LIES, DAMNED LIES AND SADISTICS

WITH DAVID DICKSON

Weighed, Measured and found Wanting?

Episode 45

Cover-ups and Crimes

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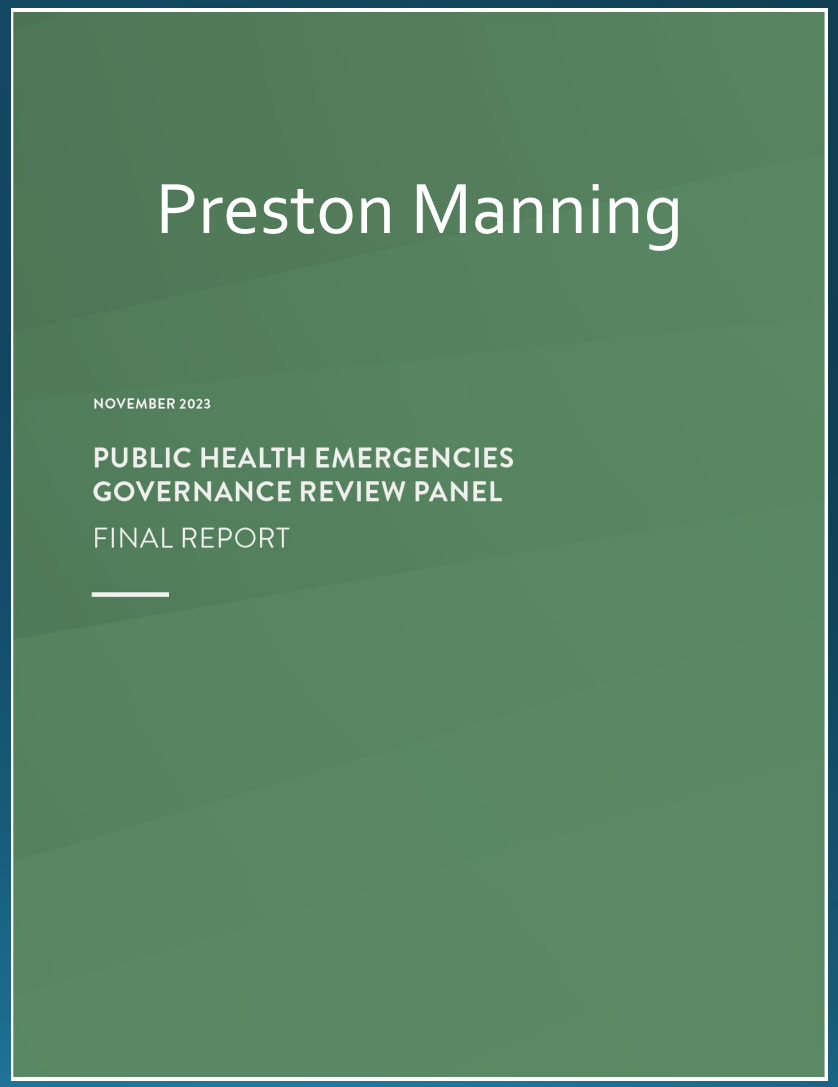

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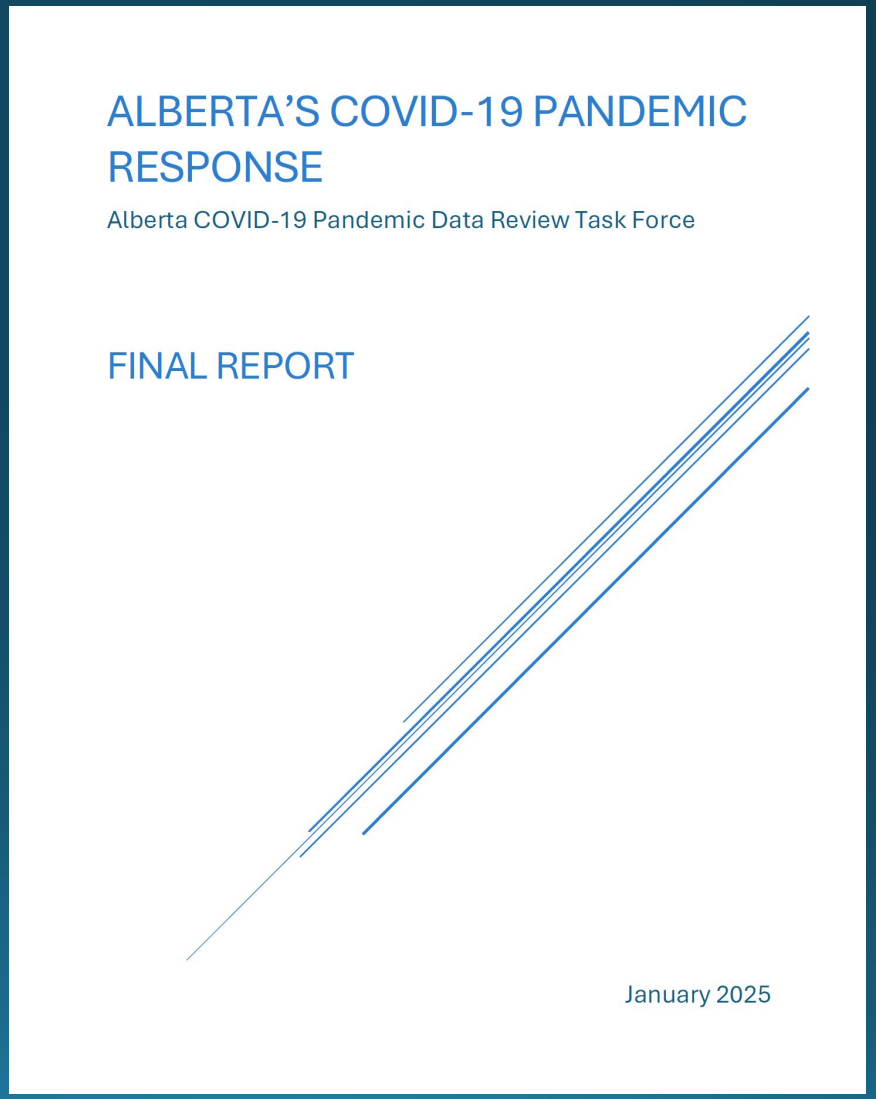

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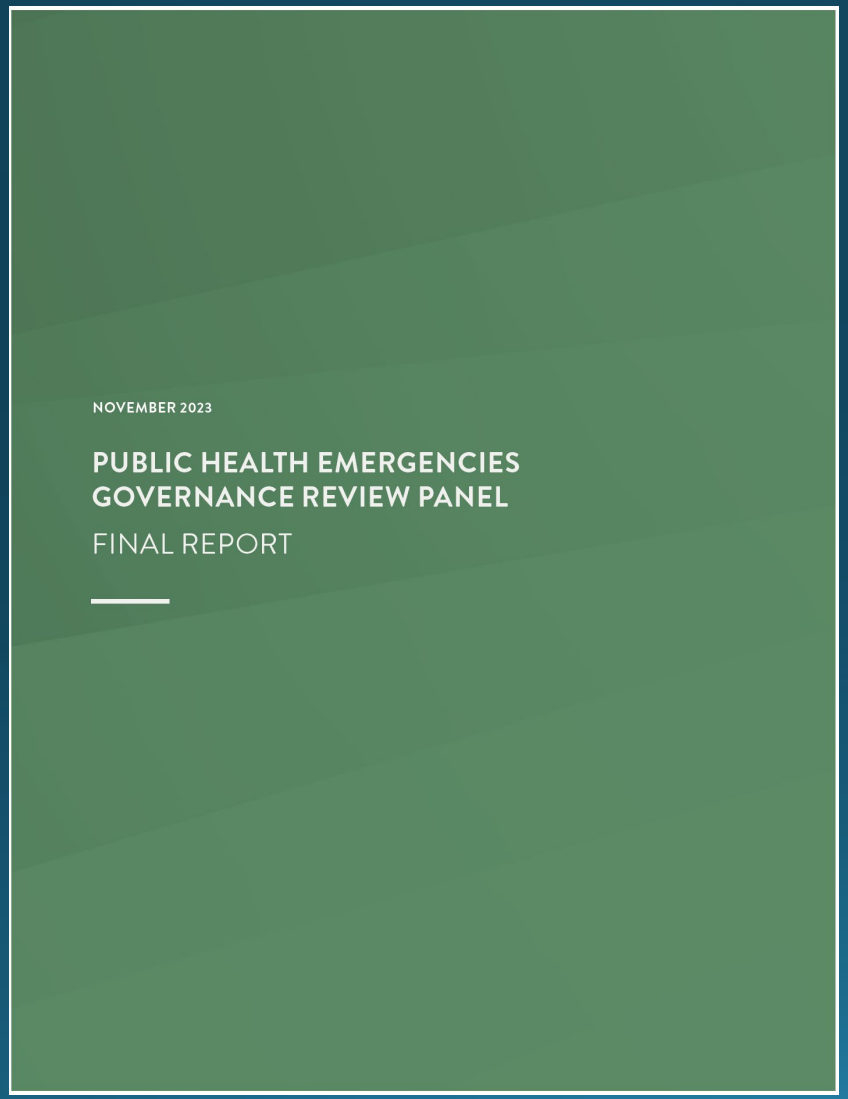

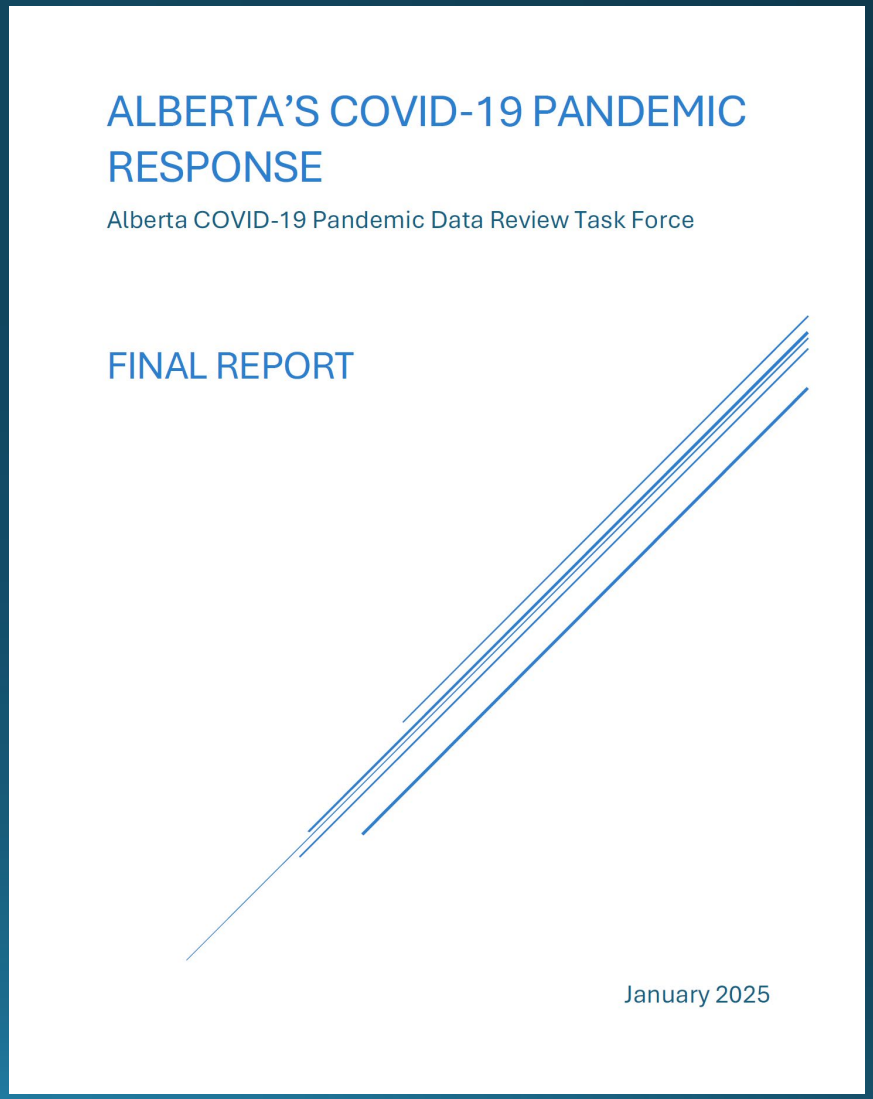

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What do they all have in common?

A framework to protect a narrative and put 'COVID' in the past.

Rewrite not just history – but also the present.

A narrative to accept the 'New Normal'

- **'Focused Protection'**
- **'The Perception of Choice'**
  - *Masks & more*
  - *Isolation*
  - *Testing*
  - *'Vaccines'*
  - *…and more.*

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What do they all have in common?

Preston Manning report & Gary Davidson Report

Frame of reference

BEFORE DANIELLE SMITH WAS ELECTED

Setting up a scapegoat while Smith et al cover up ongoing COVID crimes and ensure no one is prosecuted.

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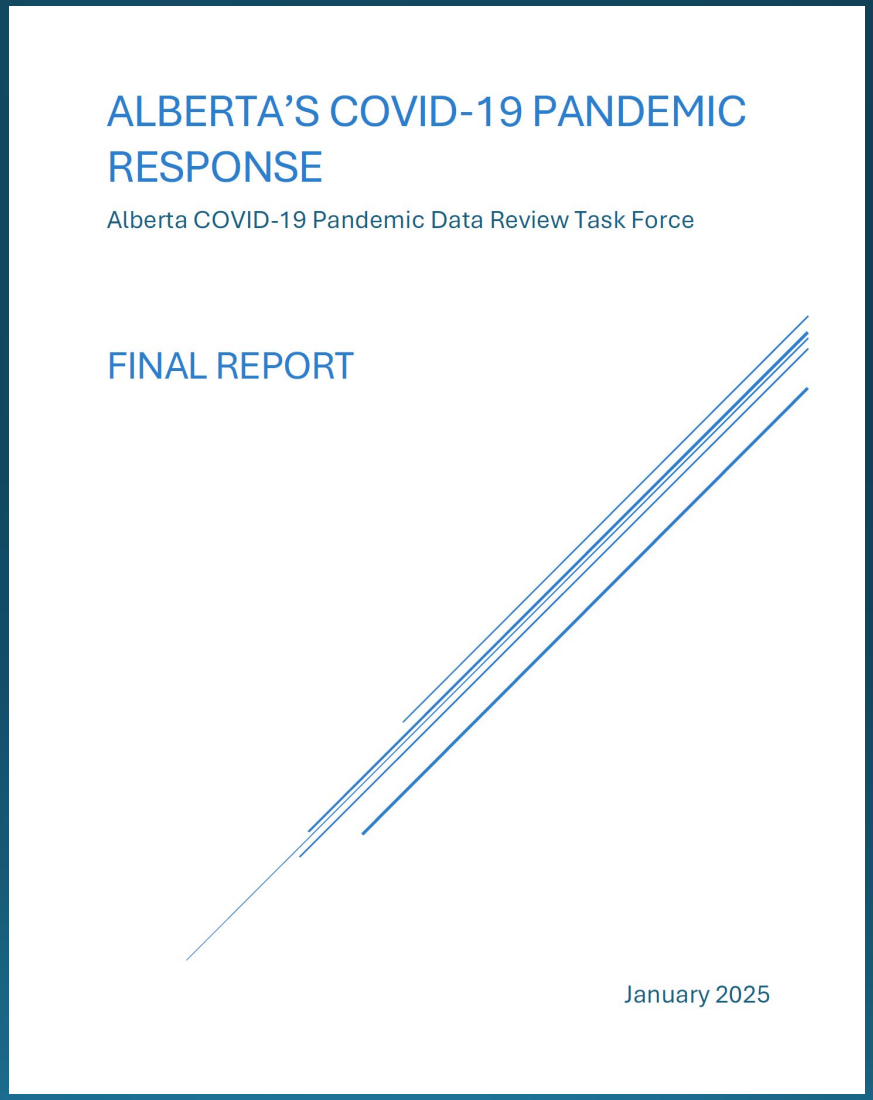

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Report says SAG ended December 31, 2020. It ended December 31, 2022. Didn't Dr. Conly tell them?

