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

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

1. I make this affidavit, as a whistle blower under the Military Whistleblower Protection Act, Title 10 U.S.C. § 1034, in support of the above referenced MOTION as expert testimony in support thereof.

2. The expert opinions expressed here are my own and arrived at from my persons, professional and educational experiences taken in context, where appropriate, by scientific data, publications, treatises, opinions, documents, reports and other information relevant to the subject matter and are not necessarily those of the Army or Department of Defense.

Experience & Credentials

3. I am competent to testify to the facts and matters set forth herein. A true and accurate copy of my *curriculum vitae* is attached hereto as **Exhibit A**.

4. After receiving a bachelor's degree from the University of Texas Austin, completed my medical degree from the University of Texas Health Science Center at Houston Medical School in 2008. I served as a Field Surgeon for ten years and went on to complete a residency in Aerospace and Occupational Medicine at the United States Army School of Aviation Medicine, Fort Rucker, AL. I hold a Master's in Public Health, and I have been trained by the Combat Readiness Center at Ft. Rucker as an Aviation Safety Officer. Additionally, I have trained in the Medical Management of Chemical and Biological Causalities at Fort Detrick and USAMIIRD.

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

6. I am currently serving as the Brigade Surgeon for the 1st Aviation Brigade Ft. Rucker, Alabama and am responsible for certifying the health, mental and physical ability, and readiness for all nearly 4,000 individuals on flight status on this post.

7. My appended *curriculum vitae* further demonstrates my academic and scientific achievements by me over the past thirteen years.

8. Prior to the outset of the pandemic, I received specialized military training from Infectious Disease doctors from the Army, Navy and Air Force on emerging infectious disease threats, FEMA training, Emergency preparedness training, Medical effects of Ionizing Radiation, OSHA, Aerospace Toxicology, Epidemiology, Biostatistics, medical research and disaster planning. More recently I have functioned as a medical and scientific advisor to an Aviation training Brigade seeking to identify risk mitigation strategies, and bio statistical analysis of SARS- Cov-2 ("Covid 19") infections in both vaccinated and unvaccinated Soldiers. In so doing, I have identified, diagnosed and treated Covid 19 pathogenic infections. I have observed vaccine adverse events following the administration of EUA vaccines and followed the success of Soldiers who obtained various Covid 19 therapies outside the military. The majority of service members within the DOD population are young and in good physical condition. Military aviators are a subset of the military population that must meet the most stringent medical standards to be on flight status. The population of student pilots I take care of are primarily in their 20s-30s, males and in excellent physical condition. The risk of serious illness or death in this population from SARs-CoV-2 is minimal, with a survival rate of 99.997%.

9. In observing, studying and analyzing all the available data, information, samples, experiences, histories and results of these treatments and inoculations provided, I have formulated a professional opinion, which requires me to report those findings to superiors in the chain of command and colleagues in the military. I have done so with mixed results in terms of acceptance, rejection and threats of punishment for so sharing.

10. The application of risk management is critical to the safety and success in both medicine and aviation. Aerospace Medicine is a specialty devoted to safety of flight by the aeromedical dispositioning and treatment of flight crew members, as accomplished by the consistent and careful application of risk

mitigation and management strategies. ATP 5-19, 1-3. Risk Management (RM)1 outlines a disciplined approach to express a risk level in terms readily understood at all echelons.

11. 1-6. States, “A risk decision is a commander, leader, or individual’s determination to accept or not accept. The risk(s) associated with an action he or she will take or will direct others to take. RM is only effective when specific information about hazards and risks is passed to the appropriate level of command for a risk decision. Subordinates must pass specific risk information up the chain of command.”

12. “When the specific information about hazards and risks is passed to the appropriate level of command for a risk decision. Subordinates must pass specific risk information up the chain of command. Conversely, the higher command must provide subordinates making risk decisions or implementing controls with the established risk tolerance—the level of risk the responsible commander is willing to accept. RM application must be inclusive; those executing an operation and those directing it participate in an integrated process”.

