unvaccinated contacts would have been driven by younger age rather than the absence of vaccination and, to our knowledge, there is no published evidence showing increased susceptibility to SARS-CoV-2 infection with decreasing age.[31] Finally, although we did not perform viral culture here—which is a better proxy for infectiousness than RT-PCR—two other studies[27,32] have shown cultivable virus from around two-thirds of vaccinated individuals infected with the delta variant, consistent with our conclusions that vaccinated individuals still have the potential to infect others, particularly early after infection when viral loads are high and most transmission is thought to occur.[30]

Our findings help to explain how and why the delta variant is being transmitted so effectively in populations with high vaccine coverage. Although current vaccines remain effective at preventing severe disease and deaths from COVID-19, our findings suggest that vaccination alone is not sufficient to prevent all transmission of the delta variant in the household setting, where exposure is close and prolonged. Increasing population immunity via booster programmes and vaccination of teenagers will help to increase the currently limited effect of vaccination on transmission, but our analysis suggests that direct protection of individuals at risk of severe outcomes, via vaccination and non-pharmacological interventions, will remain central to containing the burden of disease caused by the delta variant.

Contributors

AS, JD, MZ, NMF, WB, and ALal conceptualised the study. AS, SH, JD, KJM, AK, JLB, MGW, ND-F, RV, RK, JF, CT, AVK, JC, VQ, EC, JSN, SH, EM, TP, HH, CL, JS, SB, JP, CA, SA, and NMF were responsible for data curation and investigation. AS, SH, KJM, JLB, AC, NMF, and ALal did the formal data analysis. MAC, AB, DJ, SM, JE, PSF, SD, and ALac did the laboratory work. RV, RK, JF, CT, AVK, JC, VQ, EC, JSN, SH, EM, and SE oversaw the project. AS, SH, JD, KJM, JLB, NMF, and ALal accessed and verified the data. JD, MZ, and ALal acquired funding. NMF sourced and oversaw the software. AS and ALal wrote the initial draft of the manuscript. AS, JD, GPT, MZ, NMF, SH, and ALal reviewed and edited the manuscript. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

The ATACCC Study Investigators

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Declaration of interests

NMF reports grants from UK Medical Research Council, UK National Institute of Health Research, UK Research and Innovation, Community Jameel, Janssen Pharmaceuticals, the Bill & Melinda Gates Foundation, and Gavi, the Vaccine Alliance; consulting fees from the World Bank; payment or honoraria from the Wellcome Trust; travel expenses from WHO; advisory board participation for Takeda; and is a senior editor of the *eLife* journal. All other authors declare no competing interests.

Data sharing

An anonymised, de-identified version of the dataset can be made available upon request to allow all results to be reproduced. Modelling code will also be made publicly available on the GitHub repository.

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Oppose SB 839.pdf
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Position: UNF

Oppose SB 839

Over the past two years we saw how the narrative was developed to support establishing rules designed to make the lives of the unvaccinated unbearable. Those rules limit access not only to discretionary activities but also to means of providing for families. Yet those vaccines have just a limited benefit, even that applicable to selected groups of people only. Worse yet, they do nothing to stop the infections, as an attached study shows.

As Covid-19 vaccination does not prevent transmission or infection, there is no compelling justification to segregate society into such distinct groups and restrict activities and reduce livelihood of the “undesirable” group. In fact, as the attached article explains, the passports “may backfire” against efforts to increase immunization.

Needless to say, most businesses do not support such programs due to unnecessary burden on operations and negative perception from customers. A vaccine passport proposal has failed in Montgomery County for these reasons. Even if a business implements a vaccine passport, they would be promising a false sense of security, as there is no guarantee of preventing infections.

The decision whether to take any vaccine must be a private, voluntary decision between healthcare providers and patients based on the individual risk/benefit profile of each patient. Forced to take a vaccine by the John Hopkins Hospital to keep her only job, one local woman died from her vaccine reaction. Yet, the employer was not responsible. There are many such cases.

Various private and public systems have been hacked and personal information exposed. Besides great financial cost, this creates risks for individuals that immensely complicate their lives overall, and destroys trust in such systems.

With the need for such a sensitive system to be accessible from a great variety of devices and situations, the cost to maintain such a system will be enormous and growing by the year. With the risks so great and no benefit, why should the state invest in the program? Does any business in the state actually benefit from this implementation? And the bill even calls for marketing expenses to be paid by the state!

Please oppose bill SB 839. There is no justification for spending on such a program with questionable benefits, the program that segregates society, discriminates based on medical or genetic information, violates medical privacy, risks exposure of sensitive information, and increases costs for everyone.

No to Vaccine Passports.pdf
Uploaded by: Mary McNamara Hugo
Position: UNF

March 1, 2022

TO whom it may concern -

As a lifelong resident of the state of Maryland I vote NO to the following two bills -

SB 0839 - MD Voluntary COVID -19 Vaccine Passport by Senator Rosapepe

SB 0840 - COVID - 19 Response Act of 2022

I, Mary McNamara Hugo, a registered voter and tax payer of Maryland, **do not support** these two bills.

VOTE NO.

Mary McNamara Hugo
8528 Horseshoe Lane
Potomac, Maryland 20854

Matthew McBride - OPPOSED SB 839 - Maryland Volunt
Uploaded by: Matthew McBride
Position: UNF

Matthew McBride, MPH, MSHI
2215 227th Street
Pasadena, MD 21122

I am opposed to SB 839 - Maryland Voluntary COVID-19 Vaccine Passport.

I have worked in health care public policy for 25 years. This has included four years with the United State Department of Health and Human Services, Office of the Assistant Secretary for Preparedness and Response (HHS/ASPR), the federal pandemic response authority. At HHS/ASPR I served on the H1N1 pandemic response and the 2014 Ebola response. I wrote the H1N1 pandemic after-action report, which consolidated all federal pandemic response knowledge in preparation for the next pandemic (i.e., COVID). During Ebola I was the HHS point of contact for all US hospitals and physicians seeking patient treatment information and working with CDC to develop treatment and infection safety protocols.