Dr. John Conly

Task Force Role: Contributor

Professor and former Head of the Department of Medicine at the University of Calgary and Alberta Health Services - Calgary and Area, Canada. He is medically trained as a specialist in infectious diseases and was a past President of the Canadian Infectious Disease Society, past Chairman of the Board for the Canadian Committee on Antibiotic Resistance and a previous Vice Chair for the Canadian Expert Drug Advisory Committee. He is currently the Co-Director for the Snyder Institute for Chronic Diseases at the University of Calgary, a member of the Canadian Expert Advisory Group on Antimicrobial Resistance and a member of the WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance. He has published over 300 papers and has received multiple career honours in teaching, research, mentorship, innovation and service, including the Ronald Christie Award for outstanding contributions to academic medicine in Canada, the Medal for Distinguished Service from the Alberta Medical Association for outstanding personal contributions to the medical profession and the Order of Canada for pioneering work in antimicrobial resistance, infection control and health innovation. He continues as an active consultant in clinical infectious diseases with current interests which focus on antimicrobial resistance and stewardship, prevention of hospital-acquired infections and novel innovations in healthcare.

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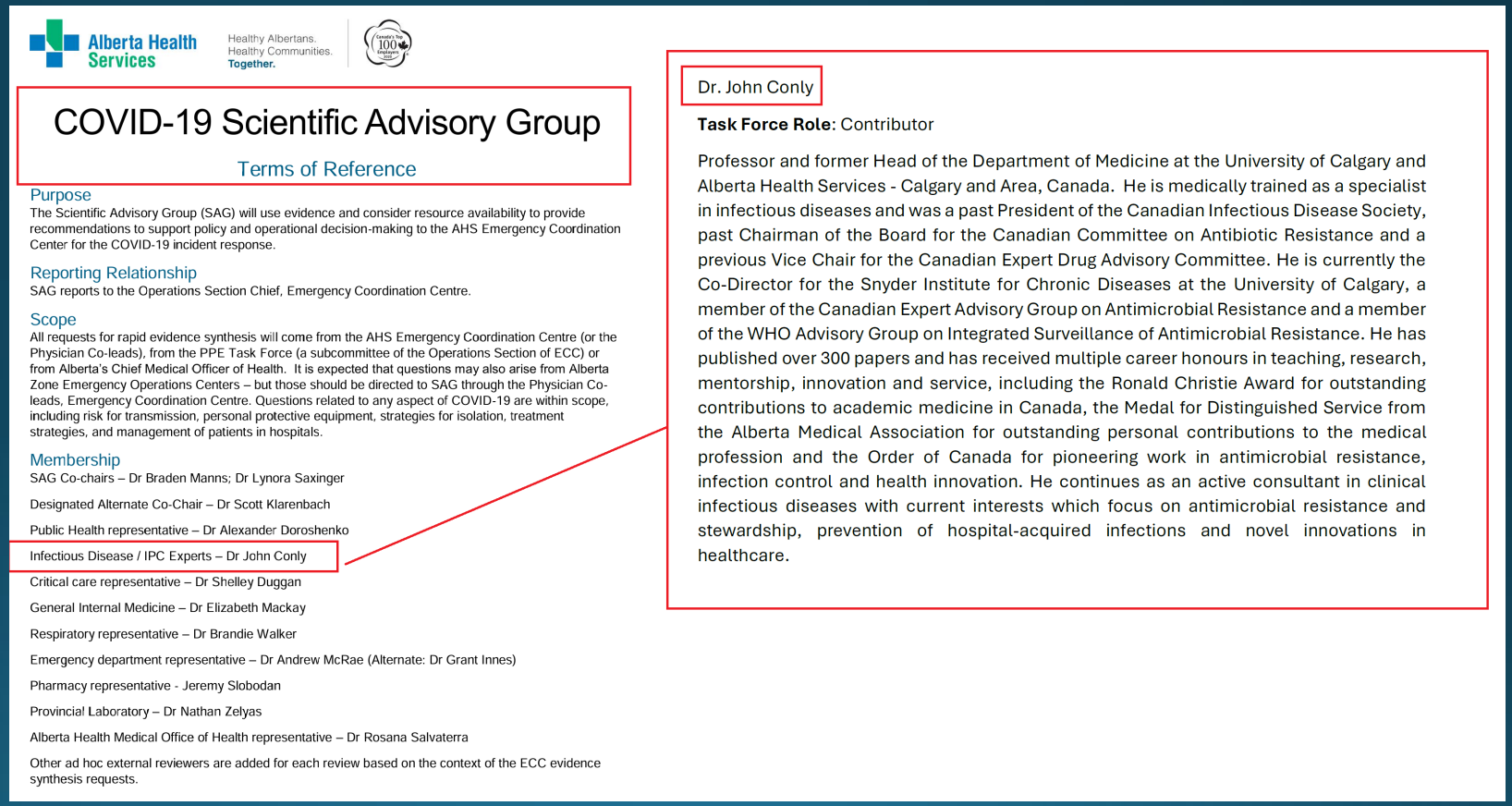

Alberta Health Services

Healthy Albertans. Healthy Communities. Together.

COVID-19 Scientific Advisory Group

Terms of Reference

Purpose

The Scientific Advisory Group (SAG) will use evidence and consider resource availability to provide recommendations to support policy and operational decision-making to the AHS Emergency Coordination Center for the COVID-19 incident response.

Reporting Relationship

SAG reports to the Operations Section Chief, Emergency Coordination Centre.

Scope

All requests for rapid evidence synthesis will come from the AHS Emergency Coordination Centre (or the Physician Co-leads), from the PPE Task Force (a subcommittee of the Operations Section of ECC) or from Alberta's Chief Medical Officer of Health. It is expected that questions may also arise from Alberta Zone Emergency Operations Centers – but those should be directed to SAG through the Physician Co-leads, Emergency Coordination Centre. Questions related to any aspect of COVID-19 are within scope, including risk for transmission, personal protective equipment, strategies for isolation, treatment strategies, and management of patients in hospitals.

Membership

SAG Co-chairs – Dr Braden Manns; Dr Lynora Saxinger

Designated Alternate Co-Chair – Dr Scott Klarenbach

Public Health representative – Dr Alexander Doroshenko

Infectious Disease / IPC Experts – Dr John Conly

Critical care representative – Dr Shelley Duggan

General Internal Medicine – Dr Elizabeth Mackay

Respiratory representative – Dr Brandie Walker

Emergency department representative – Dr Andrew McRae (Alternate: Dr Grant Innes)

Pharmacy representative - Jeremy Slobodan

Provincial Laboratory – Dr Nathan Zelyas

Alberta Health Medical Office of Health representative – Dr Rosana Salvaterra

Other ad hoc external reviewers are added for each review based on the context of the ECC evidence synthesis requests.

Dr. John Conly

Task Force Role: Contributor

Professor and former Head of the Department of Medicine at the University of Calgary and Alberta Health Services - Calgary and Area, Canada. He is medically trained as a specialist in infectious diseases and was a past President of the Canadian Infectious Disease Society, past Chairman of the Board for the Canadian Committee on Antibiotic Resistance and a previous Vice Chair for the Canadian Expert Drug Advisory Committee. He is currently the Co-Director for the Snyder Institute for Chronic Diseases at the University of Calgary, a member of the Canadian Expert Advisory Group on Antimicrobial Resistance and a member of the WHO Advisory Group on Integrated Surveillance of Antimicrobial Resistance. He has published over 300 papers and has received multiple career honours in teaching, research, mentorship, innovation and service, including the Ronald Christie Award for outstanding contributions to academic medicine in Canada, the Medal for Distinguished Service from the Alberta Medical Association for outstanding personal contributions to the medical profession and the Order of Canada for pioneering work in antimicrobial resistance, infection control and health innovation. He continues as an active consultant in clinical infectious diseases with current interests which focus on antimicrobial resistance and stewardship, prevention of hospital-acquired infections and novel innovations in healthcare.

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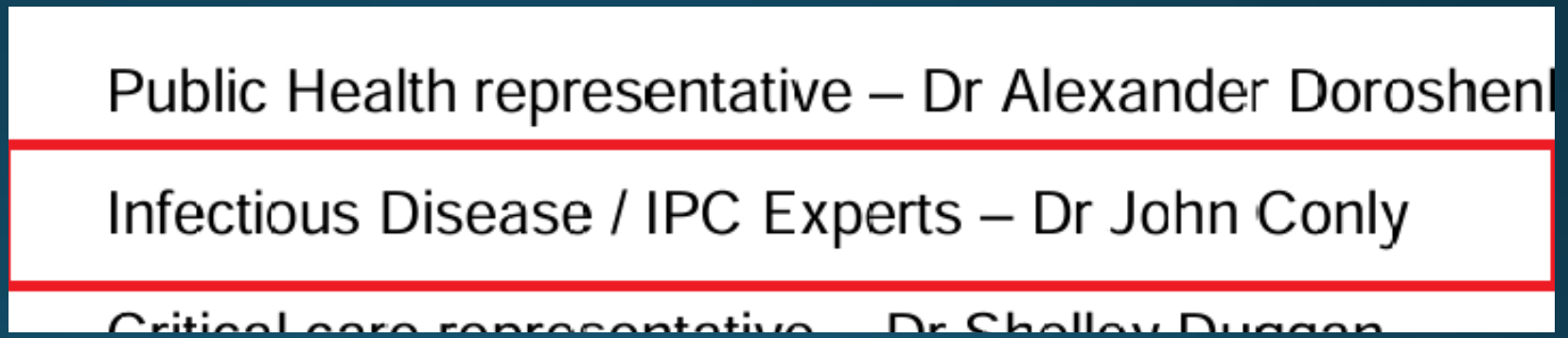

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Report says they had issues getting data from AHS…
Yet one of the authors was Quality Control for the COVID dashboard Wastewater TCR testing program.

Dr. David Vickers

Task Force Role: Author

David Vickers is a PhD and statistical associate and epidemiologist with the Centre for Health Informatics at the University of Calgary's Cumming School of Medicine. He is also a former epidemiologist for Alberta Health Services and has 16 years of experience in infectious disease epidemiology.

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"Dr. David Vickers, an infectious disease epidemiologist and statistical associate at the CHI, said like in previous waves, the exact trajectory of these trends is difficult to predict.

"Given that there's been a lot of relaxation of many of the prevention efforts going on, we might expect to see a bit of a rebound,"

Vickers said, noting similar trends in PCR test positivity in the Calgary and Edmonton Alberta Health Services zones."
https://globalnews.ca/news/8711685/alberta-covid-19-wastewater-levels-march/

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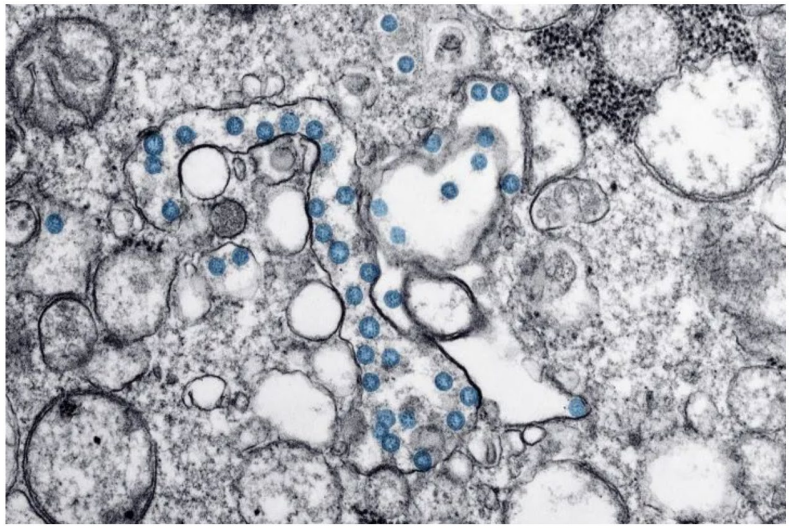
HEALTH

Alberta COVID-19 wastewater levels trending up in Calgary, Edmonton

By Adam Toy • Global News
Posted March 25, 2022 7:05 pm · 4 min read



This 2020 electron microscope image made available by the U.S. Centers for Disease Control and Prevention shows the spherical particles of the new coronavirus, colorized blue, from the first U.S. case of COVID-19. THE CANADIAN PRESS/Hannah A. Bullock, Azaibi Tamin/CDC via AP

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From: Health Minister <Health.Minister@gov.ab.ca>
Sent: Wednesday, April 19, 2023 3:31 PM
To: David Dickson <david.dickson@dksdata.com>
Cc: DraytonValley.Devon@assembly.ab.ca
Subject: COVID-19 Data and Masking

R 209982

Dear David Dickson:

Mark Smith, MLA, Drayton Valley-Devon, forwarded your correspondence regarding COVID-19 data and masking practices in the province. As Minister of Health, I appreciate the opportunity to respond on behalf of the Government of Alberta.