13. 1-7. States, “In the context of RM, a control is an action taken to eliminate a hazard or to reduce its risk. Commanders establish local policies and regulations if appropriate”.

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

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

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

17. **Step 2: Assess the Hazards:** There are numerous therapeutic agents that have been proven to significantly reduce infection and therefore provide protection from the harmful effects of SARs-CoV-2.

18. Literature has demonstrated that natural immunity is durable, completed, and superior to vaccination immunity to SARs-CoV-2. mRNA vaccines produced by Pfizer and Moderna both have been linked to myocarditis, especially in young males between 16-24 years old,2 The majority of young new Army aviators are in their early twenties. We know there is a risk of myocarditis with **each** mRNA vaccination. We additionally now know that vaccination does not necessarily prevent infection or transmission of SARs-CoV-2Therefore individuals fully vaccinated with mRNA vaccines have at least two independent risk factors for myocarditis after vaccination. Additional boaster shots add more risk. It is impossible to perform a risk/benefit analysis on the use of mRNA as counter measures to SARs-CoV-2 without further data… Use of mRNA vaccines in our fighting force, presents a risk of undetermined magnitude, in a population in which **less than 20 active-duty personnel out of 1.4 million, died of the underlying SARs- CoV-2.**

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

20. Research shows that most individuals with myocarditis do not have any symptoms. Complications of myocarditis include dilated cardiomyopathy, arrhythmias, sudden cardiac death and carries a mortality rate of 20% at one year and 50% at 5 years. According to the National Center for Biotechnology Information, U.S. National Library of Medicine, “despite optimal medical management, overall mortality has not changed in the last 30 years”.

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

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

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

24. The shots carry mRNA that causes the recipient to create trillions of spike proteins. This is a problem for five reasons. First, it turns out that the spike proteins are not remaining locally in the (shoulder) injection site but have been found circulating in the blood and in virtually all organs of the body. Second, the spike proteins themselves have been shown to be pathogenic (disease causing) attaching to endothelial, pulmonary and other cells, forming clots and attacking heart cells. Third, the spike proteins and their lipid nanoparticles cross the blood brain barrier, with unknown long-term effects on the brain and high concern for chronic neurodegenerative disorders. Fourth, these spike proteins interact in many signaling pathways which may trigger tumor formation, cancer, and other serious diseases. Fifth, according to Pfizer's Japanese distribution study of LNP accumulation, unexpected sequestering in reproductive organs and spleen raise very serious long-term concerns. As aircrew Training Program (ATP) 5-19, 1-8 states we shall: **Accept No Unnecessary Risk**. "An unnecessary risk is any risk that, if taken, **will not contribute meaningfully to mission accomplishment or will needlessly endanger lives or resources**. Army leaders accept only a level of risk in which the potential benefit outweighs the potential loss. From a risk management assessment perspective, with no long-term safety data regarding these five issues, this is an unacceptable risk management risk.

25. The labels for Comirnaty and BioNtech clearly state that the vaccination should not be given to individuals that are allergic to ingredients. One of the listed primary ingredients of these injectables is Polyethylene glycol ("PEG") which is close in molecular makeup and in the same family of synthetic polymers as Propylene Glycol, a common ingredient in antifreeze. Others seem to agree my point per recent scientific studies that caused a group of 57 doctors and scientists to call for an immediate halt to the vaccination program. The concern with this ingredient, is that Polyethylene glycol (PEG) is that it is an adjuvant which causes an immune response without carrying any vaccine at all. We believe 72% of the population already has PEG antibodies. That bodily response to PEG, ranges from severe anaphylactic response requiring hospitalization or death, to life-long allergies and anti-drug antibodies (ADAs) which could stop other medications from working in your body. Another primary ingredient of the Lipid Nanoparticle delivery system is "ALC 0315" (two attachments, parts highlighted) in the Pfizer shots. The fourth attachment is the toxicity report on ALC-0315, which comprises between 30-50% of the total ingredients. The Safety Data Sheet, (attached as Exhibit B) for this primary ingredient states that it is Category 2 under the OSHA HCS regulations (21 CFR 1910) and includes several concerning warnings, including but not limited to:

1. Seek medical attention if it comes into contact with your skin
2. If inhaled and If breathing is difficult, give cardiopulmonary resuscitation
3. Evacuate if there is an environmental spill

4. the chemical, physical, and toxicological properties have not been completely investigated
5. Caution: Product has not been fully validated for medical applications. For research use only

26. As such, due to the risk associated with the spike proteins themselves, due to the risks associated with the lipid nanoparticles (ALC 0315) and adjuvants such as PEG, I believe it is reasonable to conclude that these shots pose a serious risk to many humans due to direct adverse effect or allergic reaction, and therefore should not take vaccinations with either Comirnaty or BioNtech. Again, I have identified an agent that possess a significant hazard to Soldiers, which would fall under DA Pam 385-61 Toxic Safety Standards cited in 2-11.

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

28. I have not taken significant time to delineate the risks of other Covid 19 Vaccines other than the Safety Data Sheet of Moderna’s key ingredient, SM-102 (attached as Exhibit C). Suffice it to say that SM-102 is significantly more dangerous than the Pfizer ALC 0315 and it appears that the DOD is not actively acquiring or distributing this IND/EUA. If the DOD were to undertake use of the Moderna vaccine, one can expect a much higher Serious Adverse Event and fatality rate given that SM-102 carries an express warning “Skull and Crossbones” characterized under the GHS06 and GHS08. In other words, this Moderna ingredient is deadly.

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

30. A weekly MEDSITREP report fails to report the CDC data from VAERS or internal data regarding vaccine adverse events. Despite recommendation made by the Government Accountability Office in the GAO’s survey of Guard and Reserve Pilots and Aircrew GAO-02-445, published Sep 20,2002, in which it was recommended that the Secretary of Defense should direct the establishment of an active surveillance program (unlike the passive VAERS) to identify and monitor adverse events, was not implemented. I have been unable to locate, access or asses any data, data base or internal system to track, store, evaluate or research the effects of vaccines on our military members or pilots.

31. I have also reviewed scientific data and peer reviewed studies that discuss, analyze results and conclude that natural immunity is at least as good if not far superior to any Covid Vaccine available at this time. I have also reviewed Dr. Peter McCullough’s affidavit in support of and in relation to the Complaint filed in this case and have reviewed its supporting data. An additional peer-reviewed study not referenced in Dr. McCullough’s materials also supports the same conclusions drawn and reports that natural immunity provides a 13-fold better protection against Covid 19 infections than any currently available Covid 19 Vaccine6. More recently, in a meeting of the FDA Advisory Committee on September 17 of this year, fourteen of seventeen members voted against the authorization of any Covid booster vaccines in the juvenile age group having noted that the vaccine program has breached the defining test under the EUA statute as to whether the experimental treatment benefits outweigh the risks; in fact, they found the shots are far more dangerous than helpful in this age group and some voiced concerns that this would apply generally to all age groups.7

32. I am also aware of the Secretary of Defense Austin’s order in relation to Covid Vaccine mandates made this week. In an information paper, it was stated that, “Unit personnel should use only as much force as necessary to assist medical personnel with immunizations.” The use of force to administer a

medical treatment or therapy against the will of a mentally competent individual constitutes medical battery and universally violates medical ethics. Currently, I am not aware of the Comirnaty available within the DOD. Emergency Use Authorized vaccines, despite the attempt to characterize some of them as approved despite such approved versions not being available and regardless of a military member's prior immunity to Covid 19; even where it may be demonstrated with a recent antibody test.

