Notice of Objection

The Case Against Mandatory COVID-19 Vaccinations

Foreword: This is letter is not meant to trivialize the undue stress, hardship, and life-altering experiences this pandemic has left in its wake. For a small percentage, it has been entirely devastating and I am sincerely sympathetic to those individuals and their families. I also salute my fellow co-workers and other allied healthcare professionals for their efforts during these stressful times. I also encourage the vulnerable and those otherwise inclined to decide what is best for them and make an 'informed' decision that is completely free of coercion.

In their decision to support Alberta Health Service's mandated COVID-19 vaccines, our Union - HSAA has advised they are encouraging their members and all Albertans to be vaccinated citing the best interests of its employees and Albertans.

Their rationale is that they have come to a "science-based conclusion," yet they provide no references to the science upon which they have formulated this conclusion.

This brief will challenge these statements and assumptions using evidence-based references so that the Union can be fully informed of all of the risks and benefits of this vaccine mandate policy to guide them to make decisions that will support the health and wellness of their members.

The Union bears a responsibility to protect its members from harm that is equal to that of the responsibility of the employer and they must, therefore, challenge AHS's position based on this obligation to their members.

Seemingly, the current position of the AHS is that barring any medical or religious exemptions there are no options to consider other than vaccination to confront COVID-19. This includes natural immunity from previous Covid infection (s).

This paper is not meant to be a complete statement of facts or of a position, rather it is intended to be a summary of the more salient points and to provide the Union with several options to consider, including safe and effective prophylactic and treatment options, as well as the need to test for naturally acquired or cross-reactive immunity. **It should be noted that those who are opposed to this mandatory vaccination policy are not necessarily opposed to vaccinations in general.**
Rather, it is the nature of these specific, largely experimental vaccines, combined with the fact that there are other options which are safe and more effective that are not being considered.

HSAA and AHS should provide their members and employees with information that

details the impact that COVID-19 has had on the health and wellbeing of their employee group, as well as Albertans alike, including the statistics of cases, severity of cases, and incidents of death. This would include factual information on the origins of this virus / pandemic.

To make sweeping statements about the impact on health and safety moving forward, they must provide the actual impact the disease has had to date so that it can be determined whether a mandatory vaccine intervention is warranted.

Hospitalization and death associated with COVID-19 has been predominantly associated with very elderly populations or those associated with comorbidities. Both parties are equally responsible for providing statistical evidence that supports their positions that mandatory vaccines are an effective strategy moving forward. Part of this analysis must provide a risk/benefit assessment. They must statistically prove that the risks of vaccinating their employees (and there ARE risks) are outweighed by the benefits that the vaccines confer.

Additionally, both parties bear the burden of proving that there are no other options available to their employees to treat or prevent illness. It is the position of this paper that there are numerous risks associated with the disease itself and with the vaccines. However, an individual might not catch the disease at all with the use of effective personal protective equipment (PPE), hand washing and social distancing, or they might have already acquired the disease and cleared it with their own immune system, or they might use safe and effective medications and nutraceuticals to prevent or treat the disease. In essence, there are many risk minimizing strategies that people can employ against the disease itself.

The risks associated with the vaccines are numerous and the proposed benefits do NOT outweigh these risks for the majority of people. Once an individual is vaccinated, there is no going back. You cannot un-vaccinate someone and the serious injury and death from the vaccines are known to exist.

If HSAA and AHS are mandating vaccinations, then they are obligated to inform their respective members/employees of all risks , both short and long term as well as the absolute beneficial effect that they confer.

Finally, HSAA (and AHS) should be aware that there are serious consequences, including civil and criminal liability, to anyone that applies coercion to obtain consent for a medical intervention. AHS is applying coercion by mandating that their employees be vaccinated against their free will, and the HSAA will be complicit in this coercion if they refuse to represent their members' rights to freely decide against the medical intervention.

This document provides information on the following: Page

1. A Union's Obligation to its Members

As per Peter Bowal and Stephen Moore (Jan5,2015) in "The Duty of Unions to Fairly Represent Their Members", (https://www.lawnow.org/duty-unions-fairly-represent-members)

"Unionized employees surrender to the Union the right to negotiate and contend on all work-related matters with the employer. Such a transfer of power from workers to Unions reposes significant responsibility in the hands of the Union. Therefore, it is essential that the Union represents the best interests of its members. This legal obligation is referred to as the Union's *duty of fair representation* of the members' interests."

The Canada Labour Code is explicit in both the following requirements of a Union: a) the description of what constitutes fair representation, and b) the requirement to act in a manner reflecting fair representation of any members, or any applicable employees. Section 37 prohibits Unions from acting in an arbitrary or discriminatory manner or in bad faith when representing employees under the applicable collective agreement.

"Labour Relations Boards have further developed the duty of fair representation. They look for Unions to treat all members of a bargaining unit fairly and with good faith. Unions must carefully examine and investigate the grievance, considering its significance and consequences for the Union and the employee. It is arbitrary to give only superficial attention to the facts or matters in issue, or to decide without concern for the employee's interests."

"Favoritism and prejudice should play no part in grievance handling. Unions should consider only relevant lawful matters when deciding whether or not to file or continue grievances. The Union representation must be fair, genuine and not merely apparent. The Union must act with integrity and competence and without serious negligence. The Union must not be hostile towards the employee."

Recent Facebook posts (including responses from our Union President) would suggest that our position / standing on this matter is already compromised / marginalized.

Members who are voicing concern, asking questions, and asserting their fundamental Rights are being targeted with verbal and emotional abuse by certain HSAA executives and fellow practitioners. Even more unacceptable is the HSAA executives who are openly encouraging this behavior by 'liking' (thumbs up / heart symbols) this vitriol on social media, including our own HSAA President Mike Parker. Please be advised that we have proof of these unforgivable actions.

Further to the unethical and unsubstantiated slandering of some of our collective members, words cannot even begin to express the contempt and sense of betrayal many of us feel after 19 months on the front line, reporting for duty with the realization that we ourselves could become very ill or succumb to this embellished pandemic. To politicize and ostracize those who selflessly toiled in the frontline trenches is appalling and reprehensible.

In reference to these il intentioned actions, regrettable posts and the support there of by our union leaders, such actions clearly demonstrate a conflict of interest at minimum.

The Union's decision must not be arbitrary, capricious, discriminatory, wrongful, or in an act of bad faith.
http://www.cirb-ccri.gc.ca/eic/site/047.nsf/eng/00109.html

In short, the Union has an obligation to consider the concerns raised in this document and to ascribe them the serious consideration that they deserve. These are not frivolous concerns. They are life altering from both a medical and career perspective.

2. Differential Risk Analysis: Risks from the Disease vs Risks from the Vaccines

The risks of the disease are different across the population therefore a blanket policy of vaccination across the broad population should not be applied. Rather the risks from the disease MUST be weighed against the risks from the intervention to protect from the disease. If the risks from the vaccines, whether known or suspected, outweigh the risks from the disease, then it would be unethical and, in fact, criminal to continue with the intervention and the policy that mandates it.
http://www.cirp.org/library/ethics/nuremberg/
John Ioannidis (epidemiologist, Stanford University) estimates the infection fatality ratio (IFR) of COVID-19 globally to be approximately 0.15% and that, as of Feb. 2021, there have been about 1.5-2.0 billion people infected worldwide. Ioannidis puts COVID-19 in the same ballpark as influenza (IFR of 0.1%), which is the flu we are very familiar with. It should be appreciated that this IFR for influenza is based on estimates after the adoption of vaccination of many of those at risk, whereas vaccines have only recently become available for SARS-CoV-2.
https://onlinelibrary.wiley.com/doi/epdf/10.1111/eci.13554

Currently, the US CDC data shows the following COVID-19 infection fatality ratios. Some of are likely higher than Ioannidis' estimates, but demonstrate the huge difference based on age:

Age group	Infection fatality ratio
0–17 years old	0.001%
18–49 years old	0.057%
50–64 years old	0.57%
65+ years old	5.0%

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/burden.html

Based on this data, the Company's workforce has less than a 0.6% risk of dying from COVID-19 across all age groups. In other words, there is a greater risk of dying from the drive into work than there is from this disease. We do not want to minimize the negative impact COVID-19 has had for specific populations but this needs to be put into a broader perspective.
https://ourworldindata.org/grapher/share-of-deaths-by-cause?country=~OWID_WRL

Given that COVID-19 affects older people much more than younger people, it has been suggested by many experts that instead of everyone getting vaccinated, we should just vaccinate or otherwise protect the most vulnerable. Healthy young people could forego the vaccines, which have significant adverse and unknown long-term effects. If they get infected, they can recover and gain innate, naturally acquired immunity, which would effectively contribute to herd immunity. Furthermore, it can be calculated from US CDC data that the risk of hospitalization from COVID-19 vaccine injury is about 50-times higher than from SARS-CoV-2 for people under 18 years of age.
https://gis.cdc.gov/grasp/COVIDNet/COVID19_3.html
https://www.cdc.gov/mmwr/volumes/70/wr/mm7031e1.htm

Vaccine-induced immunity is not the only type of immunity. In addition to acquired immunity that we gain through natural infection with SARS-CoV-2, studies have shown that between 20% to 90% of the population already had some form of immunity to the virus before it came along because of previous exposure to similar coronaviruses in the past.
https://insight.jci.org/articles/view/146316

This is called a cross-reactive immunity. https://www.bmj.com/content/370/bmj.m3563

Naturally acquired immunity has been shown to be long lasting, robust and complete. In contrast, vaccine-induced immunity is proving to be narrow-spectrum and short lived. Natural immunity arises from the production of antibodies against potentially all 28 of the SARS-CoV-2 proteins. Although those against the spike protein show excellent strength, membrane and envelope proteins are the most effective as these proteins are exposed on the exterior of the virus. The antibody response in the lungs and airway spaces, with the production of IgA, IgE and IgM class antibodies are more appropriate for fighting this respiratory system

virus than the IgG class antibodies that are generated in the blood and lymphatic systems in response to the COVID-19 “vaccines” following intramuscular injection.