Regarding your query about COVID-19 data, cases are listed based on the date that laboratory results are reported to Alberta Health. On the COVID-19 Alberta Statistics dashboard, Figure 8 (under the "Severe Outcomes" tab) displays information about the number of deaths based on the date of death reported to Alberta Health. As noted in the data notes, numbers may fluctuate as case information is updated.

With respect to masking practices in the province, all remaining Alberta Chief Medical Officer of Health COVID-19 orders were lifted on June 30, 2022. Alberta Health Services (AHS) has maintained its own masking policies in AHS-operated and contracted facilities. AHS continues to review and evaluate these policies in an effort to balance the safety and preferences of patients, staff, and visitors. For more information, please refer to the AHS Use of Masks During COVID-19 Directive.

Thank you again for writing.

Sincerely,

Jason Copping
Minister of Health

cc: Mark Smith, MLA, Drayton Valley-Devon

https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#severe-outcomes
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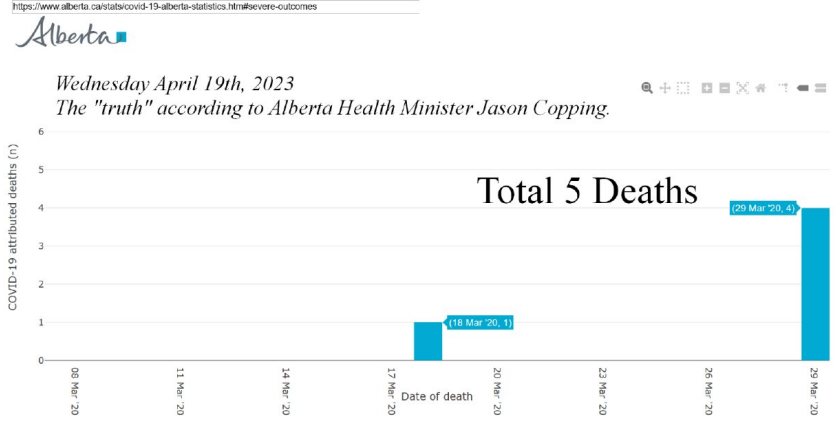

https://dksdata.com/AlbertaDead

From: Health Minister <Health.Minister@gov.ab.ca>
Date: February 27, 2024 at 3:47:13 PM MST
To: [redacted]
Cc: "Morinville-St. Albert" <Morinville.StAlbert@assembly.ab.ca>
Subject: Continuing Care Outbreak Requirements

AR 217817

Dear [redacted]:

Honourable Dale Nally, MLA for Morinville-St. Albert, forwarded your letter to Premier Smith and me, regarding COVID-19 outbreak requirements in continuing care homes. As Minister of Health, I appreciate the opportunity to respond.

Alberta lifted the remaining Chief Medical Officer of Health pandemic-related Orders on June 30, 2022. Now that we are following a more routine approach to disease management for COVID-19, Alberta Health Services (AHS) has incorporated guidance and requirements into their standard operating policies and procedures for infection prevention and control for all communicable diseases. This helps to ensure that the most appropriate level of protection is in place for residents if there is an outbreak at their site.

In alignment with pre-pandemic practice, outbreaks in continuing care homes are managed by the AHS Zone Medical Officer of Health, who works in collaboration with the home's administration to determine the appropriate management strategies and protocols. This may include isolating symptomatic residents, continuous masking and eye protection, limiting group activities, and enhanced cleaning protocols. AHS encourages site administration to manage outbreaks on a unit or floor basis to limit disruptions to residents in other areas of the building.

Alberta's government continues to emphasize the need to protect residents in continuing care from multiple health risks, including the direct risk of respiratory illness and the health risks of social isolation and disconnection that you mentioned. As these risks sometimes compete, there is no single, straightforward path to address all needs and preferences simultaneously. We continue to work with operators, residents, families, staff, and other key stakeholders to seek the right balance.

Regarding your questions about the reporting of COVID-19 deaths, you may be interested in the information provided by the Government of Alberta about severe outcomes from COVID-19 and seasonal influenza. The dashboard also includes the definition that the government uses when reporting a death from COVID-19 or influenza.

Thank you for writing, and please accept my best wishes for your wife's heath.

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Adriana LaGrange
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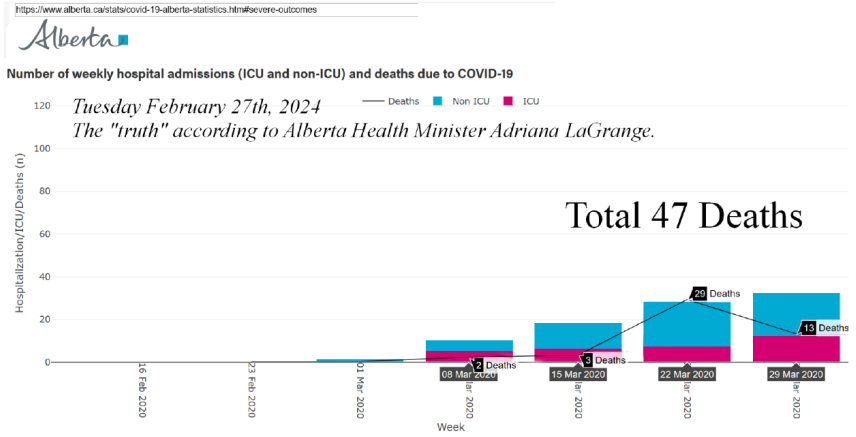

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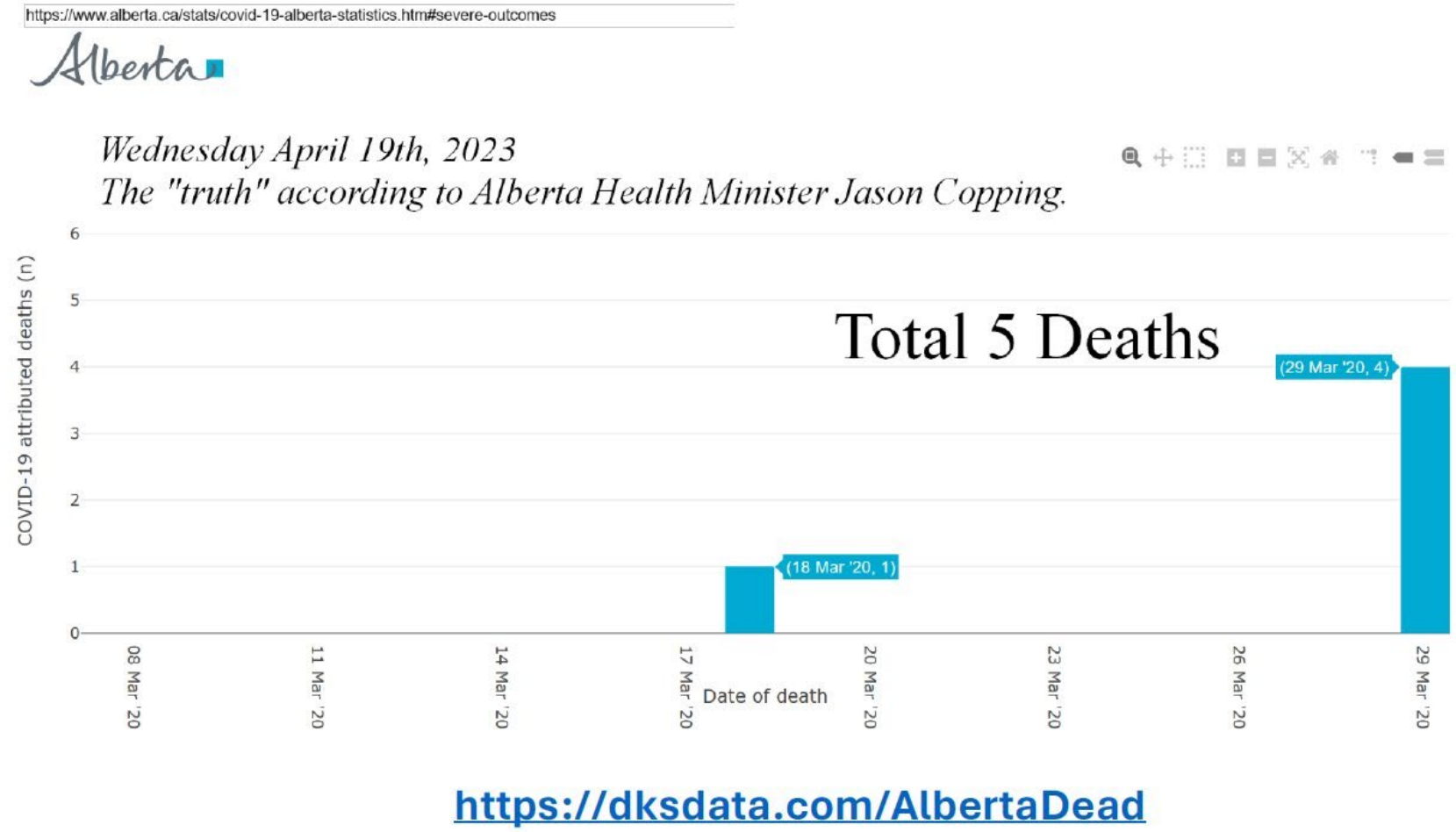

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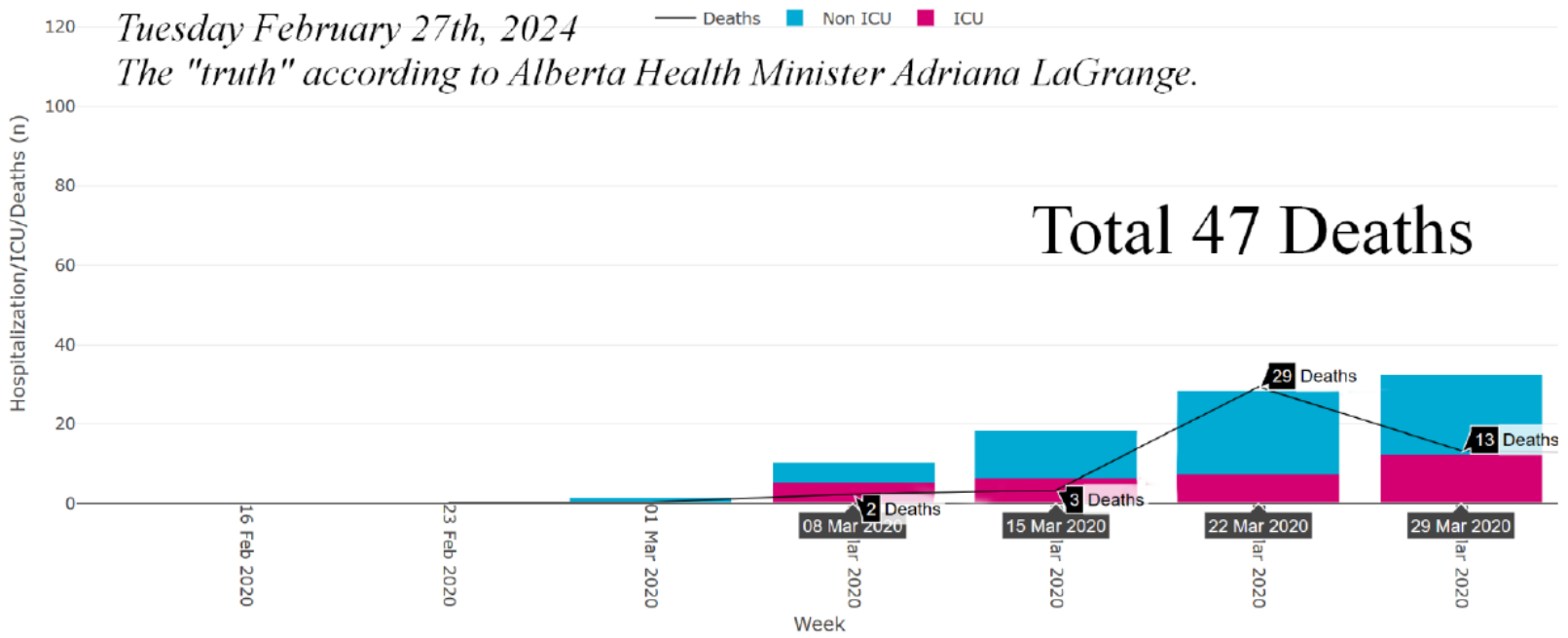
Alberta

Number of weekly hospital admissions (ICU and non-ICU) and deaths due to COVID-19



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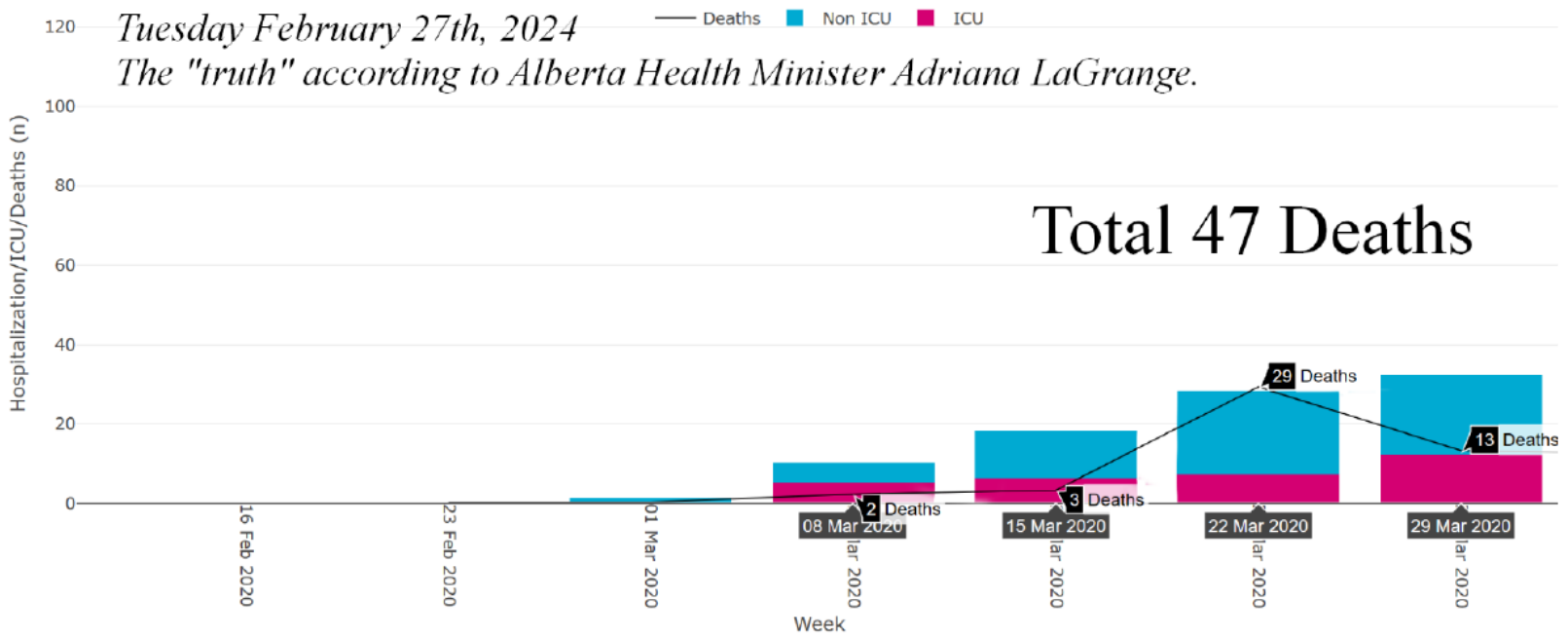