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

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

Opinion

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

36. I personally observed the most physically fit female Soldier I have seen in over 20 years in the Army, go from Collegiate level athlete training for Ranger School, to being physically debilitated with cardiac problems, newly diagnosed pituitary brain tumor, thyroid dysfunction within weeks of getting vaccinated. Several military physicians have shared with me their firsthand experience with a significant increase in the number of young Soldiers with migraines, menstrual irregularities, cancer, suspected myocarditis and reporting cardiac symptoms after vaccination. Numerous Soldiers and DOD civilians have told me of how they were sick, bed-ridden, debilitated, and unable to work for days to weeks after vaccination. I have also recently reviewed three flight crew members' medical records, all of which presented with both significant and aggressive systemic health issues. Today I received word of one fatality and two ICU cases on Fort Hood; the deceased was an Army pilot who could have been flying at the time. All three pulmonary embolism events happened within 48 hours of their vaccination. I cannot attribute this result to anything other than the Covid 19 vaccines as the source of these events. Each person was in top physical condition before the inoculation, and each suffered the event within 2 days post vaccination. Correlation by itself does not equal causation, however, significant causal patterns do exist that raise correlation into a probable cause; and the burden to prove otherwise falls on the authorities such as the CDC, FDA, and pharmaceutical manufacturers. I find the illnesses, injuries and fatalities observed to be the proximate and causal effect of the Covid 19 vaccinations.

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

39. The subject matter of this Motion for a Preliminary Injunction and its devastating effects on members of the military compel me to conclude and conduct accordingly as follows:

1. a) None of the ordered Emergency Use Covid 19 vaccines can or will provide better immunity than an infection-recovered person;
2. b) All three of the EUA Covid 19 vaccines (Comirnaty is not available), in the age group and fitness level of my patients, are more risky, harmful and dangerous than having no vaccine at all, whether a person is Covid recovered or facing a Covid 19 infection;
3. c) Direct evidence exists and suggests that all persons who have received a Covid 19 Vaccine are damaged in their cardiovascular system in an irreparable and irrevocable manner;

4. d) Due to the Spike protein production that is engineered into the user's genome, each such recipient of the Covid 19 Vaccines already has micro clots in their cardiovascular system that present a danger to their health and safety;
5. e) That such micro clots over time will become bigger clots by the very nature of the shape and composition of the Spike proteins being produced and said proteins are found throughout the user's body, including the brain;

5. f) That at the initial stage this damage can only be discovered by a biopsy or Magnetic Resonance Image ("MRI") scan;
6. g) That due to the fact that there is no functional myocardial screening currently being conducted, it is my professional opinion that substantial foreseen risks currently exist, which require proper screening of all flight crews.
7. h) That, by virtue of their occupations, said flight crews present extraordinary risks to themselves and others given the equipment they operate, munitions carried thereon and areas of operation in close proximity to populated areas.
8. i) That, without any current screening procedures in place, including any Aero Message (flight surgeon notice) relating to this demonstrable and identifiable risk, I must and will therefore ground all active flight personnel who received the vaccinations until such time as the causation of these serious systemic health risks can be more fully and adequately assessed.
9. j) That, based on the DOD's own protocols and studies, the only two valuable methodologies to adequately assess this risk are through MRI imaging or cardio biopsy which must be performed.
10. k) That, in accordance with the foregoing, I hereby recommend to the Secretary of Defense that all pilots, crew and flight personnel in the military service who required hospitalization from injection or received any Covid 19 vaccination be grounded similarly for further dispositive assessment.
11. l) That this Court should grant an immediate injunction to stop the further harm to all military personnel to protect the health and safety of our active duty, reservists and National Guard troops.

40. I am competent to opine on the medical and flight readiness aspects of these allegations based upon my above-referenced education and professional medical, aviation and military experience and the basis of my opinions are formed as a result of my education, practice, training and experience.