Novel pandemic viruses spread quickly because by definition a "novel" virus has never before been encountered by the human population, and thus there is no inherent immunity. Therefore, savings lives and preventing disease-related injuries during a pandemic or epidemic is dependent on the timely delivery of *effective* medical countermeasures (MCMs), especially personal protective equipment (PPE) and vaccines. To be effective, PPE must be rated for the specific virus, fit-tested to the user and not leak air; and unless an individual is trained in its use, self-infection will occur. Vaccines are only effective if they have high efficacy and are delivered rapidly to the general population.

It is to the point of vaccine efficacy that renders vaccine passports moot. A vaccine passport is useless whether the vaccine is effective or not:

- **Assume the vaccine is 100% effective.** Given that 74% of the Maryland population is considered fully vaccinated[1], we are far above the COVID-19 herd immunity threshold of 60%[2] simply by means of vaccination alone. Thus, there is no need for a vaccine passport.

- **Assume the vaccine is not 100% effective.** As the State of Maryland reports, "Approximately 39.17% of all confirmed COVID-19 cases in Maryland since January 2021 have been among fully vaccinated individuals."[3] (Note that it is likely higher than 39%, as individuals who are not showing signs of illness are not as likely to present to be tested and confirmed for COVID.) If nearly half of Marylanders with a valid vaccine passport can have COVID anyway, then a passport confirming their vaccination status is useless.

Finally, it should be pointed out that after nearly two years of Marylanders mixing freely in the company of their friends, neighbors, and families, the actual threat from COVID does not warrant a vaccine passport among the general population; state hospital occupancy rates show this to be true. After two years, even Ebola and H1N1 would be long gone under these circumstances.

Vaccine passports are merely an exercise in inefficiency, a complete waste of money and time. I urge the committee to reject SB 839.

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[1] https://usafacts.org/visualizations/covid-vaccine-tracker-states/state/maryland
[2] Herd immunity threshold formula is 1-(1/R0). R0 for SARS2 is between 2.5 to 2.9. Plugging in 2.5 and 2.9 for R0 returns a herd immunity threshold for the general population of 60% to 66%.
[3] https://coronavirus.maryland.gov/

Anti Vax Mandate.pdf
Uploaded by: Maureen Reim
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision.

This code of ethics must be upheld ion any civilized country.

2022 SB839.pdf
Uploaded by: Megan Montgomery
Position: UNF

OPPOSE SB 839

Prevent Marylander's Medical Data from Exposure to Foreign Threats

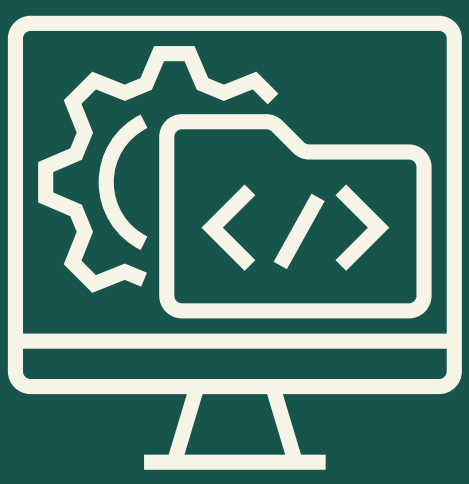
KEEP OUR MEDICAL INFORMATION PRIVATE

DANGER OF COMPROMISING DATA

This year Maryland's Health Dept data center was compromised. Creating a platform that works in conjunction with foreign countries will only further threaten private medical data.

FISCALLY IRRESPONSIBLE

The incredibly high price tag of creating an international system of medical records and maintaining it in every language makes a system like this cost-prohibitive..

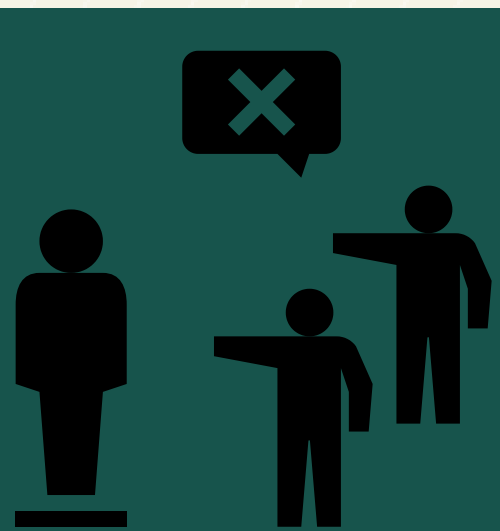


IMMUNET INEFFICIENCIES

The state's current vaccine record tracking system has been shown to be extremely vulnerable to user input errors. We have received numerous reports of missing or incomplete vaccination records.

UNNECESSARY BURDEN

Creating an expensive system such as this puts an unnecessary burden on our Health Department and risks sidelining projects that will help out most vulnerable Marylander's. Most residents have never needed to share their vaccinaiton status and never will.



DISCRIMINATION

The vast majority of venues and businesses are no longer requiring vaccination, because doing so denies access to low income communities, particularly those of color, who may not have a smart phone or an ID.

PROTECT MARYLANDER'S PRIVATE MEDICAL DATA
SAY NO TO AN INTERNATIONALLY COMPATIBLE VACCINE DATABASE

SB839 UNF Love Maryland PAC.pdf
Uploaded by: Megan Montgomery
Position: UNF

SB839

Unfavorable

Love Maryland PAC

Dear Chair Kelley, Vice Chair Feldman, and Distinguished Members of the Finance Committee,

The Love Maryland PAC submits testimony to request an unfavorable report on SB839- Voluntary Covid-19 Vaccine Passports.

These passports are unnecessary, dangerous for our citizens private medical data and simply not wanted here in the state of Maryland.