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Figure 1. COVID-19 Cases in Alberta, 2019-2020 to 2023-2024.[175]

COVID-19

Summary of laboratory-confirmed COVID-19 cases in Alberta, 2019-2020 to 2023-2024

Season	Cases (n)	Hospitalizations (n)	ICU admissions (n)	Deaths (n)
2023-2024	21,079	5,297	328	628
2022-2023	32,822	5,918	462	973
2021-2022	350,230	15,536	2,006	2,410
2020-2021	238,963	9,941	1,952	2,215
2019-2020	13,144	679	134	243

Note: A hospital or ICU admission in a laboratory-confirmed COVID-19 case is counted when the reason for admission is either directly resulting from the disease, or when the disease is a contributing factor for the admission. Information on reason for hospitalization was unavailable prior to 2022-02-01. **Data before and after that reporting change date are not directly comparable.**

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2019-2020	13,144	679	134	243

Change **June 8th, 2024 - June 22nd, 2024**

Summary of laboratory-confirmed COVID-19 cases in Alberta, 2019-2020 to 2022-2023

Season	Cases (n)	Hospitalizations (n)	ICU admissions (n)	Deaths (n)
2023-2024	366	112	5	10
2022-2023	0	0	0	0
2021-2022	0	-1	-1	0
2020-2021	0	-1	0	0
2019-2020	0	0	0	0

https://www.alberta.ca/stats/dashboard/respiratory-virus-dashboard.htm?data=historical-data#historical-dat

Change **October 7th, 2023 - June 22nd, 2024**

Summary of laboratory-confirmed COVID-19 cases in Alberta, 2019-2020 to 2022-2023

Season	Cases (n)	Hospitalizations (n)	ICU admissions (n)	Deaths (n)
2023-2024				
2022-2023	-24	-2	0	3
2021-2022	62	11	-3	-2
2020-2021	50	7	2	-1
2019-2020	10	0	0	0

https://www.alberta.ca/stats/dashboard/respiratory-virus-dashboard.htm?data=historical-data#historical-dat

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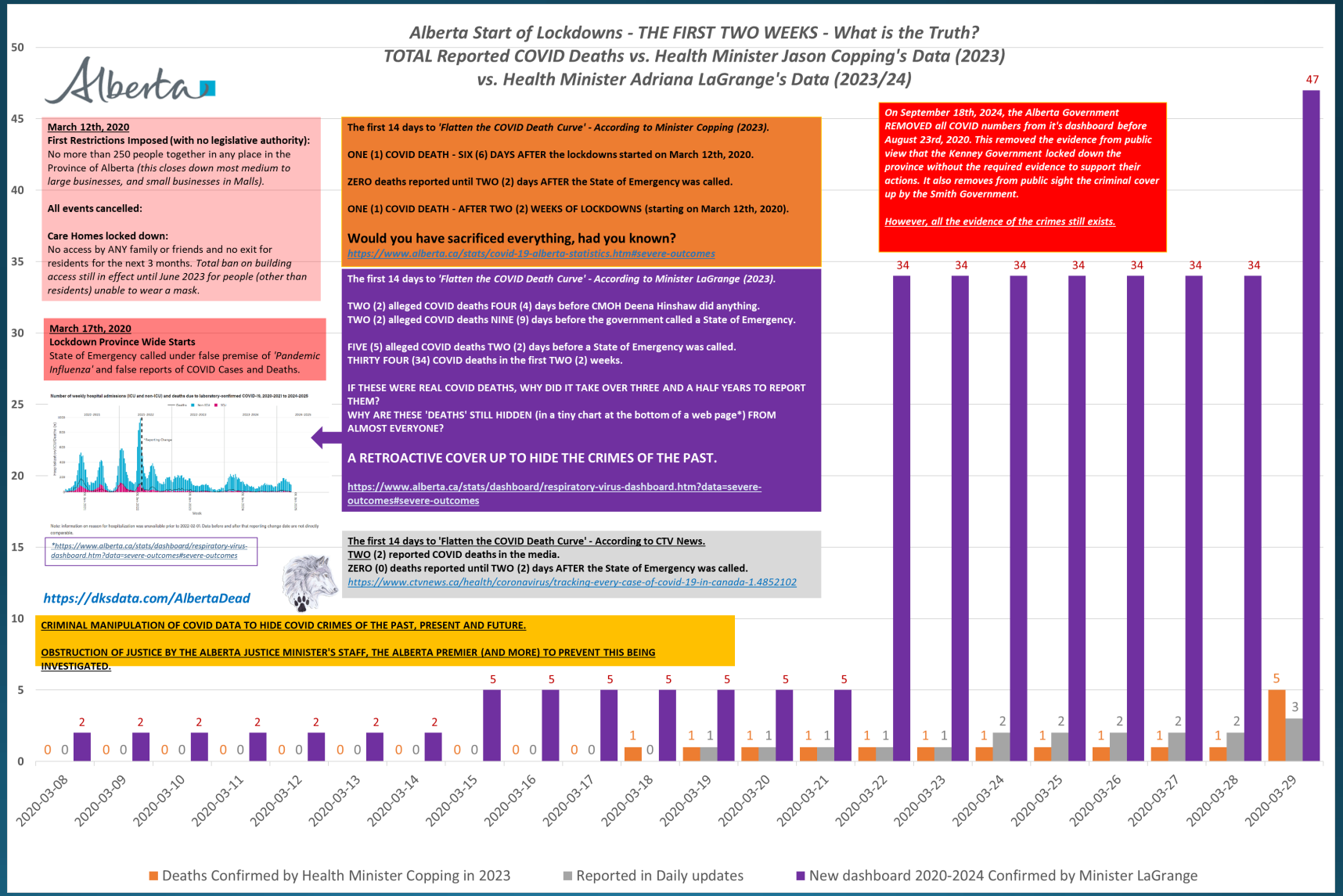

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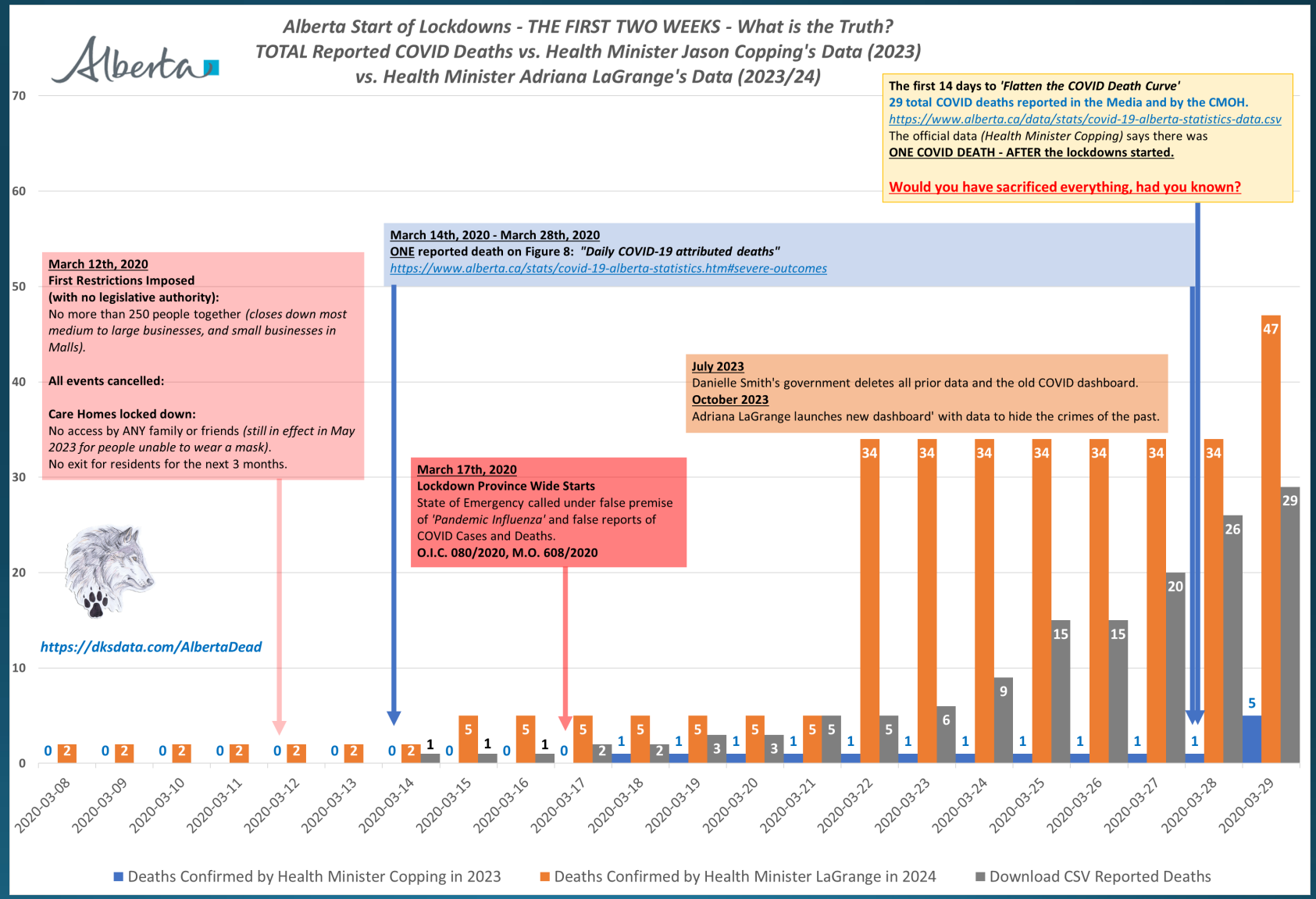

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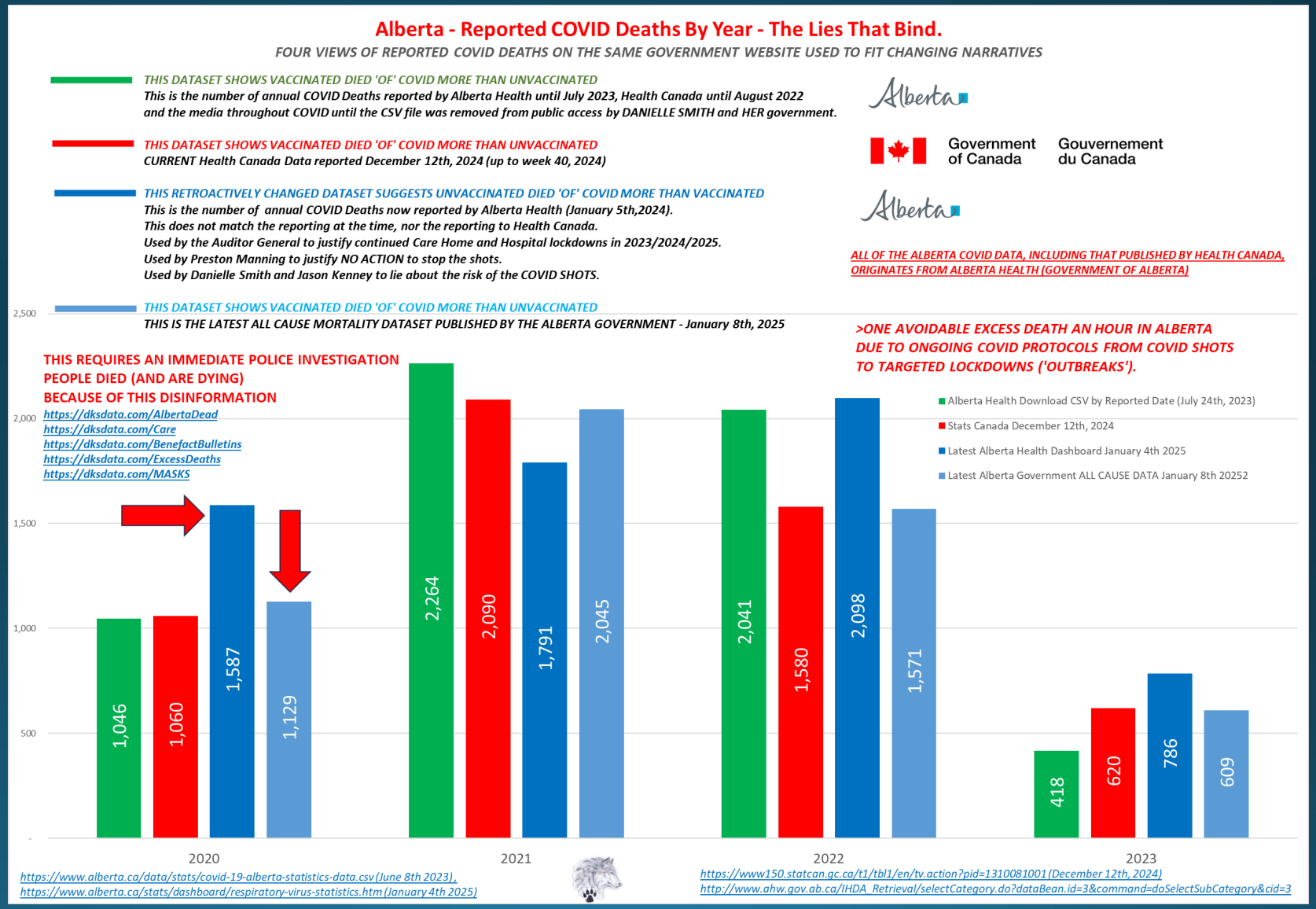

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If they are Manipulating Data, why look at it?

How many deaths 'involving' COVID were there and when. Why dates matter.

THIS WAS ALL KNOWN TO THE CMOH AND HEALTH MINISTER AT THE TIME.

HOW IS THIS A HEALTH EMERGENCY, LET ALONE A "PANDEMIC FLU" EMERGENCY!?