41 As an Aerospace Medicine Specialist, and flight surgeon responsible for the lives of our Army pilots, I confirm and attest to the accuracy and truthfulness of my foregoing statements, analysis and attachments or references hereto:

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

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

THERESA MARIE LONG, MD, MPH, FS LTC, MEDICAL CORPS, U.S. Army

Medical Education

United States Army School of Aviation Medicine Aerospace/Occupational Medicine Residency University of West Florida
Graduate Student -MPH

06/2019-6/2021

Carl R. Darnall Army Medical Center, Fort Hood, Texas Family Medicine Internship
06/2008-11/2010
Unrestricted Medical License, IN

09/2003 – 06/2008
University of Texas Medical School at Houston, Houston, Texas 06/2008 M.D.

08/2001 – 08/2004
Undergraduate – University of Texas at Austin, Austin, TX 05/2004 B.S. Neurobiology

Research Experience

08/2018 – 5/2020
School of Aviation Medicine
University of West Florida MPH program
https://tml526.wixsite.com/website
Performed a cross-sectional study on Intervertebral Disc Disease Among Army Aviators and Air Crew

08/2002 – 05/2003

University of Texas at Austin, Texas
Research Assistant, Dr. Dee Silverthorn
Performed academic research in effort to update medical facts and the latest research information for the publication of the fourth edition of Human Physiology

09/2000 – 11/2000

Neuropharmacology Research, Texas
Lab Tech, Dr. Silverthorn
Acquisition of rat cerebellums for research in gene sequencing. The focus of the project was to determine the DNA sequence of the receptor in the developing fetal brain that binds to ethanol and induces apoptosis leading to fetal alcohol syndrome.

Publications/Presentations/Poster Sessions Presentations/Posters

Poster: Intervertebral Disc Disease Among Army Aviators and Air Crew, presented during the 2021 American Occupational Healthcare Conference.
Long, Theresa M., Sorensen, Christian, Victoria Zumberge. (2003, May). Sodium dependent transport of Chlorophenol red uptake by Malpighian tubules of acheta domesticus. Poster presented at: University of Texas at Houston; Austin, TX.

Volunteer Experience

08/ 2005 – 09/2005
University of Texas – Houston, Health Science Ctr, Texas
Medical Student -Provided medical aid and support for Acute Care and triage of Hurricane Katrina evacuees.

Work Experience

06/2021- Present
1st Aviation Brigade TOMS Surgeon
Serve as the Medical Advisor to the 1st Aviation Brigade Commander regarding health and fitness of over 3600 officers, warrant officers and Soldiers. The Brigade is comprised of three aviation training battalions, responsible for initial entry rotary wing/ fixed wing flight training, advanced aircraft training. as well as Specific duties include ensuring safety of flight in Army Aviation operations by functioning as Flight Surgeon, while ensuring the health and fitness of military police, firefighters and military working dogs that support Ft. Rucker. Tasked with conducting epidemiological and biostatistical analysis of injuries and illnesses (SARs CoV-2) and medical trends that occur during training and identify and implement strategies to mitigate delays or lost training time.

05/2018-06/2021
Aerospace and Occupational Medicine Resident

Graduate Medical Education training in Aerospace and Occupational Medicine while obtaining a Master's in Public Health. Specialty training included the Flight surgeon course, The Instructor/Trainer course, Space Cadre Course, Medical Effects of Ionizing Radiation, Medical Management of Chemical and Biological Casualties course at USAMIIRD, Ft. Detrick, NASA, 7th Special Forces, Aviation Safety Officer Course, Global Medicine Symposium, OSHA, Dept of Transportation, Textron Bell Helicopters, Brigade Healthcare Course, Preventative Medicine Senior Leaders Course, Joint Enroute Critical Care Course, Army Aeromedical Activity, research on Intervertebral Disc Disease.