Establishment of immune memory in response to infection with the SARS-CoV-2 virus is well documented beyond 16 months at the point of preparation of this document.

The difference between Relative Risk Reduction (RRR) and Absolute Risk Reduction (ARR) and why it matters

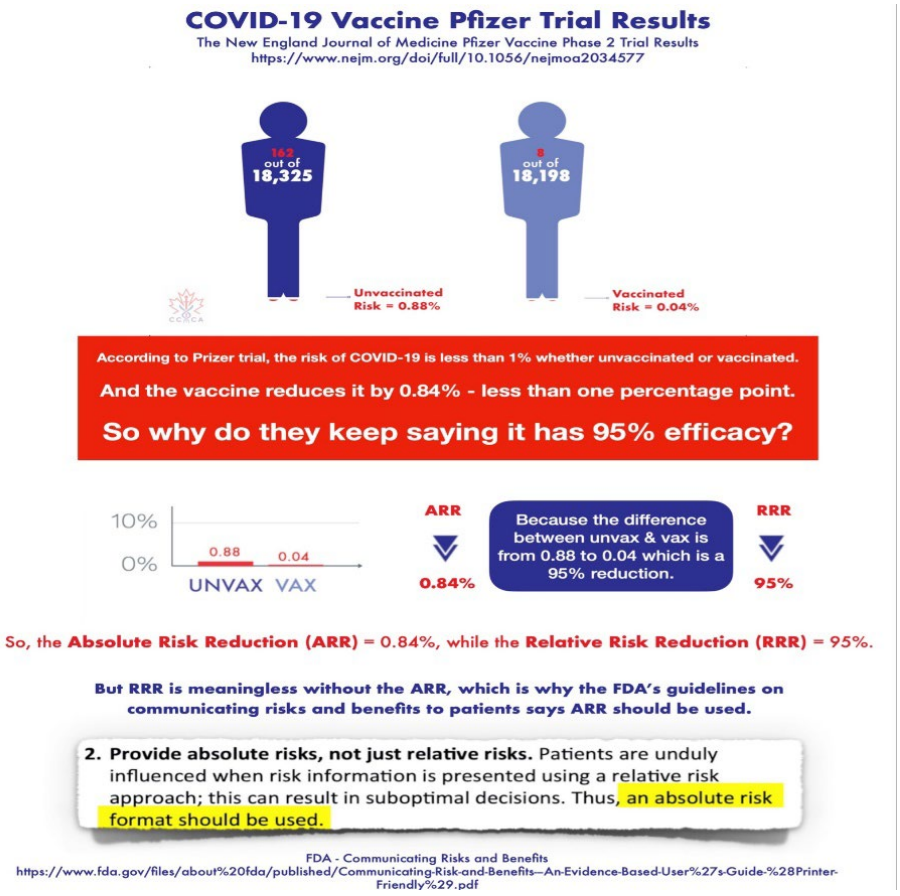
In Canada, it is the law that an individual be presented with the risk from the disease, the risk from the intervention, and the true effectiveness of that intervention so as to be able to ensure true informed consent.
https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/13290/index.do
https://www.canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html

When we consider the effectiveness of an intervention, we need to know what advantage is gained by the intervention, in this case COVID-19 vaccination. The authors of the original BNT162b2 mRNA Covid-19 vaccine (Pfizer) safety study used Relative Risk Reduction (RRR) to report the vaccine’s efficacy as being 95%. However, RRR is a statistical analysis comparing the outcomes for a study. It does not represent the actual benefit of an intervention to a person.

To calculate a person’s total reduction of risk from using an intervention, in this case the COVID-19 vaccines, we calculate the Absolute Risk Reduction (ARR). Using data from the original safety study for the Pfizer vaccine, the absolute risk reduction (ARR) offered by the vaccine for study participants was only 0.84%. This is the proper reflection of a trial participant's benefit for taking the COVID-19 vaccine; a less than 1% reduction in risk of developing symptomatic COVID-19 illness.

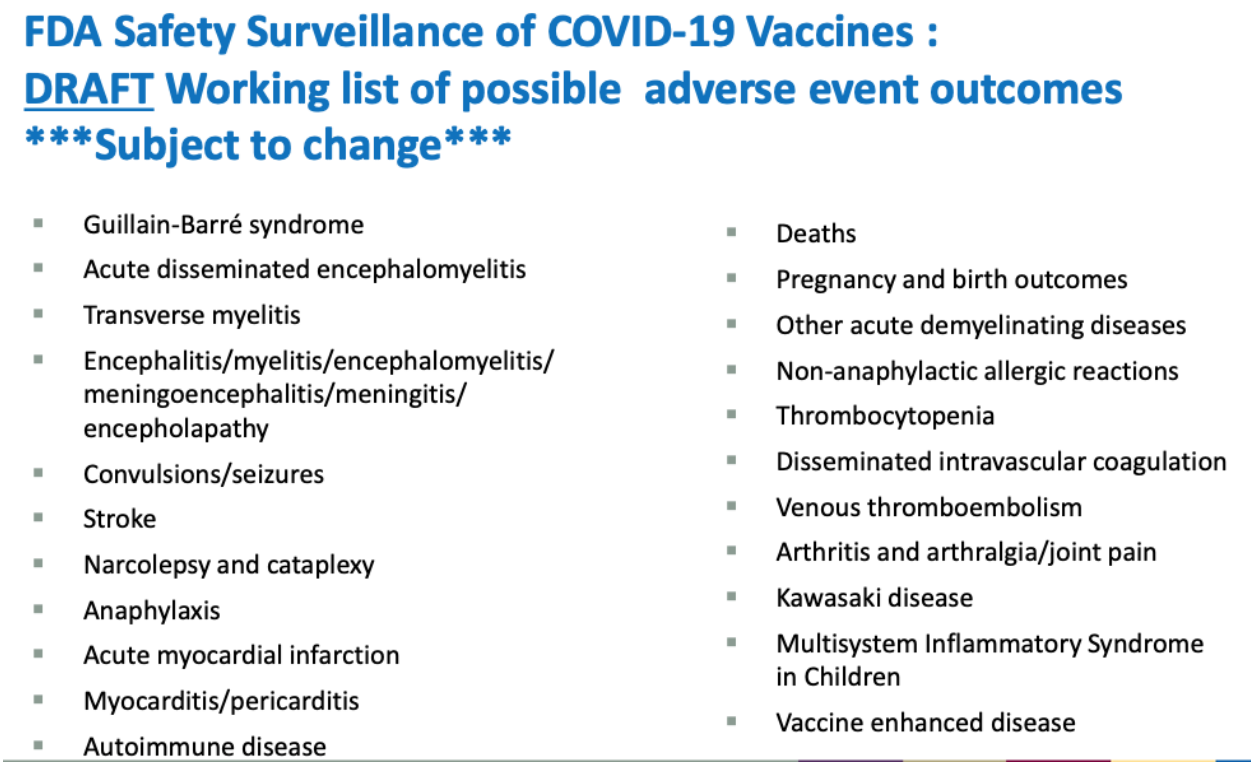
With the use of only RRRs, and omitting ARRs, reporting bias is introduced, which affects the interpretation of vaccine efficacy. In clinical publications ARRs tend to be ignored because they give a much less impressive effect size than RRRs. In this case RRRs lead people to believe that the vaccines are far more effective than they really are. The importance of this distinction is highlighted by the following statement from the FDA’s publication *Communicating Risks and Benefits: An evidence-based user’s guide*, “Patients are unduly influenced when risk information is presented using a relative risk approach; this can result in suboptimal decisions. Thus, an absolute risk format should be used.”

Thus, the vaccines were approved under interim order in Canada based on the Pfizer study which offered less than a 1% benefit to the person receiving the vaccine.



With an understanding of one's true benefit from the COVID-19 vaccine, we must compare this to its risk of adverse events or harm.