"I, Dr. Deena Hinshaw, Chief Medical Officer of Health (CMOH) have initiated an investigation into the existence of COVID-19 within the Province of Alberta.

This investigation has confirmed that COVID-19 is present in Alberta and constitutes a public health emergency as a novel or highly infectious agent that poses a significant risk to public health."

Or

"Whereas I, Dr. Deena Hinshaw, Chief Medical Officer of Health (CMOH") has initiated an investigation into the existence of COVID-19 within the Province of Alberta.

Whereas the investigation has confirmed that COVID-19 is present in Alberta and constitutes a public health emergency as a novel or highly infectious agent that poses a significant risk to public health."

"Whereas under section 29(2.1) of the Public Health Act (the Act), I have the authority by order to prohibit a person from attending a location for any period and subject to any conditions that I consider appropriate, where I have determined that the person engaging in that activity could transmit an infectious agent. I also have the authority to take whatever other steps that are, in my opinion, necessary in order to lessen the impact of the public health emergency."

Signed on this 16 day of March, 2020.

Deena Hinshaw, MD
Chief Medical Officer of Health

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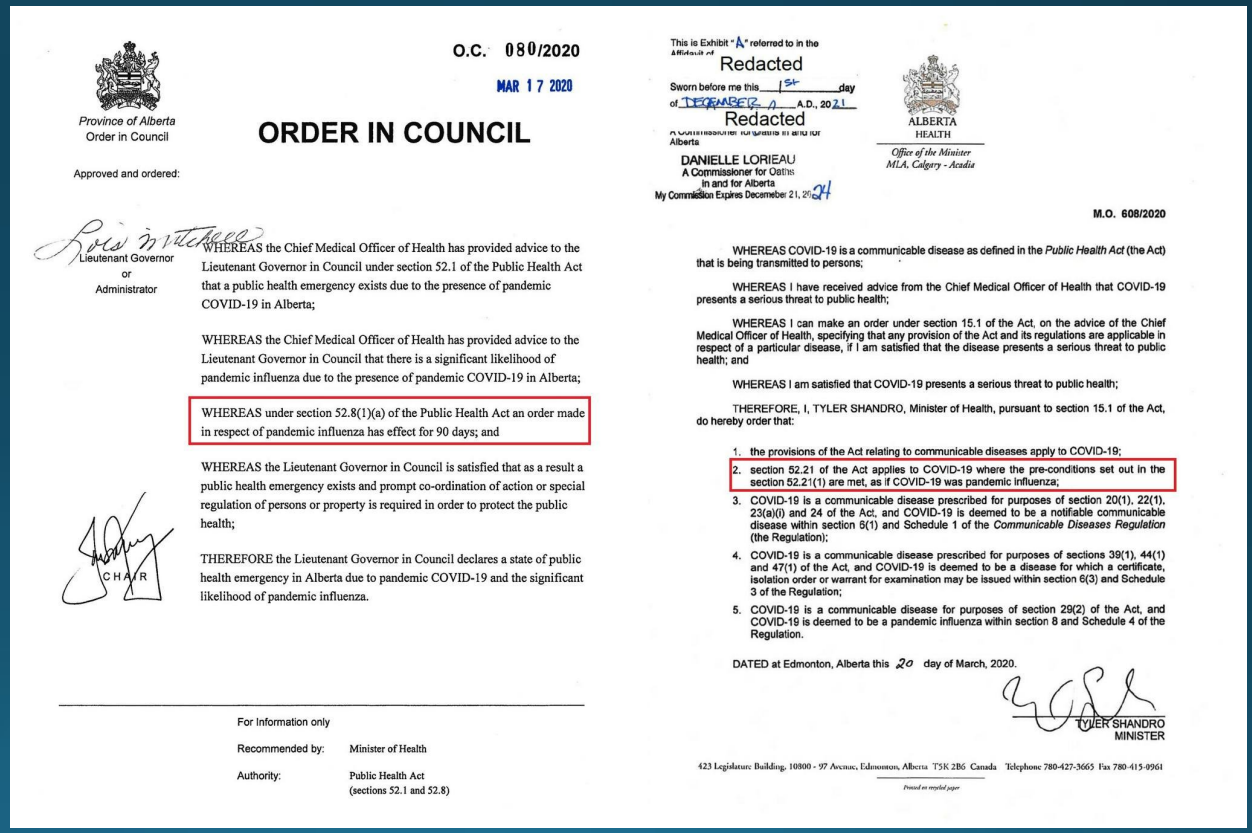

Province of Alberta
Order in Council

O.C. 080/2020

MAR 17 2020

ORDER IN COUNCIL

Approved and ordered:

Lieutenant Governor
or
Administrator

WHEREAS the Chief Medical Officer of Health has provided advice to the Lieutenant Governor in Council under section 52.1 of the Public Health Act that a public health emergency exists due to the presence of pandemic COVID-19 in Alberta;

WHEREAS the Chief Medical Officer of Health has provided advice to the Lieutenant Governor in Council that there is a significant likelihood of pandemic influenza due to the presence of pandemic COVID-19 in Alberta;

WHEREAS under section 52.8(1)(a) of the Public Health Act an order made in respect of pandemic influenza has effect for 90 days; and

WHEREAS the Lieutenant Governor in Council is satisfied that as a result a public health emergency exists and prompt co-ordination of action or special regulation of persons or property is required in order to protect the public health;

THEREFORE the Lieutenant Governor in Council declares a state of public health emergency in Alberta due to pandemic COVID-19 and the significant likelihood of pandemic influenza.

CHAIR

For Information only

Recommended by: Minister of Health

Authority: Public Health Act (sections 52.1 and 52.8)

This is Exhibit "A" referred to in the Affidavit of
Redacted
Sworn before me this 1st day of DECEMBER A.D., 2021
Redacted
A Commissioner for Oaths in and for Alberta

DANIELLE LORIEAU
A Commissioner for Oaths
in and for Alberta
My Commission Expires December 21, 2024

ALBERTA
HEALTH
Office of the Minister
MLA, Calgary - Acadia

M.O. 608/2020

WHEREAS COVID-19 is a communicable disease as defined in the *Public Health Act* (the Act) that is being transmitted to persons;

WHEREAS I have received advice from the Chief Medical Officer of Health that COVID-19 presents a serious threat to public health;

WHEREAS I can make an order under section 15.1 of the Act, on the advice of the Chief Medical Officer of Health, specifying that any provision of the Act and its regulations are applicable in respect of a particular disease, if I am satisfied that the disease presents a serious threat to public health; and

WHEREAS I am satisfied that COVID-19 presents a serious threat to public health;

THEREFORE, I, TYLER SHANDRO, Minister of Health, pursuant to section 15.1 of the Act, do hereby order that:

1. the provisions of the Act relating to communicable diseases apply to COVID-19;
2. section 52.21 of the Act applies to COVID-19 where the pre-conditions set out in the section 52.21(1) are met, as if COVID-19 was pandemic influenza;
3. COVID-19 is a communicable disease prescribed for purposes of section 20(1), 22(1), 23(a)(i) and 24 of the Act, and COVID-19 is deemed to be a notifiable communicable disease within section 6(1) and Schedule 1 of the *Communicable Diseases Regulation* (the Regulation);
4. COVID-19 is a communicable disease prescribed for purposes of sections 39(1), 44(1) and 47(1) of the Act, and COVID-19 is deemed to be a disease for which a certificate, isolation order or warrant for examination may be issued within section 6(3) and Schedule 3 of the Regulation;
5. COVID-19 is a communicable disease for purposes of section 29(2) of the Act, and COVID-19 is deemed to be a pandemic influenza within section 8 and Schedule 4 of the Regulation.

DATED at Edmonton, Alberta this 20 day of March, 2020.

TYLER SHANDRO
MINISTER

423 Legislature Building, 10800 - 97 Avenue, Edmonton, Alberta T5K 2B6 Canada Telephone 780-427-3665 Fax 780-415-0961

Printed on recycled paper

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WITH DAVID DICKSON

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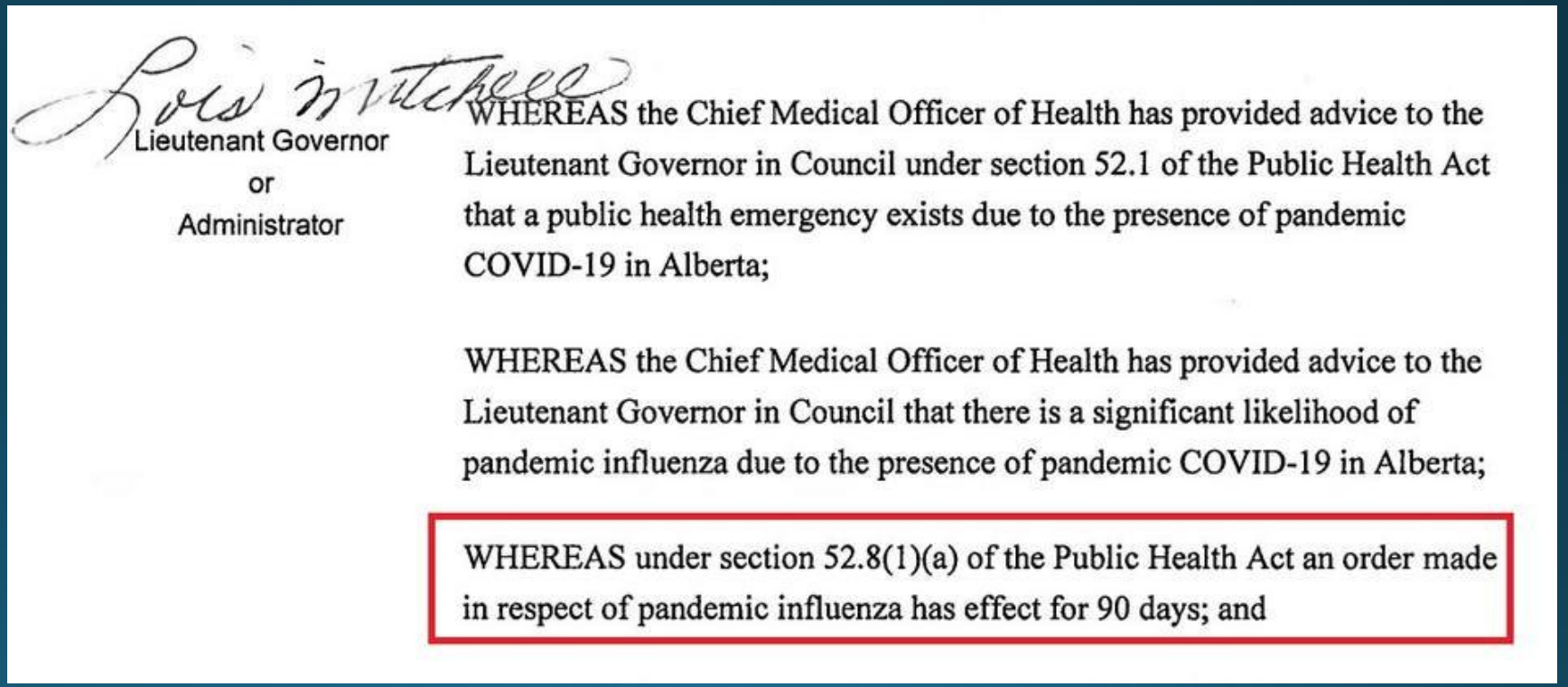

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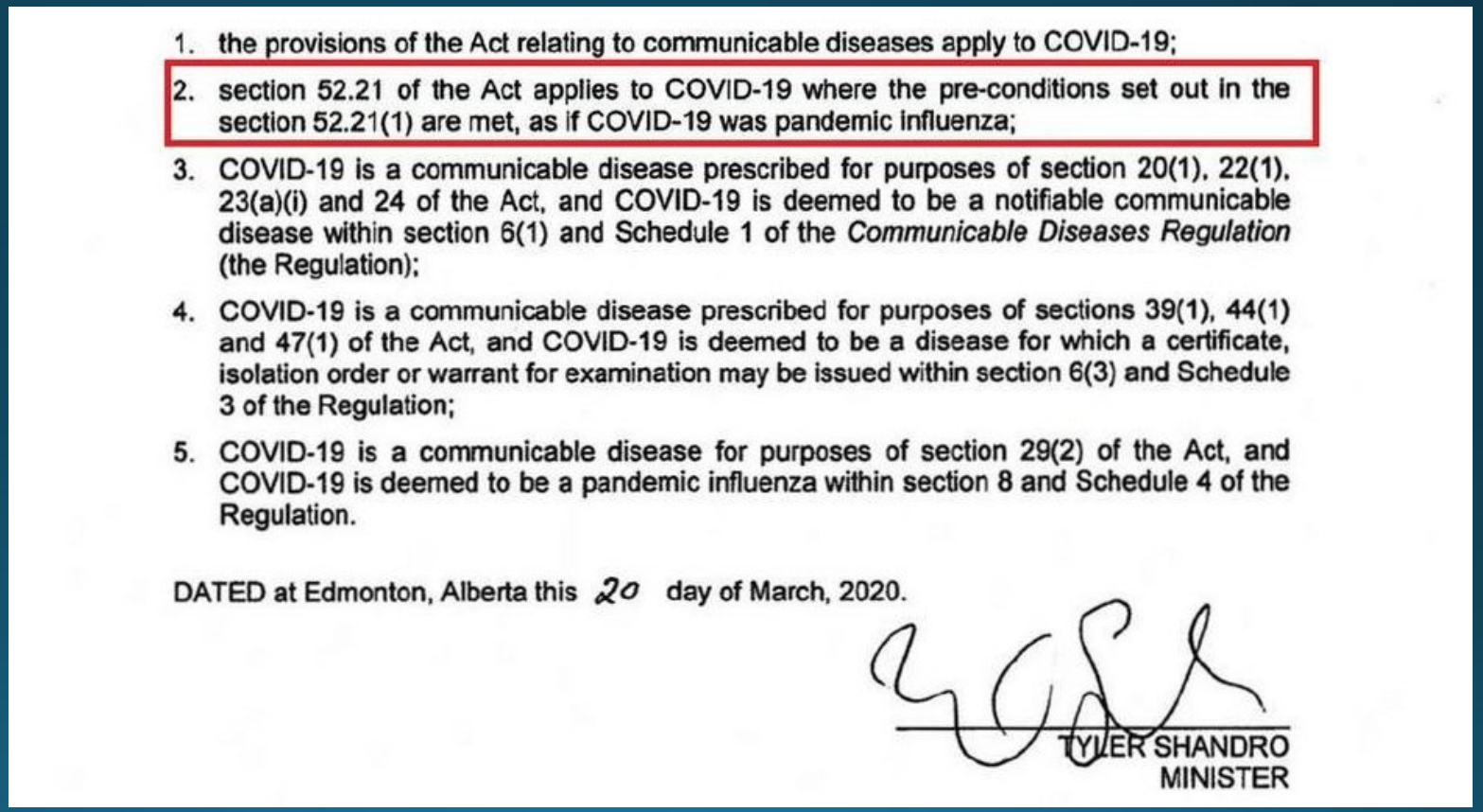

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If COVID was/is so deadly, why has it NEVER been added to the Communicable Diseases Regulation (AR 238/85) in Alberta? Despite 5 updates since 2020, it is NOT LISTED in; Schedule 1, 2 or 3 (Notifiable, Sexually Transmitted, Isolation/Warrant).