05/2015-05/2018

Department of Rehabilitation Services
General Medical Officer
Assigned to Carl R. Darnall Army Medical Center Physical Medicine clinic with special duties Function as General Medical Officer, to mitigate the number of high risk patients get referred off-post to Pain management and PM&R clinics. Functioned as the Performance Improvement officer for PM&R, the Chiropractic Clinic OIC, and the MEB/IDES Subject Matter Expert to IPMC multi-disciplinary team. Significantly increased access to care to the Physical Medicine clinic. Was instrumental in leading the hospital transition for the Chiropractic clinic, contributing to the subsequent successful Joint Commission inspection. Increased access to care in the Chiropractic clinic by 500%.

9/2013- 5/2015

Department of Pediatrics/ Department of Deployment & Operational Medicine
General Medical Officer
Assigned to the Carl R. Darnall Army Medical center Pediatric Clinic with special duties within the Department of Deployment & Operational Medicine. Provided acute and routine medical care for newborn to age 18 and collaborated with Lactation Team Leader to develop research matrix to ensure effective use of resources to meet Perinatal Core Measures PC-05 for Joint Commission Accreditation. Demonstrated initiative by providing emergency medical care to one of the victims of the April 2, 2014 FT Hood shooting.

10/2012-9/2013

Department of Deployment Medicine/ Emergency Medicine
General Medical Officer
Assigned to the Department of Deployment & Operational Medicine at Carl R Darnall Army Medical Center (CRDAMC) with specific duties directed by the CRDAMC DCCS. Supported soldier deployment/redeployment from combat, while also performing clinical rotations within the Emergency and Internal Medicine Departments to increase access to care for acutely ill patients. Improved productivity of the SMRC by conducting ETS, Chapter, Special Forces, Airborne, Ranger, SERE, and OCS/WOCS physicals. Ensured DODM success with 90% CRDAMC staff compliance of their annual PHA's. Selected to become an ACLS instructor.

06/2012-10/01/2012

Department of the Army Inspector General Agency
Disability Medicine Subject Matter Expert (SME) – Temporary Dept of the Army Inspector General
Assistant Inspector General on Medical Disability (Subject Matter Expert)
Selected above my peers, from across the Army AMEDD as one of three medical NARSUM Subject Matter Experts to function as a temporary assistant Inspector General, in a SECARMY directed inspection of the MEB/IDES system. Planed, coordinated, and conducted inspections of agencies/commands and to gather required data and perspectives relevant to the inspection topic. Developed inspection concepts, objectives, methodologies while coordinating inspection site requirements with major Army Commands ASCC, DRUs, Installations and Components. Identified trends, analyzed root causes to systemic problems and proposed solutions to the IG, Army Chief of Staff and Secretary of the Army for service-wide implementation.

06/2011-06/2012

Carl R. Darnall Army Medical Center
Integrated Disability Evaluation System
Increased patient access to care by conducting 203 acute care appointments in four months. Increased productivity by 25% by completing 202 NARSUMs, 12 TDRLs, 42 Psychiatric addendums in nine months with only a single case returned from the PEB. Performed duties of MEB chief and QA physician in their absence by performing QA on seven NARSUMS, and reviewing 13 cases for initial intake. Functioned as IDES Physician Training officer, applying PDA training to develop a comprehensive training program for new MEB/IDES NARSUM physicians.

11/2010-05/2011

Carl R. Darnall Army Medical Center, Hospital Operations, Clinical Plans and Medical Operations Officer

Served as Clinical Plans and Medical Operations Officer for Hospital Operation (HOD), responsible for the synchronization of external and internal MEDCEN operations supporting over 3,000 MEDCEN employee as well as the DoD's largest military installation and surrounding civilian population; assisted in development and execution of medical plans supporting Installation, Garrison, MEDCEN and Civilian AT/FP and MASCAL events

06/2005 – 07/2005

United States Army, Texas, Officer Basic Course – Class 1st Sergeant

Supervised 306 medical, dental, and veterinarian HPSP scholarship recipients for Officer Basic training.
10/2002 – 08/2003

United States Army – **Texas National Guard, Texas Flight Medic –**EMT/BCLS Instructor Training

10/2001 – 10/2002

United States Army Reserve, Texas, Instructor/Trainer