In October of 2020 the CDC produced a presentation examining possible side effects from the vaccines. On slide 16 of this CDC document is the following:



FDA Safety Surveillance of COVID-19 Vaccines :
DRAFT Working list of possible adverse event outcomes
*****Subject to change*****

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Transverse myelitis
- Encephalitis/myelitis/encephalomyelitis/ meningoencephalitis/meningitis/ encepholapathy
- Convulsions/seizures
- Stroke
- Narcolepsy and cataplexy
- Anaphylaxis
- Acute myocardial infarction
- Myocarditis/pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Other acute demyelinating diseases
- Non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multisystem Inflammatory Syndrome in Children
- Vaccine enhanced disease

https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-10/COVID-Anderson-508.pdf

These are only some of the adverse events that have been captured by the adverse events reporting systems around the world. Refer to section 5 for events that are related to flight crews and long distance IFT (inter-facility transport) crews.

Canadians have not been provided with any of these key pieces of information for them to be able to provide truly informed consent to these vaccinations. It begs the question; would anyone be willing to accept these risks to receive a less than 1% benefit from the "vaccines"?

3. The Delta Variant: More Contagious but Less Pathogenic (harmful)

Every time a virus replicates, there is potential for it to mutate. These mutations create the variants. Globally, there are an estimated 4000 variants of the SARS-CoV-2 virus.[1] Variants of concerns are those mutant forms of the virus that feature properties that allow them to predominate during the pandemic. Antibodies created by the COVID-19 "vaccines" are not

completely effective in neutralizing or destroying the virus and it has been reported[2] that "there is emerging evidence of variants exhibiting resistance to antibody-mediated immunity elicited by vaccines." Prior to initiating the vaccine program, scientists warned the World Health Organization (WHO) against vaccinating in the midst of a pandemic, particularly with a "leaky," or non-sterilizing, vaccine. The basis for this warning is the well-known paradigm that the use of a leaky vaccine can create ideal conditions for the proliferation of variants within vaccinated individuals. Similar to the creation of antibiotic resistant strains of bacteria, a virus that is not destroyed will continue to replicate until it develops a strain that evades its host's antibodies. On the one hand, the vaccine-induced immunity is thought to be ineffective against these new variants. Indeed, this has been illustrated in a recent study from California where breakthrough cases were found to be caused by vaccine-resistant strains of SARS-CoV-2. **The vaccine does not effectively protect against variants and may contribute to their creation.**

On the other hand, with variants of concern, like the Delta strain, less than 0.3% of the structure of the proteins encoded by the SARS-CoV-2 genome are altered by mutation. With natural immunity, antibodies are generated at hundreds of different parts of the 28 viral proteins in SARS-CoV-2. As the variant has not altered its formation grossly, those with natural immunity are better equipped to resist the variants. With the COVID-19 "vaccines", the theory suggests that antibodies are generated against just the spike protein, which is the largest protein. As scores of different spike protein-directed antibodies are produced in vaccinated individuals, mutations at best should only result in a tiny reduction in immunity. Moreover, it appears from recent research that the specific parts of the viral proteins where the mutations occur in the variants of concern, are very poor in eliciting the production of antibodies in the first place.
Therefore, the reduction of vaccine-induced immunity against the Delta variant is likely due to general waning immunity against all of the variants of SARS-CoV-2.

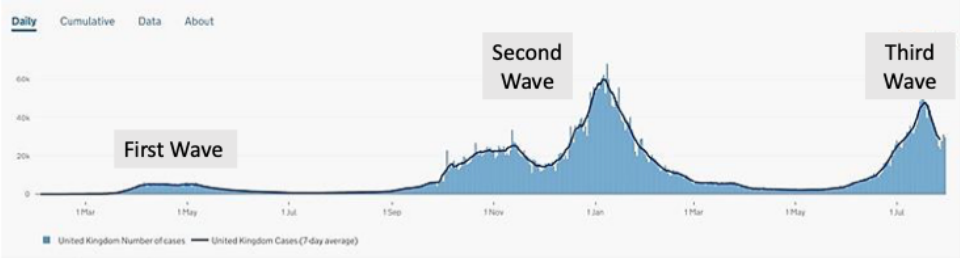
It is now abundantly clear based on emerging studies and clinical observations that both the vaccinated and the unvaccinated can contract, carry and transmit COVID-19 and carry similar viral loads.[3] According to CDC Director, Rochelle Walensky,[4] "The increased viral load associated with the Delta variant appears to make vaccinated people equal spreaders of the virus." This would explain the recent reports[5,6,7,8] of fully vaccinated individuals infecting each other, including some vaccinated individuals becoming hospitalized and even landing in the ICU, and demonstrates the futility in vaccinating groups at low risks of COVID-19. **This makes any vaccine mandates misguided.**

In the UK, which is typically several months ahead of Canada in the epidemic curve, one can see that the peak of infections of the Delta variant does NOT correspond to a peak in deaths, thus one can conclude this variant is more contagious but less lethal than previous strains of the virus. From a public policy perspective, it does not make sense to impose restrictions on people when their risk of hospitalization or death from the new variant is significantly lower than with previous versions of the virus.

[1] https://srhd.org/news/2021/coronavirus-mutations-and-variants-what-does-it-mean

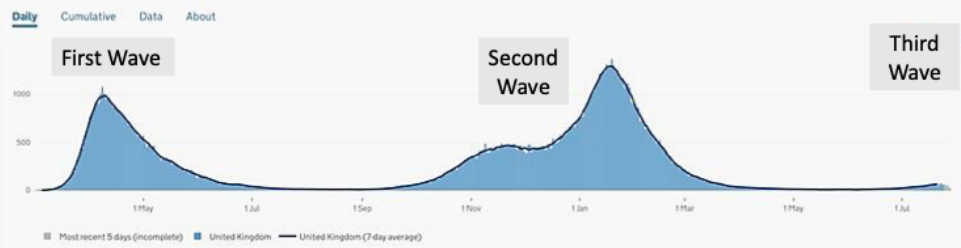
2 https://www.nature.com/articles/s41579-021-00573-0
3 https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v4
4 https://sfist.com/2021/07/27/cdc-confirms-that-viral-loads-in-vaccinated-people-with-delta-are-indistinguishable-fromunvaccinated/
5 https://www.bbc.com/news/uk-57830617
6 https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0804-breakthrough-covid-20210803-t32trfpiwzdf5okfar45f64whi-story.html
7 https://www.nbcboston.com/news/local/nearly-4000-breakthrough-covid-infections-have-now-been-reported-inmass/2408052/
8 https://rumble.com/vkba8x-update-from-sydney-all-new-covid-hospitalizations-involve-vaccinated-indivi.html

Figure 1: Cases reported by date in the UK



The three waves of the COVID-19 pandemic in the UK are indicated on Figures 1 and 2.

Figure 2: deaths within 28 days of positive test by date of death in the UK



It is evident that the third wave caused by the delta variant was associated with far fewer deaths, and this would normally be considered to be the end of the pandemic.

U.K. Figures Source:
https://coronavirus.data.gov.uk/details/cases

Figure 3: Distribution of the SARS-CoV-2 variants and Covid-19 cases (blue line) in the U.K.

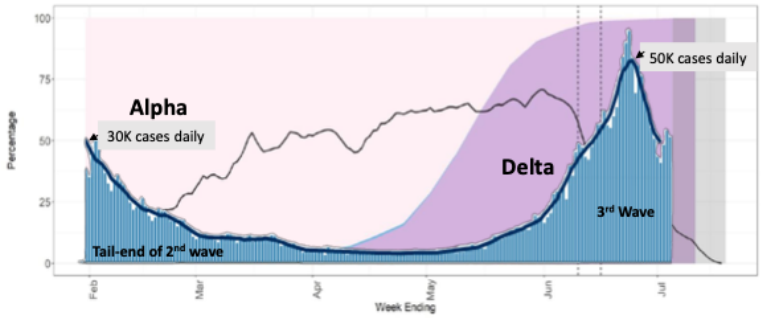


Figure 4: Distribution of the SARS-CoV-2 variants and Covid-19 deaths (blue line) in the U.K.

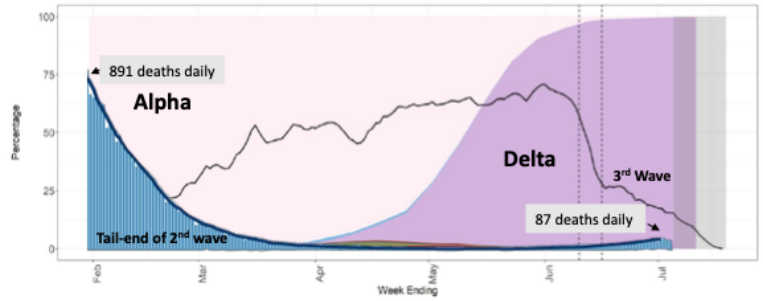


Table 1: Alpha and Delta deaths in the UK from February 1 – July 19, 2021

Variant	Age group (years)	Number of cases	Deaths
Alpha	<50	118082	66 (0.1%)
	≥50	32265	1548 (4.8%)
	All cases	150436	1614 (1.1%)
Delta	<50	205549	45 (0.0%)
	≥50	23379	415 (1.9%)

The Delta variant although more contagious is less pathogenic. Therefore, any further restrictions are not warranted. Life should go back to normal.