Link to ALL VERSIONS *https://www.canlii.org/en/ab/laws/regu/alta-reg-238-1985/latest/alta-reg-238-1985.html#history*

Public Health Act

Schedule 1

(Notifiable Communicable Diseases)

(Section 6(1) of this Regulation; Sections 20(1) and 22(1) of the Act)

Acquired Immunodeficiency Syndrome (AIDS)
Amebiasis
Anthrax
Arboviral Infections (including Dengue)
Botulism
Brucellosis
Campylobacter
Cerebrospinal fluid isolates
Chickenpox
Cholera
Congenital Infections (includes Cytomegalovirus, Hepatitis B, Herpes Simplex, Rubella, Toxoplasmosis, Varicella-zoster)
Dengue
Diphtheria
Encephalitis, specified or unspecified
Enteric Pathogens. See note below
Foodborne Illness. See note below
Gastroenteritis, epidemic. Aee note below
Giardiasis
Haemophilus Influenzae Infections (invasive)

9

Hemolytic Uremic Syndrome
Hepatitis A, B, Non-A, Non-B
Human Immunodeficiency Virus (HIV) Infections
Kawasaki Disease
Lassa Fever
Legionella Infections
Leprosy
Leptospirosis
Listeriosis
Malaria
Measles
Meningitis (all causes)
Meningococcal Infections
Mumps
Neonatal Herpes
Nosocomial Infections
Ophthalmia Neonatorum (all causes)
Pandemic Influenza
Paratyphoid
Pertussis
Plague
Poliomyelitis
Psittacosis
Q-fever
Rabies
Reye Syndrome
Rickettsial Infections
Rocky Mountain Spotted Fever
Rubella (including Congenital Rubella)
Rubeola
Salmonella Infections
Severe Acute Respiratory Syndrome (SARS)
Shigella Infections
Smallpox
Stool Pathogens, all types. See note below
Tetanus
Toxic Shock Syndrome
Trichinosis
Tuberculosis
Tularemia
Typhoid
Typhus
Varicella
Viral Hemorrhagic Fevers (including Marburg, Ebola, Lassa, Argentinian, African Hemorrhagic Fevers)
Waterborne Illness (all causes) See note below
West Nile Infection
Yellow Fever

10

Schedule 2

(Notifiable Sexually Transmitted Communicable Diseases)

(Section 6(2) of this Regulation; Section 20(2) of the Act)

Chancroid
Chlamydia Trachomatis Infections (genito-urinary)
Gonococcal Infections
Lymphogranuloma Venereum
Muco-purulent Cervicitis
Non-gonococcal Urethritis
Syphilis

AR 238/85 Sched.2;357/88;96/2005

Schedule 3

Diseases for Which a Certificate, Isolation Order or Warrant for Examination may be Issued)

(Section 6(3) of this Regulation; Sections 39(1), 44(1) and 47(1) of the Act)

Acquired Immunodeficiency Syndrome (AIDS)
Anthrax
Cholera
Chancroid
Chlamydia Trachomatis Infections (genito-urinary)
Diphtheria
Gonococcal Infections
Human Immunodeficiency Virus (HIV) Infections
Lassa Fever
Leprosy
Lymphogranuloma Venereum
Pandemic Influenza
Plague
Severe Acute Respiratory Syndrome (SARS)
Smallpox
Syphilis

11

COVID 19 is NOT SARS or PANDEMIC INFLUENZA.

On the advice of CMOH Dr. Deena Hinshaw & recommended by the Health Minister & lawyer, Tyler Shandro.

March 17th, 2020
Alberta declared a State of Emergency for *"Pandemic Influenza"* through Order in Council 080/2020.

Worded:

"there is a *significant likelihood of pandemic influenza* due to the presence of *pandemic COVID-19* in Alberta"

November 24, 2020
A second State of Emergency was declared using Order in Council 2020-354.

Worded:

"a public health emergency exists due to the *presence of pandemic COVID-19* in Alberta"

" Minister of Health has *deemed COVID-19 to be a pandemic influenza*;"

September 15, 2021
A third and final (to date) State of Emergency was declared using OC 2021-255.

Worded:

" a public health emergency exists due to the presence of pandemic COVID-19 in Alberta; "

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(Notifiable Sexually Transmitted Communicable Diseases)

(Section 6(2) of this Regulation; Section 20(2) of the Act)

Chancroid
Chlamydia Trachomatis Infections (genito-urinary)
Gonococcal Infections
Lymphogranuloma Venereum
Muco-purulent Cervicitis
Non-gonococcal Urethritis
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AR 238/85 Sched.2

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(Section 6(3) of this Regulation; Sections 39(1), 44(1) and 47(1) of the Act)

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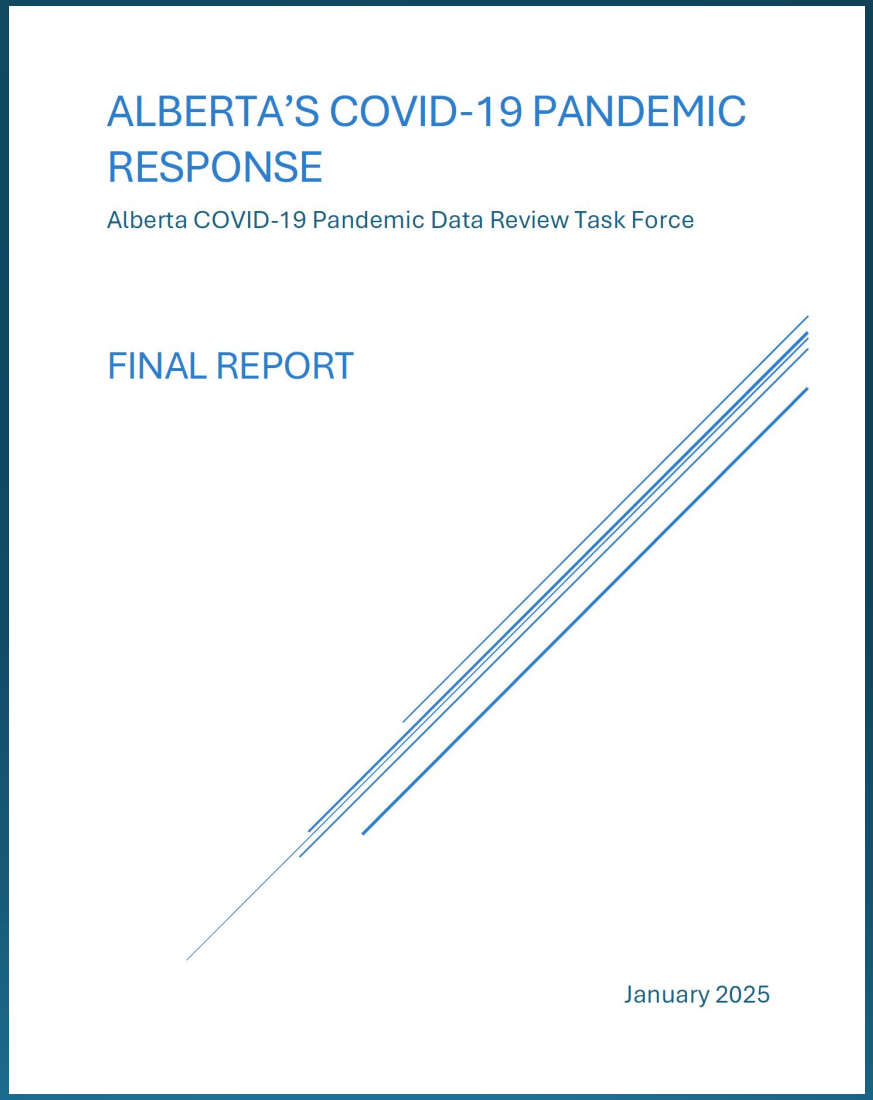

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5. **Alberta should adhere to the Canadian Biosafety Handbook which categorizes SARS-CoV-2 as a biosafety level 3 pathogen.** This requires stringent engineering controls for containment, including the need to dilute, filter and destroy SARS-CoV-2 with ventilation technologies.[187] Such approaches have already been successfully implemented by the airline industry, schools, and assisted-living facilities.[188]

[187] Canadian Biosafety Handbook, Second Edition, Section 3.1.1.3. https://www.canada.ca/en/public-health/services/canadian-biosafety-standards-guidelines/handbook-second-edition.html#s3113.

[188] https://covidvaccinesideeffects.com/do-masks-work-in-preventing-the-spread-of-covid-19-mask-expert-dr-stephen-petty/.

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3.1.1.3 Containment Level 3

Biosafety and biosecurity at CL3 are achieved through comprehensive operational practices and physical containment requirements. CL3 requires stringent facility design and engineering controls (e.g., **inward directional airflow [IDA]**, **high efficiency particulate air [HEPA] filtration** of exhaust air), as well as specialized biosafety equipment (e.g., BSCs, centrifuges with sealed rotors) to minimize the **release** of infectious material into the surrounding rooms inside or outside the containment zone, or the environment outside. Additional engineering controls, such as **effluent decontamination systems**, may be needed in some cases (e.g., Risk Group 3 [RG3] **non-indigenous animal pathogens**) to control the risks associated with pathogen release into the environment. Operational practices at CL3 build upon those required for CL2, taking into consideration the increased risks associated with the pathogen(s) and laboratory activities being carried out with RG3 pathogens.

A representative diagram of a CL3 SA zone is provided in Figure 3-1. The solid red line surrounding the CL3 zone illustrates the containment zone perimeter of the CL3 zone in this example. This diagram depicts some basic physical features such as a door to separate public areas from the containment zone, primary containment devices (e.g., BSCs) located away from high traffic areas/doors, a handwashing sink provided (located in the **"dirty" change area** in this example), as well as **anterooms**/clothing change areas equipped with a walk-through body shower for personnel, **primary containment caging**, and **pass -through chambers** (optional).

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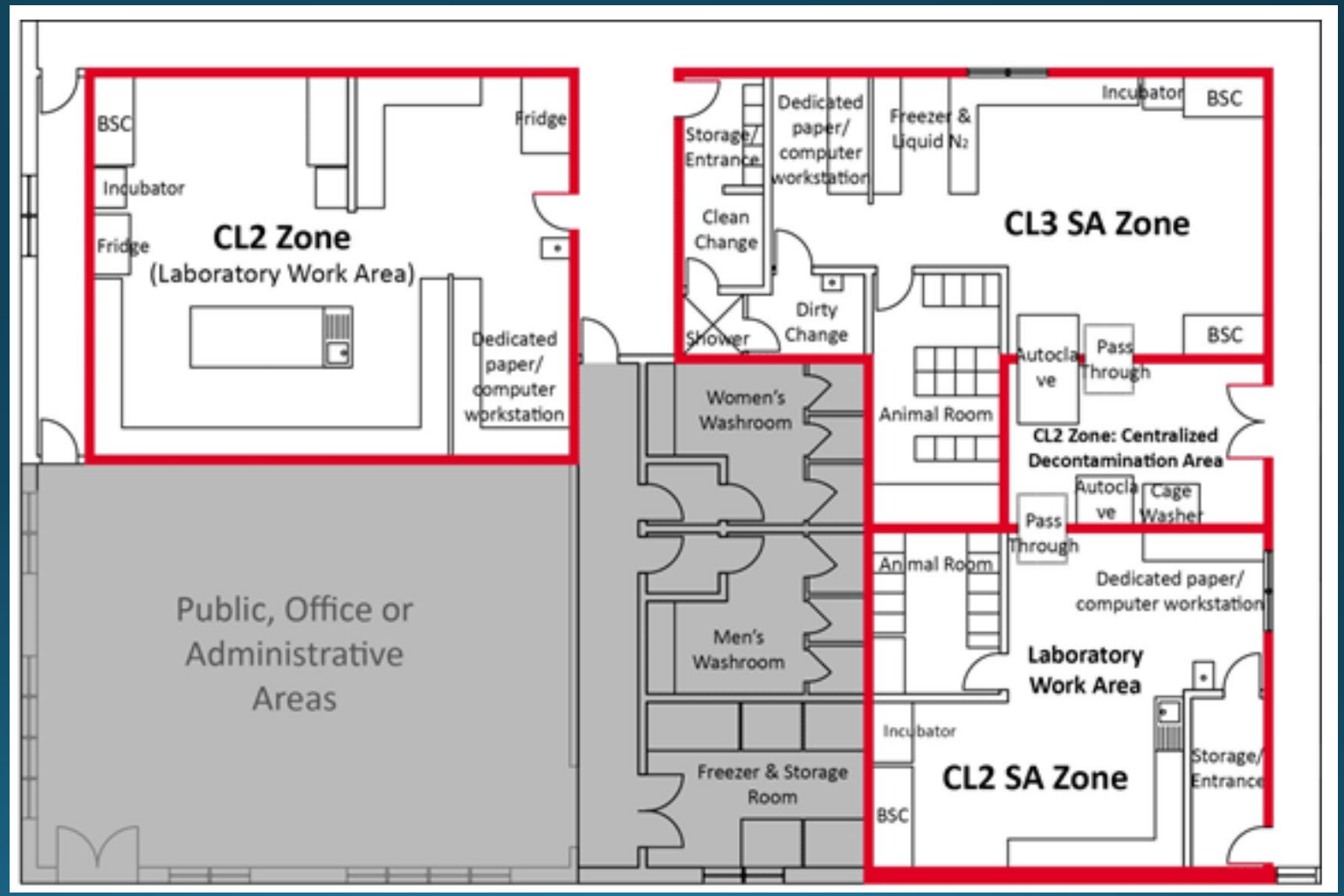