The Montgomery County Council recently held a hearing on vaccine passports. The response was overwhelming and all negative. They received so much testimony that they had to schedule a second hearing on the initiative. The Montgomery Country Chamber of Commerce opposed it, ALL businesses that spoke opposed it, every citizen that spoke opposed it. The onus on businesses (even if labeled as voluntary) was overwhelming. Businesses can barely hire enough workers to keep their doors open now, let alone having to hire additional vaccine passport checkers, is simply not possible in this employment environment.

Additionally, given the ongoing conflict and cyberattacks by Russia, the last thing we should be encouraging is for our citizens to put their private medical data on an unprotected app for anyone to hack. We request that this passport is off the table until such time as the government can guarantee that the information is secure.

This bill is fiscally irresponsible. We are in a time of great need amongst our most vulnerable citizens. The money that would be wasted on these unnecessary passports and the IT infrastructure that would be required to support such an endeavor could be spent to actually bring much needed services to our low-income residents- services desperately needed after almost 2 years of being locked out of routine medical care.

This bill discriminates against our socioeconomically disadvantaged and BIPOC communities. Not everyone has access to a computer, smartphone and the internet. This bill will serve as a racial barrier for our citizens to meet their most basic needs. Vulnerable Marylanders need actual help and support in meeting their medical needs- and this bill does nothing but divert needed resources away from the citizens who need the resources the most.

For the reasons listed above, we ask the committee to deliver an unfavorable report on SB839.

Sincerely,

Megan Montgomery

Chair

Love Maryland PAC

Testimony.pdf
Uploaded by: Melissa Burns
Position: UNF

SB839/SB840
UNFAVORABLE
Melissa Burns

I thank you for the work you do for the citizens of our state. I ask you to oppose these proposed bills in order to preserve our rights and those of future generations. These bills, if passed, can be slippery slopes to the degradation of our rights as Americans as protected by both our state and national constitutions. Thank you for your consideration and the work you do to protect the rights of Marylanders.

SB 839:

Why I oppose this bill:

1.One's medical information is one's own business and should not be used to discriminate and segregate citizens based on vaccine status. Vaccines are not safe for everyone and individuals need to have complete control over their medical decisions. I have several family members who have vaccine injuries and can no longer receive vaccines. It is discriminatory to segregate these individual in various societal situations.
2. No business should be discriminating who can or cannot use their service based on COVID or other vaccination status especially vaccines that are still only Emergency Use Approved.
3.The CDC itself has said that the vaccinated can both get and spread COVID virus. Many unvaccinated people have natural immunity which is cross protective, enduring and a benefit to the public.
4.One's medical information should be protected information but we have seen repeatedly that "protected" information can be hacked.
5.Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy and health choice.
6.Public funding would be used to develop and market an unnecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness and control.

SB 840:

Why I oppose this bill:

1. I oppose any vaccine passport as our medical information should be private and not used to divide and segregate the population into vaxxed and unvaxxed.
2. Vaccine passports have been withdrawn globally.
3. Pharmacies are not doctor's offices and pharmacists (and their assistants) are not doctors. They should not have the authority to ORDER and vaccinate our children even more so without parental or guardian informed consent.

4. This bill was originally intended to expire by the end of 2022 and it should expire. It was an emergency use bill intended for a pandemic which has passed. The authorizations given in the original bill should expire as intended.
5. The bill is a combination of all kinds of unrelated things, from listing the qualifications for certain practitioners, to rates for an urgent care center to tracking, testing and funding for a virus that no longer exists. Each of these things should be considered separately with thoughtful debate, not thrown together in a bill that is too far reaching.

Regards,
Melissa Burns

TESTIMONY OF MICHAEL RYAN VS MD SENATE BILLS 0839

Uploaded by: Michael Ryan

Position: UNF

TESTIMONY OF MICHAEL RYAN VS. MD SENATE BILLS 0839 & 0840

Requiring a vaccine passport to engage in normal life activities is a horrible idea and a violation of many personal freedoms. Whether you are in favor of vaccinations or not, people should not be required to have a foreign substance injected into their body to live normal lives. If the vaccines are very effective, then those vaccinated have nothing to fear from the unvaccinated.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion**; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country. The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

People decline COVID-19 vaccines for medical reasons or sincerely held ethical, moral, or religious beliefs. The valued and valuable ethical and legal traditions of the United States and Maryland are clear that it not acceptable to discriminate on the basis of medical condition/disability or on the basis of religion/religious belief.

Doctor/medical practitioner-patient confidentiality is legally protected and essential for a myriad of reasons, and the privacy & protection of medical records is also important. The COVID-19 passports and other COVID requirements erode or remove these legal protections.

COVID passports set the groundwork for a two-tiered society, in which persons who have received vaccinations may live normal lives (including work, schooling, right to assembly, and access to various services) and persons who have not received vaccinations are denied those rights. Do we want to live in such a society? Recall history, our worst moments and our greatest achievements! Does it not always go badly when one group is dehumanized and denied rights based on a physical or religious characteristic? Are we not proudest of those movements which restore those rights?

: Everyone has the right to bodily integrity, which includes the right to decline medical interventions. There is some serious philosophical inconsistency among the legislation under consideration this session. Bills to expand access to abortion and to enshrine abortion in Maryland law are under debate, underpinned by a 'my body, my choice' argument. Persons who wish to decline COVID vaccines are not being offered the same respect for 'my body, my choice'! You can't have it both ways!

03022022-Unfavorable-OPPOSE-SB839-red.pdf
Uploaded by: Michelle Bailey
Position: UNF

I am writing to OPPOSE SB839, Maryland Voluntary COVID-19 Vaccine Passport.

If you are intending to enforce Covid-19 vaccine passports and/or vaccine mandates in the State of Maryland, as per SB 839 and SB 840 for which hearings are scheduled tomorrow, I would presume that your reason for doing so would be to prevent the spread of the disease, and to keep Marylanders safe. If so, please consider the following:

The Covid-19 vaccines are using a novel technology and are still in their experimental phase, using undisclosed ingredients for which we do not yet know the long-term consequences, which are used only under Emergency Use Authorization (EUA), and for which vaccine manufacturers are completely exempt from any liability. To justify vaccinating, let alone coercing vaccination with such a product through vaccine passports and vaccine mandates, I challenge you to prove that (1) data shows that these vaccines are absolutely necessary in order to protect Maryland residents; (2) data shows that these vaccines are highly effective to protect against and prevent the spread of Covid-19; and (3) data shows that these vaccines are safe.