Table 2: Vaccination status among Delta confirmed cases in the UK as of July 19, 2021

	Age group (years)	Total	Unlinked	<21 days post dose 1	≥21 days post dose 1	Received 2 doses	Not vaccinated
Delta Variant	All cases	229,218	24,952	21,088	33,003	28,773	121,402
	<50	205,549	22,496	20,930	27,714	15,346	119,063
	≥50	23,379	2,169	157	5,289	13,427	2,337
Number of Deaths	All cases	460	6	5	60	224	165
	<50	45	1	3	3	4	34
	≥50	415	5	2	57	220	131

Unlinked: Not associated with a vaccinated status (i.e. unknown)

Source :
https://www.gov.uk/government/publications/investigation-of-novel-sars-cov-2-variant-variant-of-concern-20201201

The current mRNA vaccines do not appear to be effective against the Delta variant, or reduce the mortality rate. Therefore, why should there be the need for vaccination passports of any kind?

4. Natural vs Vaccine-Induced Immunity

The COVID-19 vaccines currently available under Interim Order in Canada are mRNA vaccines that stimulate our bodies to produce a version of the spike protein part of the virus.

The spike protein is only one of 28 proteins of the SARS-CoV-2 virus. As vaccines induce immunity only to the spike protein, the immunity is narrow spectrum, meaning that this type of vaccine is less protective against mutations or variants. Moreover, the vaccines code for the spike protein from the original Wuhan strain of SARS-CoV-2 virus, which does not circulate

anymore, and which has been long replaced by newer variants. This has been suggested to be a concern, because should a mutation occur in the spike protein, some spike-antibodies may no longer be able to strongly attach making them less effective in mounting an immune response. However, vaccinated individuals do generate many different antibodies against the spike protein, so a substantial part of the immune recognition will still be retained even with variants of concern like the Delta strain.

By contrast, a natural infection creates broad spectrum immunity as antibodies are created to all parts of the virus. This makes natural immunity less likely to be affected by mutations. In fact, antibodies to the natural virus and other common cold coronaviruses can offer complete protection against SARSCoV-2 infection. This is likely why most people that are infected with SARS-CoV-2 are asymptomatic or have very mild symptoms.

According to this study, just released from Israel, one of the most vaccinated countries in the world, natural immunity is superior to vaccine immunity. In fact, vaccinated individuals had a 13x greater chance of contracting the Delta Variant vs. those with naturally acquired immunity, a 7x greater risk of symptomatic disease, and a greater risk for hospitalization. Calls for mandatory vaccination or repeated PCR-based tests for the presence of SARS-CoV-2 RNA completely disregards the existence of of natural immunity that is already prevalent in our population.

https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1.full.pdf

Furthermore, Albertans have no other choice other to pay private lab services to determine to if they already have C19 antibodies. This begs the question as to why AHS does not permit APL (lab services) from collecting and analyzing these blood samples to determine the extent of natural immunity in the community. It appears that we may be well on the way to achieving herd immunity.

As cited in a letter from Ichor Blood Services – an independent antibody testing laboratory

Good evening!

There are still about 200 results pending for the next few days dependent on location and shipping timing, but I wanted to get this weeks report out before the weekend.

The same trend continues for another week, roughly 40% of unvaccinated clients are positive for antibodies, and between 10-15% of them have the same maximum 250 score as double vaccinated clients.

Vaccine effectiveness is also demonstrated with the majority of clients scoring the full 250. Many of the lower scores are from immune suppressed individuals who are in a real tough spot either way.

I will be sending this report to the Health Ministers office (Alberta) tomorrow and continuing to push them to either support some larger scale antibody testing, and the inclusion of positive results in their "vaccinated" numbers. To me this demonstrates that Alberta may not be as vulnerable to the 4th wave as the current numbers suggest which is important for all of us.

Thank you again for choosing Ichor and trusting us with your confidential vaccination status, there is power in this data which I consider to be now statistically relevant with 800 sample points, and adding an additional ~70 per day.

Please feel free to forward this email and these reports to anyone you think may find it relevant. I post these to my LinkedIn on a weekly basis so they are already public. Also as a reminder, I have started a petition that you can sign into if you agree that natural antibodies should be recognized the same as vaccination induced antibodies.

https://www.change.org/Antibodies

Cheers!
Mike Kuzmickas P.Eng., M.B.A.
Chief Executive Officer
Ichor Blood Services

5. Adverse Reactions to the Vaccines and Particular Risks to Flight Crews and long distance IFT (inter-facility transfers)

When COVID-19 first emerged, it was widely considered a respiratory disease. But as researchers from around the world have further studied the true nature of the disease, they came to realize that COVID-19 is also characterized by extensive internal inflammation and clotting. Now, over a year later, researchers have also discovered that the role of the spike protein is much more than just enabling the virus to infect the cell, rather, it has numerous toxic effects in the body. Some of this toxicity is caused by the interaction of the spike protein with the ACE-2 receptor on the surface of many cell types, including platelets.
https://www.ahajournals.org/doi/10.1161/CIRCRESAHA.121.318902

This is problematic, because there are numerous ACE-2 receptors in the blood vessels, brain, heart, liver, kidneys, eyes, and many more parts of the body. The problem lies in the fact that the spike protein makes these normally smooth surfaces rough as they become coated with the SARS-CoV-2 virus particles, which can make them prone to developing clots.

Both the Moderna and Pfizer vaccines use the spike protein part of the virus. Their mRNA technology, which has never been effectively deployed before in a vaccine, gives your body the instructions to produce billions of copies of the spike protein. In essence, the most dangerous part of the SARS-CoV-2 virus is being made by your own body. The adverse reaction databases are already showing overwhelming instances of clotting and bleeding disorders. Deep vein thrombosis (DVT) and pulmonary embolisms (PE) are already acknowledged issues with sitting on long duration airplane flights for more than 4 hours.

The COVID-19 vaccines that are currently available in Canada have been approved under Interim Order meaning that they are still largely experimental. The reviews are rolling, meaning data are reviewed as they become available. The Phase 3 trials for the vaccines are ongoing

until at least 2023. Data must be collected for 2 years for all Phase 3 trial participants, starting from 2 weeks after administration of the second dose. As such, we do not and cannot yet have the long-term safety data from these vaccines. Theoretic risks such as the development of autoimmune diseases are of serious concern in view of the way the mRNA and adenovirus vaccine work. These vaccines illicit inflammatory attacks by cells of the immune system against the cells that produce the spike protein in order to stimulate more specific antibody responses.

The fact that billions of doses have been administered worldwide is NO SUBSTITUTE for LONG-TERM data on safety and effectiveness. The fact that we don't yet know the long-term effects of these vaccines doesn't mean that they don't exist. Absence of evidence is not evidence of absence. Furthermore, some adverse effects may manifest only later as was the case with the Pandemrix vaccine and increased risk of narcolepsy in children.

In the short term, numerous points of data from adverse event reporting systems around the world are logging hundreds of thousands of adverse events including tens of thousands of deaths.

In the United Kingdom, the Yellow Card adverse events database has been analyzed by esteemed international data analyst Dr. Tess Lawrie, Director of the Evidence-based Medicine Consultancy Ltd and EbMC Squared CiC. She stated that due to the extent of the reported adverse events there is an "urgent need to communicate information that should lead to cessation of the vaccination roll out while a full investigation is conducted" as she concluded "The existing Yellow Card data covering just under a five-month period indicate that the extent of morbidity and mortality associated with the COVID-19 vaccines is unprecedented."

The US VAERS database has received an unprecedented number of reports, many of which are severe, life-altering, or fatal. As of August 6, 2021, VAERS has recorded 12,791 deaths, 51,242 hospitalizations, 16,044 permanent disabilities, 4,371 cases of myocarditis, 5,590 heart attacks, 1,505 miscarriages and more. It is noteworthy that more than a third of all reported vaccine injuries in the last 30 years has been documented with the three COVID-19 vaccines available in the US in the less than a year.

http://medisolve.org/yellowcard_urgentprelimreport.pdf?fbclid=IwAR1k77rN0K-7pcCaQ7A4heGucozyaz_JXL5ctl-wWfEtbx8kVFVLCbgUC3w

In the European Union, as of August 15, 2021, EudraVigilance (which gathers adverse event reports from 27 EU member states out of a total of 50 countries in Europe) has recorded[9] 20,595 deaths and 1.96 million vaccine injuries (of which 50% are serious in nature). Comparison of adverse drug reactions among four COVID-19 vaccines in Europe using the EudraVigilance database indicted the following regarding thrombosis at unusual sites, (August 2021): "This report[10] on EudraVigilance data strengthens anecdotal findings on CVT [cerebral vein thrombosis] following COVID-19 vaccinations."

Many other scientists, both in Canada and around the world, have expressed concern regarding the potential development of antibody-dependent enhancement (ADE) in vaccinated individuals.[11] ADE typically results in serious illness and even death by allowing the virus to more easily replicate in a person who has produced non-sterilizing antibodies (antibodies that do not destroy the virus). A study[12] published on August 9, 2021 in the Journal of Infection confirmed ADE with the delta variant and the presence of infection-enhancing antibodies in symptomatic COVID-19. ADE is a well-known phenomenon that has been previously reported with several different viruses, including coronaviruses like SARS-CoV-1 and MERS, and has hindered vaccine development in the past.