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Name	Type	Classification human	Classification animal	SSBA	CFIA	Info
Human coronavirus ➜ Coronavirus excluding SARS-CoV, SARS-CoV-2, MERS-CoV	Virus	RG2	RG1	No	No	No
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) ➜ 2019 nCoV ➜ COVID-19	Virus	RG3	RG2	No	No	Yes
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) Delta Variant of Concern ➜ B.1.617.2	Virus	RG3	RG2	No	No	No
Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) RNA	Nucleic Acid	RG2	RG1	No	No	Yes
Severe acute respiratory syndrome-related coronavirus (SARS-CoV) ➜ Severe acute respiratory syndrome	Virus	RG3	RG1	Yes	No	Yes
Vesiculovirus indiana rVSVΔG SARS-CoV-2 pseudovirus	Virus	RG2	RG2	No	Yes	No
Vesiculovirus indiana VSVΔG SARS 2 SPIKE	Virus	RG2	RG2	No	Yes	No
Vesiculovirus indiana VSVΔG-SARS-CoV-2.Delta	Virus	RG2	RG2	No	Yes	No
Vesiculovirus indiana VSVΔG-SARS-CoV-2.V590	Virus	RG2	RG2	No	Yes	No

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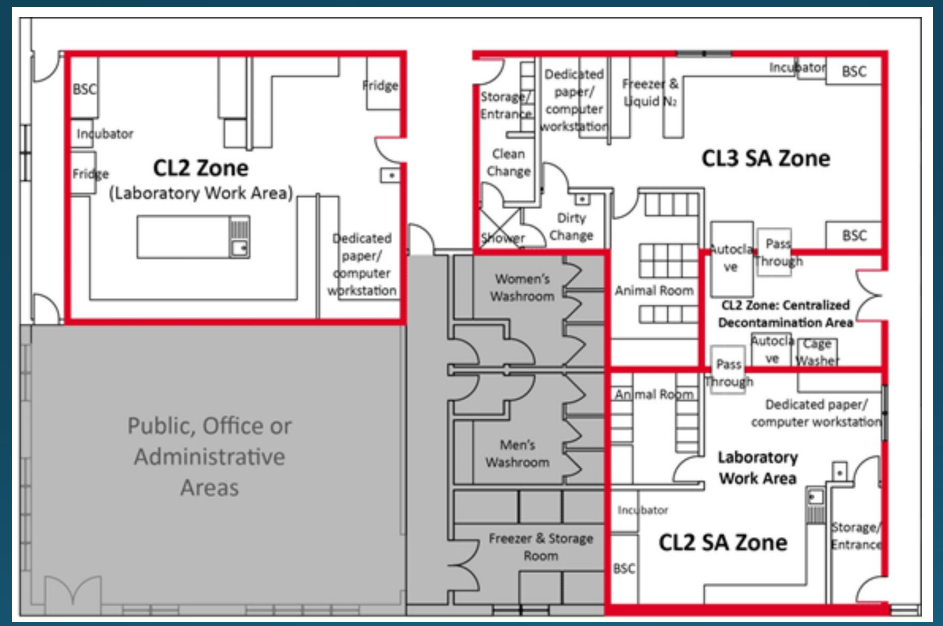
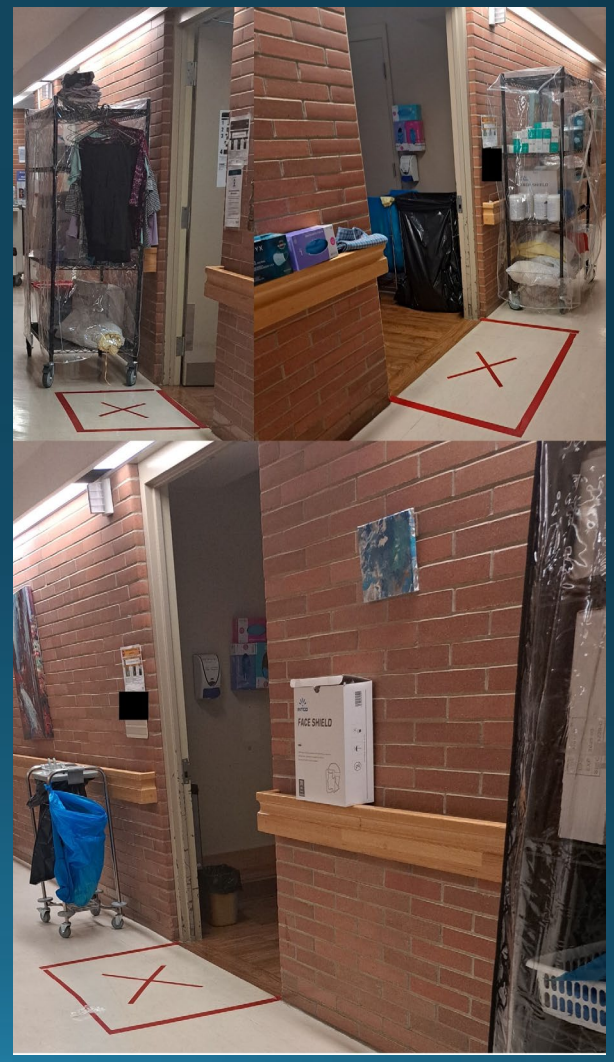
[187] Canadian Biosafety Handbook, Second Edition, Section 3.1.1.3. https://www.canada.ca/en/public-health/services/canadian-biosafety-standards-guidelines/handbook-second-edition.html#s3113.





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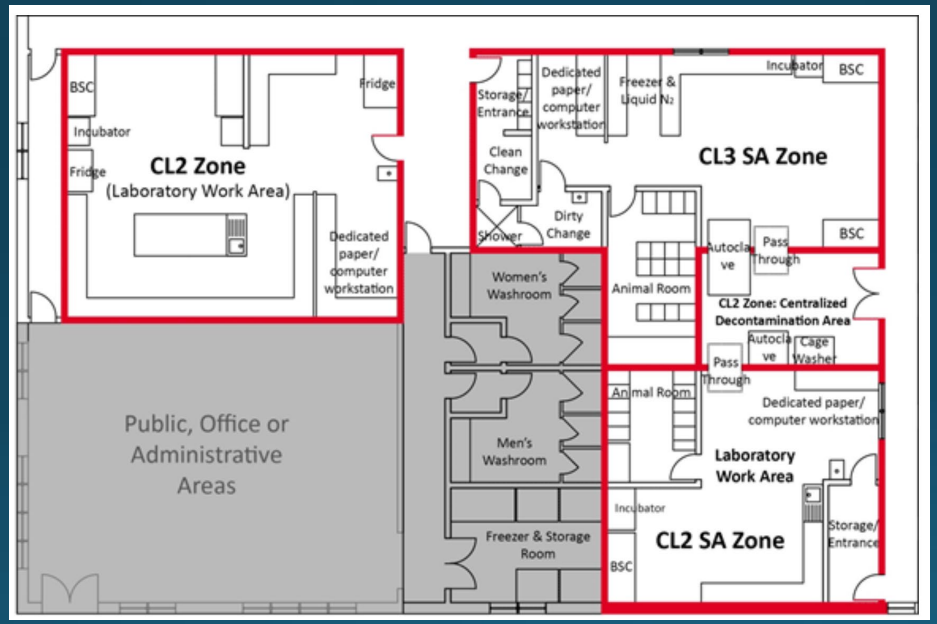

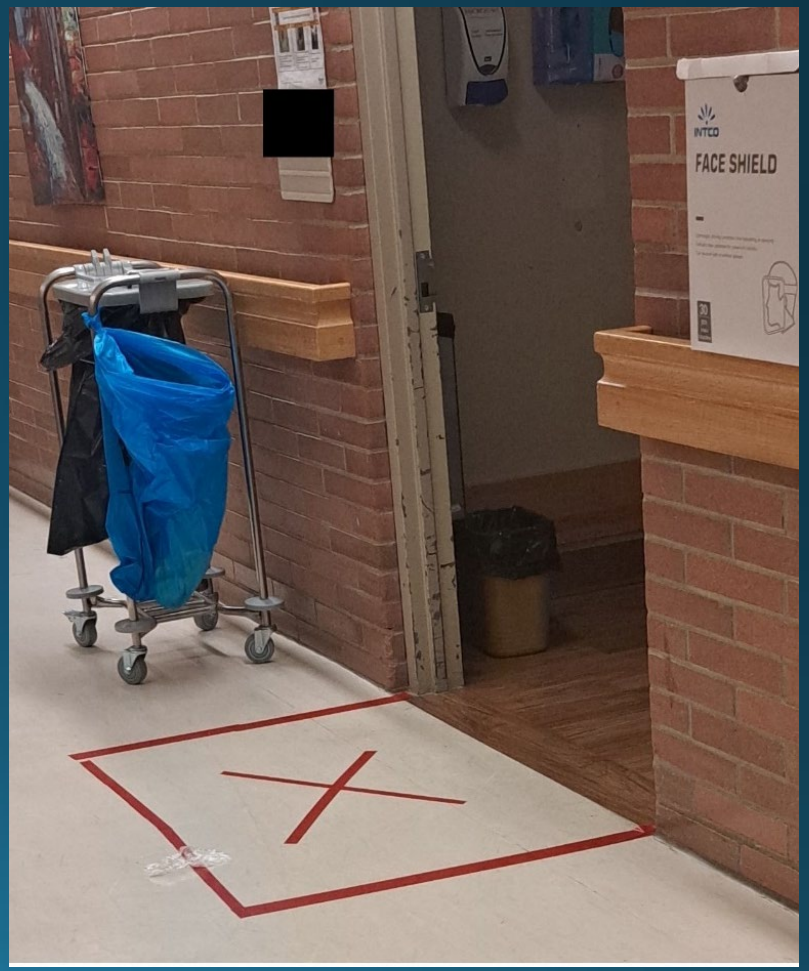

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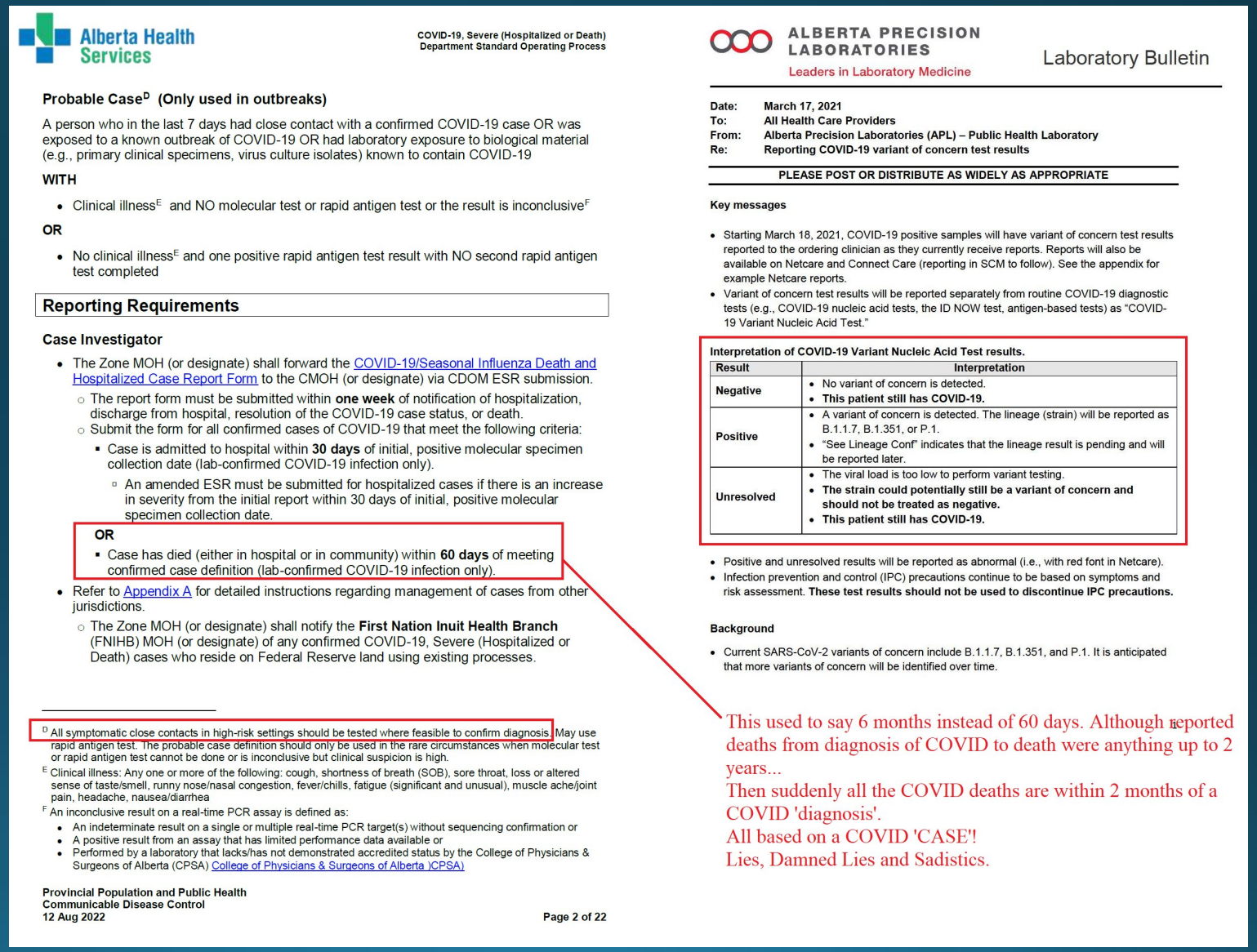

Alberta Health Services

COVID-19, Severe (Hospitalized or Death)
Department Standard Operating Process

Probable Case[D] (Only used in outbreaks)

A person who in the last 7 days had close contact with a confirmed COVID-19 case OR was exposed to a known outbreak of COVID-19 OR had laboratory exposure to biological material (e.g., primary clinical specimens, virus culture isolates) known to contain COVID-19

WITH

- Clinical illness[E] and NO molecular test or rapid antigen test or the result is inconclusive[F]

OR

- No clinical illness[E] and one positive rapid antigen test result with NO second rapid antigen test completed

Reporting Requirements

Case Investigator

- The Zone MOH (or designate) shall forward the COVID-19/Seasonal Influenza Death and Hospitalized Case Report Form to the CMOH (or designate) via CDOM ESR submission.
  - The report form must be submitted within **one week** of notification of hospitalization, discharge from hospital, resolution of the COVID-19 case status, or death.
  - Submit the form for all confirmed cases of COVID-19 that meet the following criteria:
    - Case is admitted to hospital within **30 days** of initial, positive molecular specimen collection date (lab-confirmed COVID-19 infection only).
      - An amended ESR must be submitted for hospitalized cases if there is an increase in severity from the initial report within 30 days of initial, positive molecular specimen collection date.