The data clearly supports three compelling and urgent reasons why passing this regulation, paving the way for vaccine passports, will put Maryland residents at unnecessary and unimaginably high risk:

The Covid-19 vaccines are:

1. **UNNECESSARY** due to the *high survivability* of Covid-19; due to *natural immunity* being far stronger and long-lasting than vaccine-induced immunity; and because – for those who do get seriously ill – there is *safe and efficient outpatient treatment* of Covid-19 that saves lives.

   Supporting data:

   - The median Infection Fatality Rate (or IFR – **the risk of dying from Covid-19, if infected**, is 0.0013% in 0 - 19-year-olds; 0.0088% in 20 - 29-year-olds; 0.021% in 30 - 39-year-olds; 0.042% in 40 - 49-year-olds; 0.14% in 50 - 59-year-olds; 0.65% in 60 - 69-year-olds; and 2.9% in over-70-year-olds.

     See Axfors, Cathrine and John P. A. Ioannidis: "Infection fatality rate of COVID-19 in community-dwelling populations with emphasis on the elderly: An overview" (This pre-print article is providing updated findings from Stanford Professor John Ioannidis May 2021 article "Reconciling estimates of global spread and infection fatality rates of COVID-19: An overview of systematic evaluations" European Journal of Clinical Investigation, 2021-05, Vol.51 (5))

- There is mounting evidence that natural immunity against COVID-19 not only exists, but is robust and long-lasting.
  See 146 Research Studies Affirm Naturally Acquired Immunity to Covid-19: Documented, Linked, and Quoted

- For an overview of the effectiveness and amplitude of early treatments for Covid-19, see COVID-19 Early Treatment: Real-Time Analysis of 1,316 Studies

2. **NOT EFFECTIVE** in protecting against and preventing the spread of Covid-19

Supporting data:

- A recent large study published in the journal *Science* showed that by the end of September 2021 the effectiveness of all three Covid-19 vaccines had fallen dramatically (Moderna: 58%, Pfizer: 45%; Johnson & Johnson: 13%) and even more recent data suggests that with the Omicron variant the effectiveness has fallen even further.
  See Cohn, Barbara et al., "SARS-CoV-2 Vaccine Protection and Deaths Among US Veterans During 2021" *Science*, November 4, 2021.

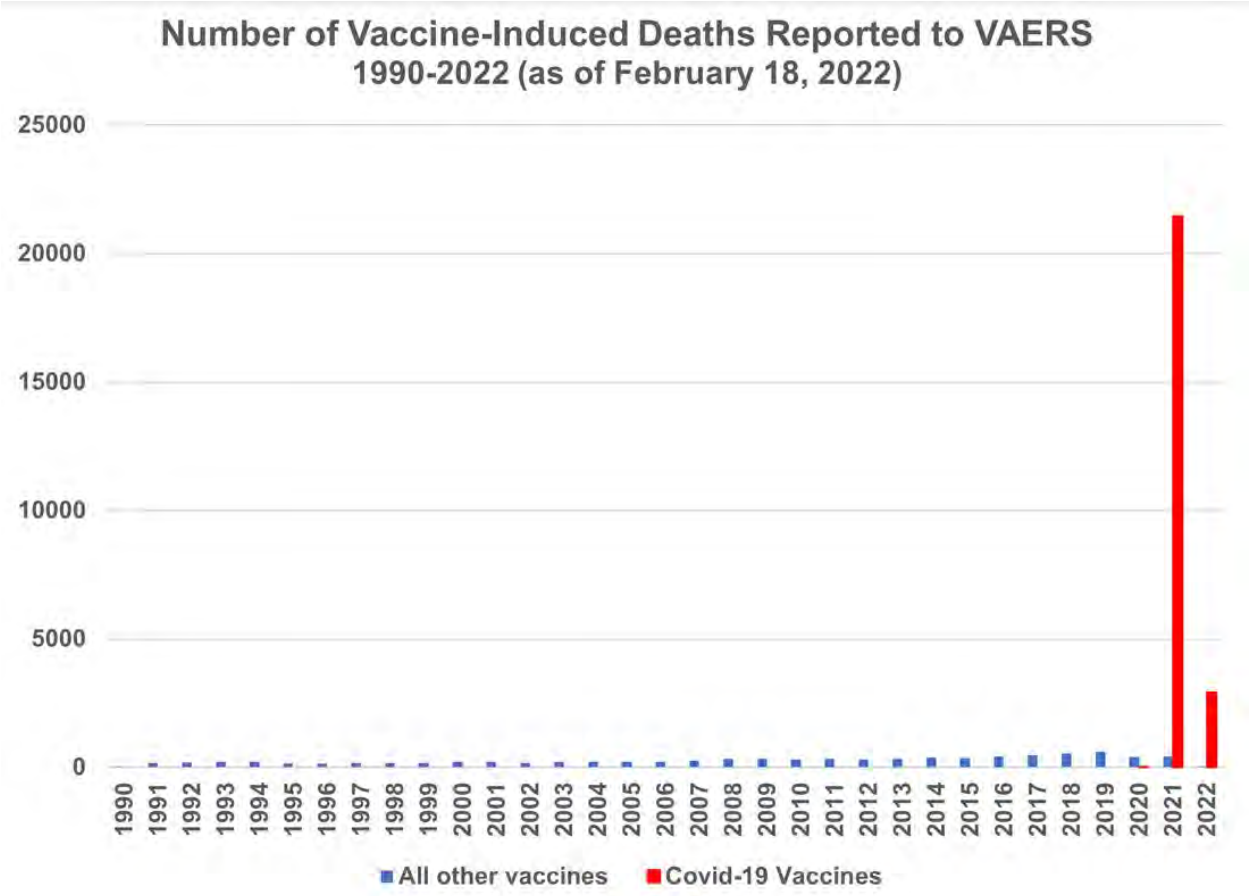
- The argument that the Covid-19 vaccines, when they work, protect against serious illness and death are also being disproven as we speak, for example as 83% of COVID-19 deaths between mid-October and mid-November of 2021 were among vaccinated individuals in Scotland
  See page 55 in Public Health Scotland COVID-19 Statistical Report (Published December 1, 2021)

- Recent UK government data as well as a recent German study find that Covid-19 vaccine boosters neither prevent infection nor transmission, and also continue to lead to severe illness and death among triple-vaccinated.