We must remember that these vaccines have been administered for less than a year, we therefore have no way to know the long-term effects including, but not limited to, fertility issues, cancers, and autoimmune disorders.

Thrombosis

Thrombosis events have always been of particular concern to during extended periods spent sitting. Combine this with the extensive evidence (as presented in the list below) of increased risk of clotting and bleeding disorders associated with the current vaccines, and it becomes apparent that the risk of serious events from the vaccines far outweigh the benefit that they actually confer.

1) In early 2021, Canadian physician Dr. Charles Hoffe discovered that several of his patients were being harmed by the Moderna vaccine. Through D-dimer testing, Dr. Hoffe discovered that 62% of his post vaccinated patients showed elevated D-dimer levels, which are associated with signs of micro clotting, a potentially very serious condition whose long-term effects are yet to be determined.

[9] https://www.winterwatch.net/2021/08/20595-dead-1-9-million-injured-50-serious-reported-in-european-unionsdatabase-of-adverse-drug-reactions-for-covid-19-shots/

[10] https://pubmed.ncbi.nlm.nih.gov/34375510/

[11] ADE occurs when the antibodies generated bind to a pathogen but are unable to prevent infection. Instead, these antibodies act as a "Trojan horse," allowing the pathogen to enter cells, worsening the disease in persons already exposed to the virus through a previous infection or vaccination.

[12] https://pubmed.ncbi.nlm.nih.gov/34384810/

2) On July 12, 2021, the U.S. FDA identified 4 adverse events of interest related to the use of the Pfizer vaccine using MediCare real-time surveillance https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/initial-results

a) Immune thrombocytopenia
b) Pulmonary embolisms
c) Myocardial infarctions
d) Disseminated intravascular coagulation.

3) In a very large study carried out in Spain[13], it was determined that the Pfizer vaccine was associated with significant increases in the risks of venous thromboembolism and

thrombocytopenia relative to historic rates. Although risks of these events also were significantly greater following COVID-19 infection relative to historic rates, there are 2 critical issues:

a) Vaccination and infection are not mutually exclusive: It is clear that, with the original Wuhan strain of the virus in circulation (which is no longer the dominant strain), and with "fresh" immunity, the Pfizer and Moderna vaccines seemed really efficacious at stopping transmission. Now, it is clear that breakthrough infections are very common, given that (i) the vaccines do not cause sterilizing immunity, (ii) immunity wanes over time, and (iii) new variants can evade the vaccines. Thus, what is the risk of venous thromboembolic events or thrombocytopenia if someone is **both** vaccinated and infected with SARS-CoV-2? And add to this profession where risk of thromboembolic events is already increased, such as in flight crews.

b) With vaccinations, there is 100% certainty of introducing the spike protein that is known to be associated with clotting and bleeding events into the body. However, with the proper use of PPE, handwashing and social distancing measures, the risk of acquiring COVID-19 can be minimized. In case of developing the disease, negative health impact can be minimized with an early treatment.

3) Other studies[14] also have reported thromboembolic events for the mRNA vaccines (e.g., study from Sweden using VigiBase).

4) Below is the incidence count of the following symptoms from the Vaccine Adverse Event Reporting System (VAERS) related to clotting events:
a) Thrombosis or thrombus: 4,246
b) Embolism/embolus: 1,857
c) Infarction: 1,863
d) Ischemia: 902
e) Occlusion: 370

Bottom line:

• Sitting for long periods is well known to increases risk of thromboembolic events.
• Vaccination with the current COVID-19 vaccines is well known to increase risk of thromboembolic events.
• Infection with SARS-CoV-2 increases risk of thromboembolic events to a greater degree than vaccination; BUT, as the vaccines do not provide sterilizing immunity, vaccination and infection can occur concurrently, and potentially compounding the risk of thromboembolic events compounded.

[13] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3886421
[14] https://erj.ersjournals.com/content/58/1/2100956

The fact that a person can still be infected with the SARS-Co2 virus while being fully vaccinated leads to the possibility of combining and compounding the risks of clotting and bleeding events. Now add to this the additional risk of clotting events associated with the flight crew occupations, and it becomes apparent that requiring flight crews to be vaccinated can put them at a much higher risk of a clotting event.
If flight crews suffered any of these very serious clotting or bleeding events while they were operating a flight, the consequences to passenger safety could be disastrous.

6. Vaccines are Not the Only Option. Very Effective Prevention & Treatment Options are Available

With an ever-growing list of published, peer-reviewed clinical trials, the evidence is overwhelming that COVID-19 is a treatable and largely preventable illness. Physicians and scientists have come to understand many aspects of the immune response and the phases of the illness caused by SARS-CoV-2. They are able to tailor effective prophylactic and treatment therapies to the specific underlying process at each phase so as to prevent hospitalization, ICU admission, and death.

The goals of treatment are not only to stop one from developing COVID-19, but to prevent the progression through to the severe stages of the disease. Scientific Studies[15] have shown that multidrug early treatment with combinations of repurposed drugs and nutraceuticals prevents this progression to critical disease.

Since March 2020, numerous studies[16] relating to early treatment of COVID-19 demonstrate the effectiveness and safety of using repurposed drugs, such as Ivermectin, Hydroxychloroquine, Fluvoxamine, Colchicine, Budesonide and others, to stop viral replication and prevent long-haul symptoms.

For example, the inhaled steroid budesonide has already been included in several treatment guidelines (UK, British Columbia, New Brunswick). Moreover, the biggest outpatient trial has been the Canadian COLCORONA trial[17] that showed positive effects of a well-known drug colchicine on decreasing hospitalizations and deaths.

A meta-analysis[18] of Ivermectin published in the American Journal of Therapeutics on June 21, 2021 concluded: “Moderate-certainty evidence finds that large reductions in COVID-19 deaths are possible using ivermectin.

Using ivermectin early in the clinical course may reduce numbers progressing to severe disease. The apparent safety and low cost suggest that ivermectin is likely to have a significant impact on the SARSCoV-2 pandemic globally.”

[15] https://www.cureus.com/articles/63131-ivermectin-as-a-sars-cov-2-pre-exposure-prophylaxis-method-in-healthcareworkers-a-propensity-score-matched-retrospective-cohort-study

[16] https://c19early.com

[17] https://www.sciencedirect.com/science/article/pii/S2213260021002228?via%3Dihub
[18] https://pubmed.ncbi.nlm.nih.gov/34145166/

Physicians around the world are successfully managing COVID-19 in the outpatient setting using a variety of treatment and preventative protocols. The common message amongst them all is that treatment is most successful when initiated early.

7. The Elements of Informed Consent and Coercion

The vaccines that are currently authorized in Canada under Interim Order are still considered investigational, therefore they are subject to the "Directives for Human Experimentation". Please view this website to confirm that they are indeed in trial phases until May 2, 2023. https://clinicaltrials.gov/ct2/show/NCT04368728

The Nuremberg Military Tribunal's decision in the case of the United States v Karl Brandt *et al.* includes what is now called the Nuremberg Code, a ten-point statement delineating permissible approaches to medical experimentation on human subjects. According to this statement, humane experimentation is justified only if its results benefit society and it is carried out in accord with basic principles that "satisfy moral, ethical, and legal concepts."

According to the Nuremberg Code:

"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 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 latter element requires that before the acceptance of an affirmative decision by the experimental subject, there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; **all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.** The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."
http://www.cirp.org/library/ethics/nuremberg/

The Supreme Court decision of Her Majesty the Queen v Steven Brian Ewanchuk states that consent must be "freely given". Consequently, if a person is fearful of losing his/her job, education or ability to travel, and is, therefore, being coerced to be vaccinated, consent is not freely given. The decision[19] states: "As enumerated in **[the Criminal Code],** these include submission by reason of force, fear, threats, fraud or the exercise of authority, and codify the

longstanding common law rule that **consent given under fear or duress is ineffective**."
"Authority" in this case could be the government (i.e., not permitting travel) or one's employer.

Coercion is present if an individual is threatened with job loss if they do not get vaccinated. The employer is over-reaching into the domain of medical autonomy and is applying duress to force their employee to concede to something that they do not want. Some legal experts have opined that forcing someone to take a vaccine also constitutes assault.
https://rumble.com/vk8otq-dont-talk-tv-episode-51-vaccine-passports-coercive-and-unconstitutional.html
Given all the uncertainties about the risk of thromboembolic events following vaccination, coupled with the limited data on risk in professions wherein risk is already increased (e.g., flight crew) and the limited data on how vaccine evasion by variants further compounds this risk, consent is not given. And it is a person's right, according to the Helsinki declaration[20], to refuse to consent, without fear of reprisal.

[19] https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1684/index.do

AHS Medication Administration Policy HCS-244

6.1 Health care professionals shall verify that informed consent (express or implied) for the treatment/procedure (including medications to be administered) was obtained from the patient, unless a valid exception to informed consent applies, as per the AHS Consent to Treatment/Procedure(s) Policy Suite.