  See COVID-19 vaccine surveillance report - Week 45 (Published by the UK Health Security Agency on November 11, 2021) and Kuhlmann, C. et al., "Breakthrough Infections with SARS-CoV-2 Omicron Variant Despite Booster Dose of mRNA Vaccine" (Published December 10, 2021)

3. **NOT SAFE**, as unconscionable numbers of reports of serious side-effects have been submitted into the U.S. Government-run Vaccine Adverse Event Reporting System (VAERS), including 24,402 of which resulted in death, 133,057 of which resulted in hospitalization, 44.512 of which resulted in permanent disability, 12,511 of which resulted in heart attacks, and 34,448 of which resulted in myocarditis/pericarditis, all following Covid-19 vaccination. To put things in perspective, here is a graph that shows the total number of deaths reported into

VAERS since 1990, when this system was created to serve as a safeguard in order to stop new vaccines that prove to be unsafe. Note that all blue bars represent all of the the 196 vaccines that have been put through the system since 1990, except the three Covid-19 vaccines which are depicted in red:



Source: United States Department of Health and Human Services (DHHS), Public Health Service (PHS), Centers for Disease Control (CDC) / Food and Drug Administration (FDA), Vaccine Adverse Event Reporting System (VAERS) 1990 - 01/07/2022, CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/vaers.html on March 1, 2022 9:24 PM

The graph above speaks for itself. Add to the picture the fact that scientific analyses from Harvard University and Columbia University have concluded that the reporting rate to VAERS is somewhere between 1% and 5% of true cases. Multiply the COVID-19 vaccine deaths by those proportions, and **a stunning 480,040 to 2,400,200 Americans have died from the Covid-19 vaccines**, with at least as many being permanently disabled.

Recent reports from life insurance companies around the U.S. confirm that there is a stunning increase in death claims in 2021 compared to 2020, by as much as 40% among people ages 18-64 (as in this reported case of Indiana-based life insurance company OneAmerica).

Supporting Data:

- Vaccine Adverse Event Reporting System (VAERS)
- The weekly updated summaries and charts from OPEN VAERS provide an easier way to browse through key data

If you pass this proposed legislation effectively coercing Maryland residents to take this vaccine despite being aware of the severe risks and deficiencies outlined above, you are NOT acting in the best interest of the citizens of Maryland, but are knowingly putting them at risk. For this, we will hold you liable.

I have expressed no matter of mere “concern” or any other non-substantive matter, but solely matters of substance, of fact, and law. I accept and appreciate your oath of office.

Sincerely,

Michelle Bailey and Anna Olsson (Silver Spring)

SB839 UNFAV.pdf
Uploaded by: Michelle Borowy
Position: UNF

SB839

UNFAV

Michelle Borowy

Citizen's medical information should be protected information and should not be used to discriminate and segregate citizens based on vaccine status.

Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy and health choice. Furthermore, we have witnessed a decline in the efficacy of the vaccines that you propose to track.

Vaccine passports neglect to consider immunity conferred by natural infection. This immunity has proven to be MORE durable than the vaccine. The CDC itself has said that the vaccinated can both get and spread COVID virus.

Public funding should not be used to develop and market an unnecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness and control.

This bill puts us one step closer to medical fascism. Government should stay clear of personal and private medical choices. No business should be discriminating who can or cannot use their service based on COVID or other vaccination status especially vaccines that are still only Emergency Use Approved.

mandate.pdf
Uploaded by: Paul Hartley
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

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This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

OPPOSE SB0839_a.pdf
Uploaded by: Peggy Williams
Position: UNF

OPPOSE SB0839 Maryland Voluntary COVID-19 Vaccine Passport

Dear Committee Members:

Please withdraw this bill. There is only one purpose for having vaccine passports, and that is to propel us into a social credit system. The bill says this is “voluntary” but this is a slippery dangerous slope into preventing people from engaging in society unless they bow to tyranny. This should not happen in America, nor in Maryland, THE FREE STATE!

Sincerely,

Peggy Williams
Severna Park
D33

Covid testimony Peter D'Orazio .pdf
Uploaded by: Peter DOrazio
Position: UNF

Hello Distinguished Members of the Maryland Senate,

I am writing today as a Maryland citizen and registered pharmacist in opposition of SB839 and SB840.

I hope by now the Senate realizes that vaccination for Sars-Cov-2 does not significantly prevent infection or transmission of the virus. My own Montgomery County, MD is one of the most vaccinated in the country, yet during the height of Omicron we experienced 5000 positive tests in one day; approximately one in every 200 citizens. However, at no time did our hospitals become overrun or even rise above the 'Low" occupancy threshold of 80%, which would be a normal rate during a non-covid year. Current occupancy is 64.7%, a level at which is extremely low and rarely seen.

Therefore, I am opposed to vaccination mandates and passports as they are ineffective in preventing disease, as proven in NY, DC, and most of Europe. Now that the CDC is finally focusing on morbidity and mortality as opposed to "cases", we need to follow suit and end all exorbitant and wasteful state funded testing, tracing, vaccination, and electronic passports. What purpose does a passport serve if a vaccinated, yet infected individual can walk into an establishment while a healthy, unvaccinated individual is prevented from entry?

Our tax dollars must be spent on recovery from the heavy-handed restrictions that caused so much damage. Our schools need therapists to treat the anxious and depressed students who are so scared of a 10-day quarantine with no academic support. Many will not remove their masks to eat lunch s they fear being traced and quarantined, despite being vaccinated and already having covid.

In a recent Board of Education meeting, I listened to MCPS members state that they cannot afford to pay licensed therapists their current rate and directed their team to investigate hiring student therapists in training. This is appalling, especially since MCPS led country in virtual days of learning. Let's use our state surplus to heal our kids and support businesses that were unjustly affected. Please end the idea of vaccine passports, quarantining healthy people, etc. now and in the future. Vaccinations have been available for a long time and those hesitant accept their risk. Please return to normal now.

Even though I am no longer a retail pharmacist, I am opposed to expanding vaccination privileges for pharmacists to administer all vaccines to 3-year-olds and up. Pharmacists are already too busy to comply with mandatory counseling regulations, much less keep up with the constant interruption of vaccination. Interruption is a primary cause of dispensing errors. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6499714/. However, we all know retail chains will jump on this financial windfall and ask even more of their pharmacists and technicians, who are quitting now in record numbers. https://www.nbcbayarea.com/news/national-international/im-so-burned-out-pharmacy-staffs-struggling-to-keep-up-with-ever-rising-demands/2765456/. Please do not aggravate an already dangerous situation by adding this burden to our pharmacists.

In conclusion, please let our state end the fixation on Covid mitigation and let our citizens return to pre-pandemic life. Remove all mask and vaccination mandates in workplaces, schools (UMD especially) and anywhere else, as well as required quarantining. The time is now.

Sincerely,

Peter D'Orazio

Peter D'Orazio, RPh.

senate witness testimony 839.pdf
Uploaded by: Rochelle Kane
Position: UNF

Vote **UNFAVORABLE** for **SB0839**
Rochelle Kane 47 S Church St Westminster, MD

Unconstitutional Tyrannical Overreach

Senators of Maryland,

Given the information concerning the origin, statistical danger, and political narrative surrounding the covid 19 “phenomenon” I feel that this bill in consort with other covid legislation sets into motion very dangerous precedents including but not limited to unnecessary government overreach and intervention into the private lives of Maryland citizens, unlawful tracking of citizens, and a potential for unlawful and egregious discrimination based on private medical information.

I oppose bill SB0839 for several reasons

1. Forcing a human being to take a vaccine violates the Nuremberg Code of 1947. A person should have the legal capacity to give consent, power of free choice, and to act without intervention of force, fraud, deceit, government overreach or any other ulterior form of coercion.
2. Vaccines have not been tested for long term effects and are experimental. Statistically these vaccines have saved 1 in 20,000 people, but have killed 5 people per 20,000. They are killing more people than they help.
3. This bill provides for extreme medical and religious discrimination flying in the face of valued ethical and legal traditions of the state of Maryland as well as the United States of America, in that it is unacceptable to discriminate on the basis if medical or religious belief.
4. Future implications: covid passports set the ground work for a two tiered society wherein vaccinated people can live normal lives and unvaccinated are denied rights. Our most noble movements in history have been those which restore rights not take them away as this bill would.
5. Potential for the misuse of the MYIR mobile app is widely acknowledged as dangerous to our liberties by expanding illegal and unjust overreaching surveillance of American citizens. It would open the door to a communist style credit system.

I highly oppose the bill SB0839 for these reasons. YOU SENATORS took an oath to uphold the Constitution Of the United States of America and this bill infringes on our GOD GIVEN RIGHTS and is highly Unconstitutional. You are accountable to not only the people of America, but to GOD! This bill must be killed!!!!

SB839_Unfav_Cusack.pdf
Uploaded by: Sarah Cusack
Position: UNF

SB839: Maryland Voluntary Covid-19 Passport
UNFAV
Citizen

Dear Members of the Senate Finance Committee,

I oppose SB839. I never want to see any type of medical passport in our state. I want to see equity and inclusion in Maryland. To see the proposition for a passport with this particular vaccine is very troubling. They do not even stop spread or transmission. This was clear in the initial filings to the FDA from Pfizer and Moderna. They always knew that the vaccines would not stop the spread.

Voluntary passports lead to exclusion of healthy Marylanders from participation in society. Voluntary passports lead to involuntary passports.

Where does this lead? Could someone be excluded from a restaurant in the future if their digital health record reveals they have HIV or Hepatitis?

Please, I ask that the Committee give this bill an UNFAVORABLE report.

Sarah Cusack, MPT
Ashton, MD 20861
District 14

SB839_ACRWC_UNF.pdf
Uploaded by: Sarah Reichert-Price
Position: UNF

Senator Delores G. Kelley, Chair
and Members of The Finance Committee
Maryland Senate
Annapolis, MD

RE: SB 839- Maryland Voluntary COVID-10 Vaccine Passport- OPPOSE

Dear Senator Kelley and Members of The Committee,

I sincerely urge you to return an UNFAVORABLE report for SB 839 for the following reasons:

- There is no COVID-19 vaccine currently available which effectively prevents infection or transmission of COVID-19. There is no public health justification for limiting access to any public spaces based on vaccine status;
- Vaccine passports have not reduced COVID-19 prevalence or mortality rates in populations where they have been implemented. Implementation of vaccine passports has interestingly had an inverse effect on vaccine uptake in several countries;
- Currently available scientific evidence indicates that universal indiscriminate vaccine mandates may increase prevalence and mortality of COVID-19 variants;
- Implementation of vaccine passports may have a negative economic impact on sole proprietors, local businesses, and local economies, and;
- Most importantly, vaccine passports violate the fundamental rights of citizens to medical privacy and individual autonomy, while failing to confer any demonstrable benefit to individuals or groups.

It is for these reasons that I strongly urge you to vote an UNFAVORABLE report against SB 839- MD Voluntary COVID-19 Vaccine Passport.