6.2 Prior to medication administration, the health care professional shall verify each medication against the Medication Administration Record (MAR) and shall assess the patient for allergies and previous adverse drug reactions.

a) In emergency situations, the MAR may not be populated with the medication being administered. The health care professional should verify the medication with the appropriate AHS kit (e.g., epinephrine, naloxone) or authorized prescriber.

6.3 Health care professionals shall use the 'eight rights' of medication administration:
a) right patient (use at least two [2] patient identifiers per the AHS Patient Identification Policy);
b) right medication;
c) right dose;
d) right time and frequency;
e) right route;
f) right reason;
g) right documentation; and
h) **right to refuse.**

As AHS employees will now become the patient, they will therefore have this right.
MEDICATION ADMINISTRATION policy HCS-244 (ahsnet.ca)

AHS Covid-19 Administration HCS-276

1.5 Informed consent shall be obtained from patients in accordance with AHS' Consent to Treatment/Procedure(s) Policy and procedures prior to providing immunization services.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-covid-19-immunization-hcs-276.pdf

AHS Consent to Treatment / Procedures PRR-01

OBJECTIVES

- To facilitate an informed consent process within Alberta Health Services (AHS) that reflects good practice, contributes to patient safety, and enhances the patient experience.
- To facilitate a fair, respectful process for informed consent that is achieved consistently across all care areas within AHS.
- To facilitate compliance with applicable law.

PRINCIPLES

The principle of respect for persons is foundational within this policy and demonstrated by patients being supported in determining what happens to their own bodies, in keeping with their own values and beliefs. Where patients cannot make their own decisions, respect for persons is upheld by recognizing the decision-making role of an appropriate alternate decision-maker.

Informed consent:
- requires capacity;
- shall be **informed**;
- shall be specific;
- shall be voluntary;
- requires understanding;
- and shall be documented.

On an exceptional basis, patient-informed consent decisions can be overridden in accordance with legislation such as the Mental Health Act and the Public Health Act.

The most responsible health practitioner (MRHP) providing the treatment/procedure(s) to a patient has a duty to obtain informed consent. AHS is committed to providing continuing education for all personnel to implement this policy and the subsequent procedures.

3.2 Informed:

a) The MRHP shall ensure all necessary information has been provided to the patient so that the patient can make an informed decision about the treatment/procedure(s). Necessary information shall include but is not limited to:

(i) the condition for which the treatment/procedure(s) is proposed;
(ii) the treatment/procedure(s) plans/interventions and/or list of agreed upon treatment/procedure(s), that are clinically indicated and approved for the condition;
(iii) the potential risks and benefits of the proposed treatment/procedure(s);
(iv) information applicable to the patient's particular circumstances or as specifically requested by the patient;
- If the patient alerts the MRHP of particular circumstances that might affect the information the patient would want for their treatment/procedure(s), the MRHP shall be responsible for addressing those particular circumstances with further information as requested by the patient.

(v) alternatives to the proposed treatment/procedure(s);
(vi) the potential consequences of both providing consent or refusing to provide consent for the proposed treatment/procedure(s); and
(vii) who will perform the treatment/procedure(s) and who may provide assistance, including whether the treatment/procedure(s) will include health care providers in training (i.e., residents, students).

3.3 Specific:

a) The provision of **informed consent** shall relate to each specific treatment/procedure(s) or a plan of treatment/procedure(s).

b) Treatment/procedure(s) that:
(i) are in addition to the treatment/procedure(s) already consented to;
(ii) are different from the treatment/procedure(s) consented to;
(iii) were unanticipated at the time informed consent was obtained;
(iv) may be convenient to do; or
(v) may be beneficial to the patient,

shall not be performed without obtaining further informed consent, unless a valid exception to informed consent applies (see Section 5 below).

c) New informed consent shall be obtained when one (1) or more of the following occurs:
(i) the patient's condition has materially changed;
(ii) the medical knowledge about the patient's condition or the treatment/procedure(s) available has materially changed;
(iii) when the treatment/procedure(s) for the patient changes;
(iv) the previously given consent and/or any portion of the previously given consent has been withdrawn (see Section 4 below); and
(v) the patient has refused the involvement of particular individuals in their treatment/procedures(s) (i.e., medical students).

d) If the previous informed consent was evidenced using a consent form, then the new or subsequent informed consent should also be evidenced using a consent form.

3.4 **Voluntary**:

a) The patient shall have the opportunity, without undue influence, to accept or refuse a treatment/procedure(s).
b) As time permits in the clinical circumstance, informed consent discussions shall occur when the patient has a reasonable opportunity to reflect on the decision and ask questions.
c) When appropriate to do so, informed consent discussions should not take place in the operating room or the operating room environment.
d) The patient shall be given an opportunity to take the time required to reflect on the information and to consult with whom they choose prior to making a decision.
e) **A patient's decision to accept or refuse a treatment/procedure(s) shall not prejudice their access to ongoing or future health care.**

CONSENT TO TREATMENT/PROCEDURE(S) policy PRR-01 (ahsnet.ca)

8. Biggest Pharmaceutical Settlements in History

Often, when a drug is recalled or when lawsuits are filed, it's because the manufacturer failed to warn doctors and patients about dangerous side-effects or long-term issues. When the manufacturer doesn't share important risk information with doctors, the doctors can't provide their patients with a clear picture of the risks and benefits. As a result, patients use a drug that they think will help them, but they can end up having serious health problems in the long term.

The subject of many of the largest drug lawsuit settlements to date is how companies have misrepresented the drugs and their uses to physicians. In many of these cases, the lawsuits were filed because drug manufacturers promoted their products for uses outside of the scope of FDA approval.

Why do pharmaceutical companies misrepresent drugs?

Put simply: money.

When a company can claim that a drug is used for more purposes than it's actually approved for, it can sell more product. And, in some cases, these uses aren't inherently unsafe — they're just not approved by the FDA.

But sometimes they *are* unsafe.

Some of the cases involve drugs being prescribed at higher doses than recommended, and in other cases the drugs have yet to be tested in clinical trials.

GlaxoSmithKline	$3 billion	2012
Pfizer	$2.3 billion	2009
Johnson & Johnson	$2.2 billion	2013
Abbott	$1.5 billion	2012
Eli Lilly	$1.42 billion	2009
Merck	$950 million	2011
Amgen	$762 million	2012
AstraZeneca	$520 million	2010
Actelion	$360 million	2018
Purdue Pharma	$270 million	2019

This is like Big Pharma playing roulette with your health. Your doctor is acting in good faith and prescribing medications according to what the manufacturer specifies is correct. That's why the manufacturers are the ones being sued — they're misleading doctors and the public about how these drugs function and what they can do.

Let's take a look at the top 10 pharmaceutical settlements, in order of dollar amounts (highest to lowest). These can include a combination of criminal fines and civil settlements:

Top 10 Largest Pharmaceutical Lawsuits & Settlement Amounts (enjuris.com)

City News reported:

Covid-19 vaccine makers not legally liable in Canada for rare side effects

OTTAWA – The federal government says Pfizer and other drug makers won't be held legally liable if there are severe side effects to their COVID-19 vaccines.

Just last week, Health Canada cited contract confidentiality in refusing to tell us if any drug makers received indemnification for their vaccines, meaning they wouldn't be held legally responsible in the very rare scenario that a vaccine causes injury or a severe reaction.

COVID-19 vaccine makers not legally liable in Canada for rare side effects (citynews1130.com)

Toronto Sun Reported:

Burial costs approved by Canadians killed by approved vaccines…

Burial costs will now be covered by Ottawa for individuals killed by federally approved vaccines.

A briefing note from the department says vaccine injuries are rare but do happen.

"The program will provide death benefits and support for funeral expenses in the rare case of a death as a result of having received a Health Canada authorized vaccine," said the note Vaccine Injury Support Program.

The department has budgeted $75 million for all claims but said it was unclear how many submissions there could be. Management of the program is contracted to RCGT Consulting.

"In the rare event a person in Canada is seriously and permanently injured as a result of vaccination, they should be fairly supported," wrote department staff. "The Vaccine Injury Support Program provides financial support to individuals who are seriously and permanently injured due to vaccination with a Health Canada authorized vaccine."

Canada's COVID-19 health experts admit there are unknown long-term effects of vaccines, but they provide another layer of protection.

Dr. Theresa Tam, chief public health officer, said she has always been realistic about vaccines.

"We have never said the vaccine was going to be a 100% effective. But people pick at that concept for unrealistic expectations. So, we have to go out there and set some expectations," she said, adding the pandemic has been stressful and that "everyone is an armchair epidemiologist." https://torontosun.com/news/national/burial-costs-covered-for-canadians-killed-by-approved-vaccines?fbclid=IwAR1jRXY8BIzymJrilfLPCre6uFKbIro-ssCvZdui17WjYK-4gB6JokzSah0

9. Justice Centre for Constitutional Freedoms

On September 9, 2021 – the JCCF announced they would be proceeding with legal action against AHS's vaccine mandate citing the staggering infringement on Constitutional, Human, and Employee (Contractual) Rights. This alone should give HSAA and AHS pause until this can be properly vetted through the courts.

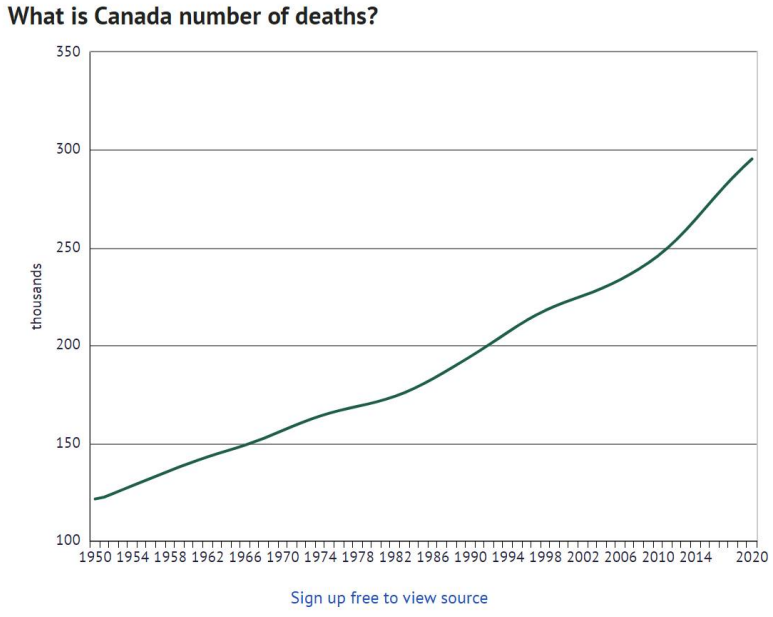
10. Stats Canada, no extra deaths in 2020…

A pandemic with no extra annual deaths?

In a pandemic, death rates rise rapidly as people that would not normally die start to die. 2020 numbers from the Canadian government now show that Canada had not only no extra deaths, but the annual increase in deaths dropped.

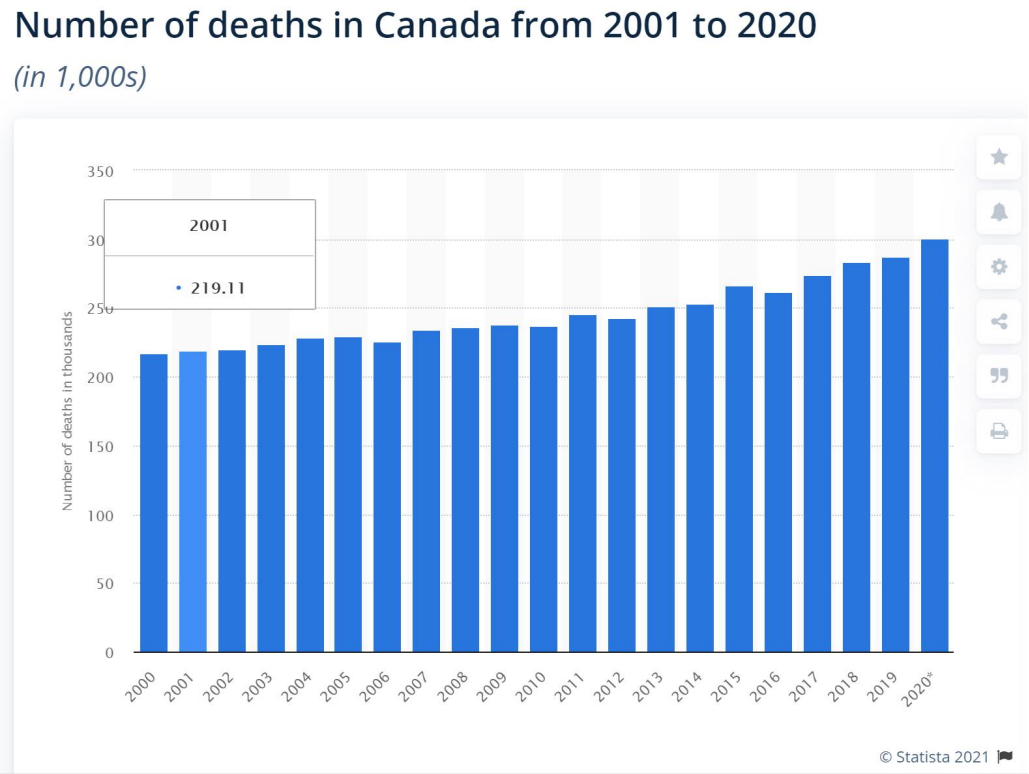
"Canada - Number of deaths 295.37 thousand in 2020. Over the last 50 years, number of annual deaths in Canada grew from 158.43 to 295.37 thousand rising at an increasing annual rate that reached a maximum of 2.08% in 2015 and **then DECREASED to 1.55% in 2020.**"

The chart below shows the annual deaths from 2001 to 2020. As you can see there are no anomalies whatsoever.



DATE	VALUE	CHANGE, %
2020	295.37	1.55 %
2019	290.85	1.68 %
2018	286.04	1.82 %
2017	280.93	1.95 %
2016	275.56	2.05 %
2015	270.03	2.08 %
2014	264.52	2.05 %
2013	259.22	1.94 %
2012	254.29	1.79 %
2011	249.81	1.62 %
2010	245.82	1.45 %

SOURCE:
https://knoema.com/atlas/Canada/topics/Demographics/Mortality/Number-of-deaths



So how can you have a pandemic with lots of people dying from "Covid-19" but have no extra deaths?

https://www.statista.com/statistics/443061/number-of-deaths-in-canada/
No Extra Deaths in 2020, Stats Canada (publicrelationscanada.com)

11. Conclusions

The Union has been presented with the following arguments (which are not exhaustive) that have been substantiated with evidence-based science:

1. The spike protein causes inflammation and blood clotting and bleeding injuries to the body.
2. The spike protein is found in the COVID-19 virus and in all of the vaccines currently authorized
under Interim Order in Canada.
3. Both the Moderna and Pfizer vaccines use the spike protein part of the virus. Their mRNA technology, which has never been effectively deployed before in a vaccine, gives your body the instructions to produce billions of copies of the spike protein. In essence, the most dangerous part of the SARS-CoV-2 virus is being made by your own body. The adenovirus based vaccines also result in the similar presentation of spike protein on the surface of the body's cells.
4. The adverse events databases from around the world are reporting unprecedented numbers

of adverse events from these vaccines including clotting and bleeding disorders, and death.
5. Flight crews and long distance inter-facility crews are already prone to more clotting events than the general population.
6. The current vaccines provide a narrow band of protection and are showing in studies to be ineffective against variants of concern. In other words, vaccinated people can still catch and transmit the virus.
7. A study from Israel, one of the most vaccinated countries in the world, shows that vaccinated people have a 13x greater risk of contracting the Delta Variant, a 7x greater risk of symptomatic disease, and a greater risk for hospitalization.
8. If someone is vaccinated (increasing their risk of clotting and bleeding), but then catches the virus (increasing the risk of clotting and bleeding), and is a flight paramedic / IFT (long distance) crew member (increasing their risk of clotting and bleeding), are all of these risks cumulative?
9. The current vaccines have an absolute risk reduction of less than 1%.
10. For people under age 65 (the average working population) the risk of dying from COVID-19 is
less than 0.6%. There is a greater risk of dying in a car accident driving to work than dying from COVID-19.
11. If the risk of death in the working population is less than 1% and the absolute benefit conferred from the vaccines is less than 1% vs an unvaccinated person, then the risk to benefit analysis would indicate that vaccination is not warranted.
12. There are numerous options available to prevent and treat COVID-19 at all stages of the disease. It is false to assume that none exist and therefore vaccination is the only option.
13. These vaccines are still in Phase 3 trials; therefore, they are governed by the "Directives for Human Experimentation". These directives dictate that participation must be voluntary and that consent must not be coerced or made under duress. The threat of loss of one's job constitutes duress and coercion.
14. The Union has a legal obligation referred to as the Union's *duty of fair representation* of the members' interests.
15. Section 37 prohibits Unions from acting in an arbitrary or discriminatory manner or in bad faith
when representing employees under the applicable collective agreement.
The Union needs to prove they are not acting in an arbitrary manner by facetiously negating these concerns without considering their merit or the weight of evidence in their favour.

12. Worrisome Postscript…

(As shared by the Ontario Civil Liberties Coalition)

Prime Minister Trudeau recently warned that "there will be consequences" if federal employees do not comply with vaccine mandates. This is a voice of tyranny that has reverberated fear and heightened agitation across our country. It has launched our nation into deep division around mass vaccination and brought our collective recovery from this pandemic to a critical head. In fact, it forces us, as a country, to finally ask: indeed, what are those consequences?

What are the societal consequences of being divided along the lines of vaccination status? What are the consequences of mandating such an insufficiently tested medical intervention? How is this all supposed to end well?

The consequences will be dire, to be certain. And the consequences will affect all of us, the vaccinated and the unvaccinated alike.