Thank you for your time,

Sarah Price (ACRWC)
221 Miller Street
Westernport, MD

SB839_UNFAV.pdf
Uploaded by: Shawna Sherrell
Position: UNF

SB839
UNFAV
Shawna Sherrell

Dear Senate Finance Committee,

I'm writing as a Maryland resident who is opposed to this proposed bill: "Maryland Voluntary COVID-19 Vaccine Passport" - SB839.

A statewide digital vaccine passport does nothing to make Maryland citizens safer. The vaccine does not prevent transmission or spread of the virus. A vaccine passport (even voluntary) will make it much easier to legally segregate others and discriminate against populations who medically cannot receive this vaccine as well as provide economic barriers for small businesses. It's a waste of time and resources when many localities are consistently dropping any mandates they may have had in place.

The time and resources dedicated to this effort could be used in more productive ways to help the community's health.

Please oppose this bill.

Sincerely,

Shawna Sherrell

Document SB0839 (1).pdf
Uploaded by: Stephanie Gorecki
Position: UNF

This bill would facilitate the development and implementation of a digital “vaccine passport” that would make private health information the basis for government sanctioned discrimination against, and segregation of Maryland citizens. It would make an individual’s personal health decisions, specifically the acceptance of emergency use only approved, experimental vaccines a prerequisite for admission to certain venues and create a system that would promote overreaching government tracking and control.

The latest research from Johns Hopkins, and recent opinions issued by the CDC supports the value of natural immunity and underscores the inability of the vaccine to prevent the transmission of COVID. In light of recent studies, vaccine requirements and “passports” are being withdrawn across the globe. Public funding should not be used to develop an invasive and outdated program that violates the medical privacy of Maryland citizens but is of little benefit to public health.

Document SB0839 (1).pdf
Uploaded by: Stephanie Gorecki
Position: UNF

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Position: UNF

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SB 839 UNFAV.pdf
Uploaded by: Stephanie Quaerna
Position: UNF

SB839

UNFAV

Stephanie Quaerna

6546 Blackhead Road

Baltimore, MD 21220

3/2/2022

As a citizen of MD, I strongly oppose this bill and the implications it has for infringing upon our individual liberties and privacy.

Thank you!

Testimony.pdf
Uploaded by: Stephen Lawrence
Position: UNF

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise **free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion**; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision."

This code of ethics must be upheld in any civilized country.

The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

V/R,

SB839.pdf
Uploaded by: Sue Pappas
Position: UNF

I oppose this bill:

1.One's medical information is one's own business and should not be used to discriminate and segregate citizens based on vaccine status.
2. No business should be discriminating who can or cannot use their service based on COVID or other vaccination status especially vaccines that are still only Emergency Use Approved.
3.The CDC itself has said that the vaccinated can both get and spread COVID virus. Many unvaccinated people have natural immunity which is cross protective, enduring and a benefit to the public.
4.One's medical information should be protected information, but we have seen repeatedly that "protected" information can be hacked.
5.Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy, and health choice.
6.Public funding would be used to develop and market an unnecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness, and control.

testimony for bills SB0839 and SB0840.pdf
Uploaded by: Susan Murphy
Position: UNF

From Susan Murphy

I was informed that the legislature is considering bills that would facilitate the use of vaccine passports. What a terrible idea to discriminate against individuals who choose not to be vaccinated! Those vaccinated are protected from the disease so why deprive others of their freedom to choose. Many are doing this for religious reasons and should be admired for risking their health and perhaps their life for their religious beliefs. What is freedom of religion worth if one is punished for exercising it? We need to respect our fellow citizens and allow them to make their own choice.

Why are elected officials afraid of public opinion? Why give so little time for public comment? Why even consider laws that go against the constitution? Elected officials are supposed to serve the people not rule over them and treat them like children. These social changes should be widely discussed and discussed without censoring opposing opinions. Punishing people for making decisions for themselves and what is injected into their body is wrong. The bill uses the term voluntary but that is a clear deception because the whole purpose of the vaccine passports is to reduce the freedom of those who do not wish to be vaccinated.

testament.pdf
Uploaded by: Teresa Morales
Position: UNF

It is our personal right to control the substances that at put into our body. We should have full knowledge and fully consent. It is not reasonable or just to coerce anyone to take something into their body that they do not want. Our jobs are being taken away and our liberty to travel to certain places because we want the freedom our country promised us: life liberty and the pursuit of happiness. Do we really have life if we are forced to take something that could be detrimental to our health? Is it liberty if we are forced to take something that goes against our religious, moral and ethical or scientific beliefs? Please do not harass, intimidate or coerces me by fear, by taking away privileges, or any other abusive measure just because I have made a choice that I think is proper to me. Influenza vaccines have always been voluntary. All vaccines including the Covid vaccine, should be strictly voluntary. It is my life, liberty and pursuit of happiness that is at stake.
Thank you for listening!

Document (2).pdf
Uploaded by: Tricia Roberts
Position: UNF

SB840/HB1084

UNFAV

This Bill would violate my medical privacy and endanger children's medical care safety.

SB840 includes verbiage which would allow for pharmacists to administer any vaccines to children ages 3 and over. This is absurd and potentially dangerous. Pharmacists/techs receive only about 3 hours of vaccine training. How is this considered a safe practice for such young children? Just recently in November of 2021 a pharmacy in Virginia administered incorrect dosing to 112 children! This pharmacy KNEW that they did not have the correct dose for children ages 5-11, however, they decided they could make the unauthorized decision to administer doses meant for ages 12 and older at "smaller amounts." They knowingly and carelessly made the medical decision to purposely administer a wrong dosing. This is an extremely dangerous and slippery slope. Vaccines should ONLY be administered to children by licensed medical professionals, not pharmacists! A pharmacy error could have adverse effects or even lead to death. This should worry lawmakers, not encourage you to pave a pathway for even more egregious errors! A bill like this is harmful to children and families. You should be focused on protecting them, not setting them up for medical mistreatment.