Over the last six months, many of us made our decision to accept the vaccine in good faith – doing the right thing in order to work, travel and visit the people we love. Sadly, some of us have been pressured or coerced. And now, mounting evidence worldwide shows that these vaccines cannot stop the transmission of the virus and variants, yet vaccination mandates continue.

Meanwhile, the pharma corporations are earning billions of dollars of public money, and pushing to fast-track the vaccines towards full approval, without due process or public discussion. It is abundantly clear that when money and politics intertwine, science and ethics take a back seat.

Maybe you once resented those who hesitated to get the vaccine, as people who were not doing their part; but maybe it is time to consider that we have all become passengers on the same runaway train. The meaning of "fully vaccinated" is rapidly changing as leaders demand the next booster upgrade and threaten ousting us from public spaces if we don't comply. So, if you are among the "fully vaccinated" today, by tomorrow you may become one of the "insufficiently vaccinated" and be coerced into taking another shot.

If history is any indication, this will not stop with barring admission to concerts or bars. When you can no longer buy food, access banking, vote in person or cross a provincial border, it will be crystal clear that the same discriminatory practices that you hope to abolish will be ever more firmly established. The real consequences await all of us.

Perhaps you've had your full round of doses and are now having doubts about whether to continue based on the alarming number of infections among the vaccinated. Or maybe you know someone who has been vaccine-injured or are concerned about the mounting death reports in conjunction with vaccinations.

We keep asking ourselves, "Why is the data not allowed to be scrutinized and why are independent experts being censored if they attempt to do just that?" It is incomprehensible, and decidedly un-Canadian, to see the silencing of highly regarded doctors and health scientists in our country and around the globe.

History has taught us that one-sided arguments and outlawed dissent are signs of totalitarianism lurking at the doorstep. Soon, asking questions will make you an enemy of the State. Mandating vaccines is a breaking point. "My body, my choice" has been one of the hallmarks of a free and democratic society, but this is changing. Canadians are being robbed of personal decision making.

With lockdowns already scheduled for the fall, and boosters at the ready, we are entering a watershed moment. Are we all willing to continue being injected indefinitely? In Canadian provinces and around the world vaccine passports are demonstrating our new, long-term relationship with medical coercion in exchange for basic freedoms. Thus far, each treatment has been promised to be the last, but it couldn't be clearer that there is no end in sight.

And now they're coming for our children.

With extremely low risk of becoming ill and practically no risk of dying from COVID-19, the mass vaccination of children and adolescents remains unwarranted. Lining up our healthy children for medical treatment was never part of the deal. Most disturbingly of all, we are being primed for mass vaccination campaigns in our schools that do not require parental consent. Does the government decide what is best for our children? Without question, the family ties that bind us are being undone. Justifiably, parents are appalled by this unprecedented overreach and are debating pulling their children out of schools.

Despite our best intentions, families are scarred, friends are divided, and partners are at odds with each other. We have been weakened by our division and manipulated through fear.

Just how far will we allow this to go? "All the way!" some of us declare. But "all the way" is a place we will never reach. We need to stop this medical catastrophe and face the truth: this isn't about our health; it is about politics and it is about control.

The consequences of following Prime Minister Trudeau's current orders are greater than his threatened consequences. We entered into this for one another, not for our politicians. We have done what we felt we had to do, and now we must say, 'This is far enough, no more!'

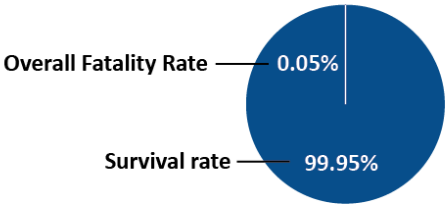
Angela Durante, PhD
Denis Rancourt, PhD
Jan Vrbik, PhD
Laurent Leduc, PhD
Valentina Capurri, PhD
Amanda Euringer, Journalist
Claus Rinner, PhD
Maximilian C. Forte, PhD
Julie Ponesse, PhD
Michael Owen, PhD
Donald G. Welsh, PhD

Covid Statistics Alberta

Data was accessed on August 23, 2021

Justice Centre for Constitutional Freedoms
www.jccf.ca

Deaths with Covid (Mortality Rate)



Survival Rates = Based on 2,348 Deaths
Overall Fatality Rate = 0.05% (2,348/4,421,876)
Survival rate = 99.95% ({4,421,876-2,348}/4,421,876)
Case Survival Rate = 99.01% (1-(2,348/{244,969-7,777}))
Infection Survival Rate = 99.83% (1-(2,348/{1,440,994-45,747}))
https://www.alberta.ca/stats/covid-19-alberta-statistics.htm

Population

Population total = 4,421,876

Total PCR tests taken = 5,037,810
Total people tested = 2,297,362

Confirmed/Unconfirmed cases = 244,969
https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1710000901

https://www.alberta.ca/coronavirus-info-for-albertans.aspx

Purported Cases with Covid

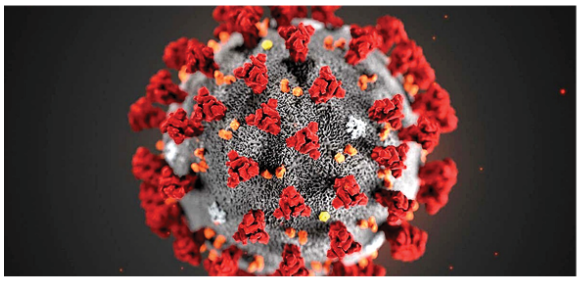
PCR Cycle Threshold = 35 - 40 *https://www.sciencedirect.com/science/article/pii/S138665322030175X*

Total Positive PCR tests and probable cases, all time = 244,969

% tested = 52% (2,297,362/4,421,876)
% positive = 4.86% (244,969/5,037,810)
% negative = 95.14% ({5,037,810-244,969}/5,037,810)

% unresolved/population total = 0.18%
(7,777/4,421,876)
https://www.alberta.ca/coronavirus-info-for-albertans.aspx

Estimated total cases including antibody testing = 1,440,994 (244,969/.17) *https://globalnews.ca/news/7235508/alberta-covid-19-update-july-30/*



Hospitalizations with Covid

 # Patients in hospital = 244 *(includes those in ICU)*

 # Patients in ICU = 54 *https://www.alberta.ca/coronavirus-info-for-albertans.aspx*

Deaths by Age

0-19	0
20-39	25
40-49	47
50-59	119
60-69	301
70-79	492
Over 80	1,363

Average age of deaths with Covid 80
https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#severe-outcomes

Average provincial life expectancy 81.6
https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310011401

Total Deaths Alberta 2019 26,138
https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310070801

Definitions

Case Survival Rate - considers deaths versus resolved cases. Calculate by taking total deaths divided by {total positive PCR tests and probable cases (minus current unresolved cases}(tested and probable).
Infection Survival Rate - total deaths/estimated total confirmed/unconfirmed.
Overall Fatality Rate - total deaths with Covid/Total population (also called Mortality Rate).
All information provided by Government of Alberta/Statistics Canada/referenced sources - none of which has been verified by third party.

13. Table of Footnotes

[1] https://srhd.org/news/2021/coronavirus-mutations-and-variants-what-does-it-mean
[2] https://www.nature.com/articles/s41579-021-00573-0
[3] https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v4
[4] https://sfist.com/2021/07/27/cdc-confirms-that-viral-loads-in-vaccinated-people-with-delta-are-indistinguishable-fromunvaccinated/
[5] https://www.bbc.com/news/uk-57830617
[6] https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0804-breakthrough-covid-20210803-t32trfpiwzdf5okfar45f64whi-story.html
[7] https://www.nbcboston.com/news/local/nearly-4000-breakthrough-covid-infections-have-now-been-reported-inmass/
2408052/
[8] https://rumble.com/vkba8x-update-from-sydney-all-new-covid-hospitalizations-involve-vaccinated-indivi.html
[9] https://www.winterwatch.net/2021/08/20595-dead-1-9-million-injured-50-serious-reported-in-european-unionsdatabase-
of-adverse-drug-reactions-for-covid-19-shots/
[10] https://pubmed.ncbi.nlm.nih.gov/34375510/
[11] ADE occurs when the antibodies generated bind to a pathogen but are unable to prevent infection. Instead, these antibodies act as a "Trojan horse," allowing the pathogen to enter cells, worsening the disease in persons already exposed to the virus through a previous infection or vaccination.
[12] https://pubmed.ncbi.nlm.nih.gov/34384810/
[13] https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3886421
[14] https://erj.ersjournals.com/content/58/1/2100956
[15] https://www.cureus.com/articles/63131-ivermectin-as-a-sars-cov-2-pre-exposure-prophylaxis-method-in-healthcareworkers-
a-propensity-score-matched-retrospective-cohort-study
[16] https://c19early.com
[17] https://www.sciencedirect.com/science/article/pii/S2213260021002228?via%3Dihub
[18] https://pubmed.ncbi.nlm.nih.gov/34145166/
[19] https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/1684/index.do
[20] https://www.wma.net/what-we-do/medical-ethics/declaration-of-helsinki/