I appreciate your time and urgently request that you oppose SB840.

Regards,

Tricia Roberts

SB839 Testimony .pdf
Uploaded by: Victoria Harvey
Position: UNF

Dear Finance Committee Members:

Unfortunately, none of the vaccines have demonstrated that they stop infection or transmission of C19. The last stats from a bar graph through the end of Dec on the state of Maryland C19 page show that 51% of those infected with C19 are those that are fully vaccinated.

Any form of digital proof of vaccination is openly discriminatory. Vaccination does nothing to stop or slow the spread of the virus, what is the end goal of digital proof of vaccine other than forced compliance and discrimination for those that will not comply? Segregation & discrimination will once again affect our marginalized residents of Maryland

Vaccination passports/green passes are being dropped throughout the world. The pandemic is now endemic. SB 839 is an unnecessary bill which will build a framework for a potential social credit system. It will start off voluntary, but the voluntary portion will be short-lived. Similar to the mantra "two weeks to flatten the curve". SB 839 has the possibility of changing the way we all live, and not for the better.

Evidence is becoming more obvious each day that the vaccines are not the magic bullet that was sold to us. Once a system like what is proposed in SB 839 is in place, where will it stop? Will we all need to get mandatory flu shots yearly to participate in society? Health care decisions and history are personal, none of this private information should be held on a smart phone within a QR code or any other type of app. We are on the dangerous road to dehumanizing a large portion of society.

Maryland residents overwhelmingly do NOT support this bill.

SB839_UNF.pdf
Uploaded by: vince mcavoy
Position: UNF

UNFAVORABLE on SB 839

This bill proposes creating mobile technology to track your COVID immunization record as a vaccine passport allegedly for admission to certain venues. I strongly oppose vaccine passports; we know that Annapolis will slow-crawl this to a mandatory mandate. Senator Rosapepe wants to break into children's schools and force-vaccinate Gestapo-style (as per Senate COVID hearing, May 2021). He's not fooling anyone.

There is no Covid-19 vaccine currently available which effectively prevents infection or transmission of Covid-19. This is why country after country are removing mandates, even Nova Scotia and the tyrannical lock-down island of England. There is no public health justification for limiting access to any public spaces based on vaccination status and when Maryland was riddled with AIDS, caring parents couldn't even get restrictions on the carriers of AIDS for fear of offending sodomites. What this is is is pathological favoritism...deciding which diseases you will take action based upon their political donations & sexual proclivities.

Vaccine passports have not reduced Covid-19 prevalence or mortality rates associated to covid-19; but rather have increased mortality as “experimental vaccine” uptake increased. Don't try to tell us how these poisons are safe. Mandating a poison or a construct of a poison-delivery system, culture, coercion, or technology is assault and/or murder of the Maryland constituency. This bill has the foul stench of Marie Antoinette.

Either directly or indirectly, implementation of vaccine passports violate the fundamental rights of citizens to medical privacy and individual autonomy. People note that several of you lawmakers have received substantial donations from the pharmaceutical industry. Senators are not delegates, true. Senators are also not Maryland's parents nor the lobbyist-arm of our nation’s business sector. It is not the job of Maryland's legislature to develop and promote this outrageous system. One's medical information is one's own business and should not be used to discriminate and segregate citizens based on vaccine status. This is the pure Nazism of pasting yellow-stars on those who don't kowtow to Rosapepe's fear tactics.

I propose if you pass these we also apply this to the LGBTQP sector - who, oddly, have a huge amount of buy-in to these experimental serums. They clearly live in an immunodeficient state and are more prone to transfer of HIV as well as any weaponized flu-like viruses. That would be discriminating who can or cannot obtain services; but the LGBTQP's own talking-heads readily admit to said immunodeficiency. This is what it looks like, Senators, when Maryland applies- “equally” and “with equity” - discrimination based on COVID “status”, sexual proclivities & vaccination status, especially when it comes to vaccines that are still only “Emergency Use Approved”. Funny how Lam's SB547 was withdrawn, eh?
The CDC itself has said that the vaccinated can both get and spread COVID virus. Many unvaccinated people have natural immunity which is cross protective, enduring and a benefit to the public.
One's medical information should be protected information but we have seen repeatedly that "protected" information can be hacked. Vaccine passports have been withdrawn across the globe. They are unnecessary and represent a violation of personal freedom, privacy and health choice.
Public funding would be used to develop and market an unnecessary program which lays the foundation for chilling government tracking, surveillance, divisiveness and control.

vince mcavoy

covid passport testimony.pdf
Uploaded by: warren feldman
Position: UNF

Position against Covid Vaccine Passport:

There is no valid reason for creating a Covid 19 Vaccine passport at this time. Every Marylander's Health information should be theirs and theirs alone (with the possible exception of their doctors) to know. By creating Vaccine Passports, Maryland is implying that others have the right to request information about my personal health. This violates the HIPPA laws and my civil rights. This passport would make it easier for them to think that they have the right to that information.

While this law currently makes it voluntary for a person to participate, that fact that the passport exists at all makes people think they have the right to know my personal medical information.

If a Maryland resident elects not to get the "vaccine", that is their right. No one has the right to tell another person what they should or should not inject, ingest, or otherwise consume. This passport will no doubt lead to further coercion of individuals who do not feel comfortable (for whatever reason) in taking the vaccine.

Forcing or coercing someone in any way to take a vaccine or any medication violates the Nuremberg Code established in 1947 after the terrible acts that took place by the Nazi regime. The first of its ten points begins as follows:

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The COVID-19 vaccines were not tested for long-term effects and thus were and are experimental. Each person should choose whether to take the vaccine or not. Future vaccines may have similar experimental natures or may be carefully tested. Regardless, each person must have the right to accept or refuse the vaccine without any coercion, or penalty.

In the free society that we as citizens of the United States have chosen to live in, we are entitled to do so without interference from the State or Federal Governments in our personal health decisions.

Sincerely

Warren G Feldman