    OR

    - Case has died (either in hospital or in community) within **60 days** of meeting confirmed case definition (lab-confirmed COVID-19 infection only).
- Refer to Appendix A for detailed instructions regarding management of cases from other jurisdictions.
  - The Zone MOH (or designate) shall notify the **First Nation Inuit Health Branch** (FNIHB) MOH (or designate) of any confirmed COVID-19, Severe (Hospitalized or Death) cases who reside on Federal Reserve land using existing processes.

[D] All symptomatic close contacts in high-risk settings should be tested where feasible to confirm diagnosis. May use rapid antigen test. The probable case definition should only be used in the rare circumstances when molecular test or rapid antigen test cannot be done or is inconclusive but clinical suspicion is high.

[E] Clinical illness: Any one or more of the following: cough, shortness of breath (SOB), sore throat, loss or altered sense of taste/smell, runny nose/nasal congestion, fever/chills, fatigue (significant and unusual), muscle ache/joint pain, headache, nausea/diarrhea

[F] An inconclusive result on a real-time PCR assay is defined as:

- An indeterminate result on a single or multiple real-time PCR target(s) without sequencing confirmation or
- A positive result from an assay that has limited performance data available or
- Performed by a laboratory that lacks/has not demonstrated accredited status by the College of Physicians & Surgeons of Alberta (CPSA) College of Physicians & Surgeons of Alberta)CPSA)

ALBERTA PRECISION LABORATORIES
Leaders in Laboratory Medicine

Laboratory Bulletin

Date: March 17, 2021
To: All Health Care Providers
From: Alberta Precision Laboratories (APL) – Public Health Laboratory
Re: Reporting COVID-19 variant of concern test results

PLEASE POST OR DISTRIBUTE AS WIDELY AS APPROPRIATE

Key messages

- Starting March 18, 2021, COVID-19 positive samples will have variant of concern test results reported to the ordering clinician as they currently receive reports. Reports will also be available on Netcare and Connect Care (reporting in SCM to follow). See the appendix for example Netcare reports.
- Variant of concern test results will be reported separately from routine COVID-19 diagnostic tests (e.g., COVID-19 nucleic acid tests, the ID NOW test, antigen-based tests) as "COVID-19 Variant Nucleic Acid Test."

Interpretation of COVID-19 Variant Nucleic Acid Test results.

Result	Interpretation
Negative	• No variant of concern is detected. • **This patient still has COVID-19.**
Positive	• A variant of concern is detected. The lineage (strain) will be reported as B.1.1.7, B.1.351, or P.1. • "See Lineage Conf" indicates that the lineage result is pending and will be reported later.
Unresolved	• The viral load is too low to perform variant testing. • **The strain could potentially still be a variant of concern and should not be treated as negative.** • **This patient still has COVID-19.**

- Positive and unresolved results will be reported as abnormal (i.e., with red font in Netcare).
- Infection prevention and control (IPC) precautions continue to be based on symptoms and risk assessment. **These test results should not be used to discontinue IPC precautions.**

Background

- Current SARS-CoV-2 variants of concern include B.1.1.7, B.1.351, and P.1. It is anticipated that more variants of concern will be identified over time.

This used to say 6 months instead of 60 days. Although reported deaths from diagnosis of COVID to death were anything up to 2 years...
Then suddenly all the COVID deaths are within 2 months of a COVID 'diagnosis'.
All based on a COVID 'CASE'!
Lies, Damned Lies and Sadistics.

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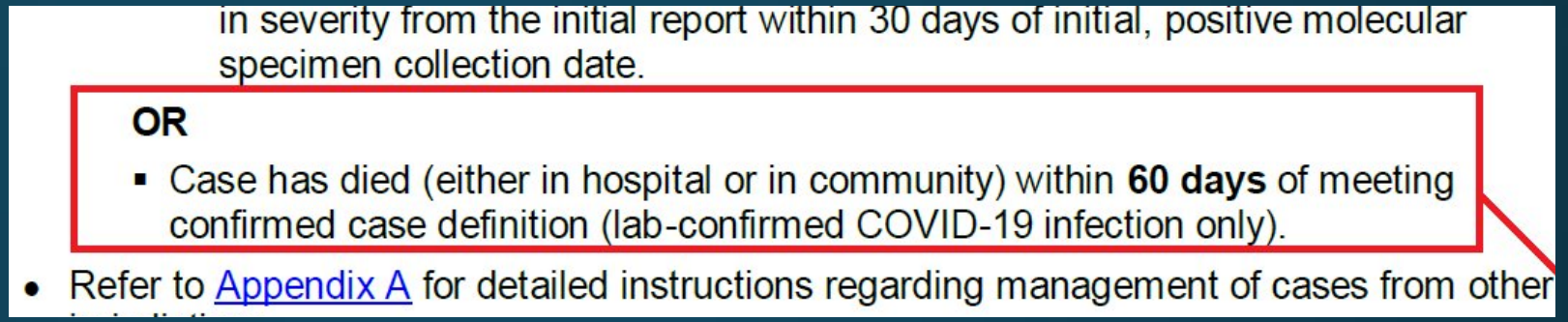
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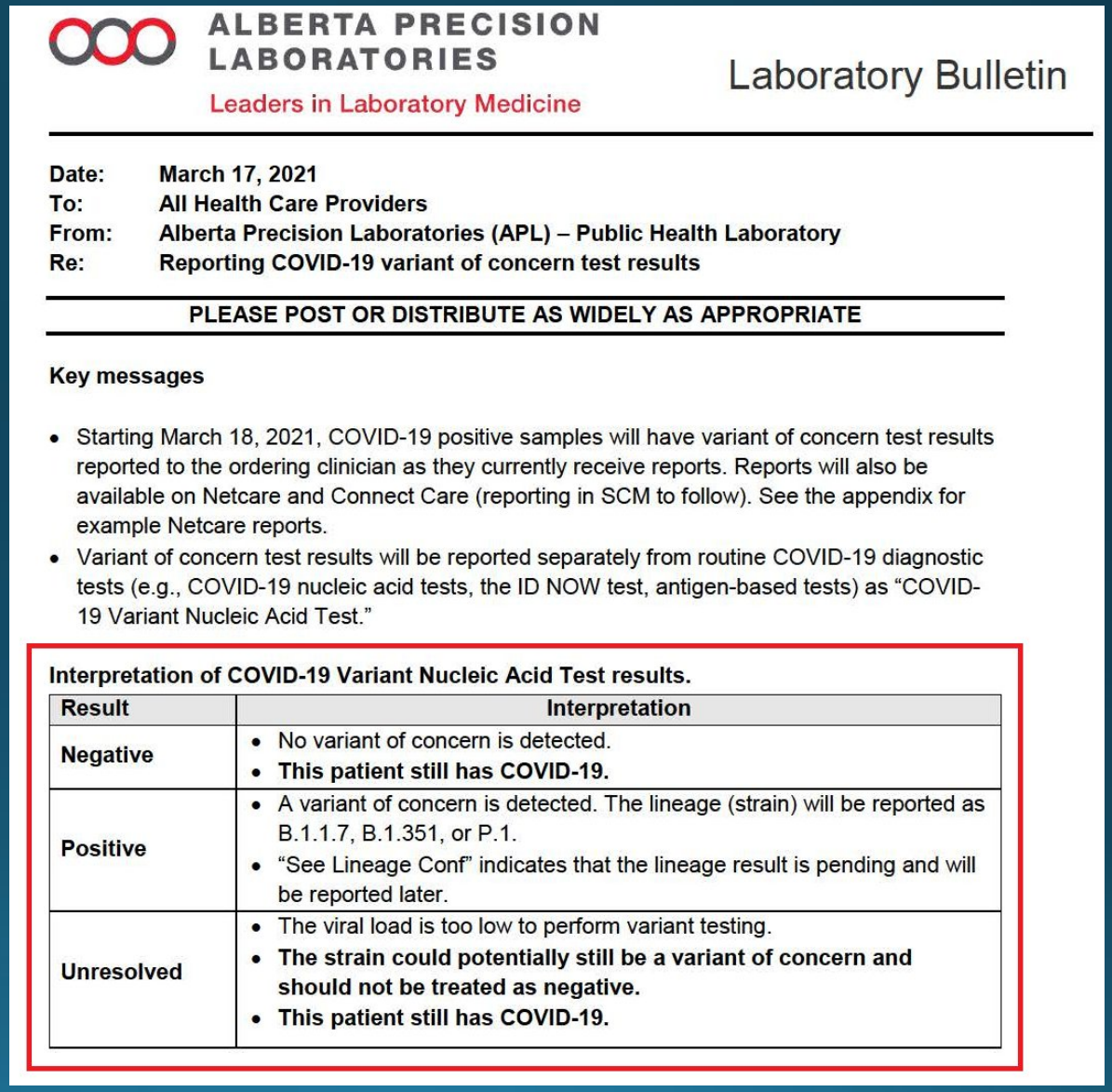

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Kenney 9th December 2020.

"What doctor Fauci has said is that anything over 35 cycles may produce false positives. That is to say, cases that were their test identifies dead or dormant viral fragments which are not indicative of infectiousness or the likely to have someone to become symptomatic. So basic doctor Fauci said with the PCR testing there should be a degree of caution. And we should understand that we are testing above 35 cycles on PCR. You're likely likely picking up a fair degree of false positives defined as people who are not infectious…"

"…That there are many people who get a positive PCR test are not infectious. And many will never be symptomatic or will only experience minor symptoms. Here in Alberta, I understand that we test up to 41 cycles on the PCR and anybody that gets over 35. We go back and run a second test on if they're positive."

(see attached lab directions for the second test.)

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Chapter 8: Vaccines

- Pfizer vaccine safety data from the three-month post-authorization trial was alarming.
  - 1,223 deaths attributed to the vaccine.
  - 42,086 people injured within 4 days of vaccination.
  - 45% of these were between the ages of 18-50 (who were at negligible risk from COVID-19 infection).

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Made Public - Nov 17, 2021
https://phmpt.org/document/5-3-6-postmarketing-experience-pdf/

Table 1. General Overview: Selected Characteristics of All Cases Received During the Reporting Interval

Characteristics		Relevant cases (N=42086)
Gender:	Female	29914
	Male	9182
	No Data	2990
Age range (years): 0.01 -107 years Mean = 50.9 years n = 34952	≤ 17 18-30 31-50 51-64 65-74 ≥ 75 Unknown	175[a] 4953 13886 7884 3098 5214 6876
Case outcome:	Recovered/Recovering	19582
	Recovered with sequelae	520
	Not recovered at the time of report	11361
	Fatal	1223
	Unknown	9400

a. in 46 cases reported age was <16-year-old and in 34 cases <12-year-old.

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Appendix 1

Figure 11. Adverse Events by COVID-19 Treatments and Other.

Data retrieved from WHO/Uppsala VigiAccess pharmacovigilance database (22.03.2021)				
Medicine	**Year reporting started**	**Deaths**	**Deaths per year**	**Adverse events**
Ivermectin	1992	16	< 1	4702
Aspirin	1968	1432	8	177606
Remdesivir	2020	467	467	5733
Tocilizumab	2005	769	48	47545
COVID-19 vaccines	2020	2402	9612	309403
Tetanus vaccine	1968	32	< 1	14725

Adverse events in the VigiAccess pharmacovigilance database associated with ivermectin, aspirin, a tetanus vaccine, and different COVID-19 pharmaceutical interventions with regulatory approval.[362]

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End Notes

[359] Analysis, C. (2024, June). Retrieved from https://c19early.org/smeta.html.

[360] Health, T. L. (2021, October 27). Effect of early treatment with fluvoxamine on risk of emergency care and hospitalisation among patients with COVID-19: the TOGETHER randomised, platform clinical trial. Retrieved from https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00448-4/fulltext.

[361] Gilmar et al, R. P. (2021, October 27). Effect of early treatment with fluvoxamine on risk of emergency care and hospitalisation among patients with COVID-19: the TOGETHER randomised, platform clinical trial. Retrieved from The Lancet: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00448-4/fulltext.

[362] Dr. Theresa Anne Lawrie written testimony to the Science and Technology Committee of the UK Parliament, June 2021; accessed November 7, 2023.

[363] https://aapsonline.org/CovidPatientTreatmentGuide.pdf.

committees.parliament.uk/writtenevidence/36858/pdf/

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Written Evidence Submitted by Dr Theresa Anne Lawrie, Director, The Evidence-based Medicine Consultancy Ltd

(CLL0115)

I am the Director of the Evidence-based Medicine Consultancy Ltd in Bath, United Kingdom. I have a medical degree (MBBCh) and a Doctorate in Philosophy (PhD) from the University of the Witwatersrand in Johannesburg, South Africa. Whilst I have practiced clinical Medicine in both the United Kingdom and South Africa, I now perform non-clinical research work only. My United Kingdom General Medical Council registration number is 3634680.

As the director of E-BMC Ltd, which I established in 2013, I am committed to improving the quality of healthcare globally through rigorous research. My research expertise is drawn from experience in both developing and developed countries, which uniquely positions me to evaluate and design research for a variety of healthcare settings. As a result, I am a frequent member of Technical Teams responsible for developing international clinical practice guidelines and am currently employed as the Guideline Methodologist on two World Health Organization (WHO) clinical practice guidelines due to be published in 2021. My peer-reviewed publications have received in excess of 3000 citations and my ResearchGate score is among the top 5% of ResearchGate members. Please note that E-BMC Ltd does not undertake pharmaceutical industry-sponsored work and I have no conflicts of interest to declare.

My involvement in the ivermectin story

On the 26th of December 2020, I watched Dr Pierre Kory's testimony on ivermectin before the United States Senate in which he asked that ivermectin be approved for the treatment of covid-19. Dr Pierre Kory is an intensive care specialist physician who is part of a group of called the Frontline Covid-19 Critical Care Alliance that has been monitoring potential treatments for covid-19. This group was the first to identify dexamethasone as a useful treatment for covid-19.

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I obtained a copy of the Kory/FLCCC review on ivermectin on the 26th December and was impressed with the number of studies included on ivermectin – I was surprised that I had not heard about ivermectin in the context of covid-19 before. I noted that a limitation of the FLCCC review was that the authors had not performed a meta-analysis of the included trials. Meta-analysis is a research method that involves pooling data from different studies to produce an overall estimate of the effect of a treatment for critical and important health outcomes. Evidence synthesis is one of my areas of expertise. Given the urgent need for therapeutics against covid-19, I undertook to do this evidence synthesis work for free during my Christmas holiday because I thought it might help to clarify whether ivermectin would be useful against covid-19 and in the context of the pandemic, speed was of the essence. I approached this work with professional equipoise.

Following my evaluation of the evidence, I concluded that ivermectin was an essential drug to reduce the morbidity and mortality from covid-19. Therefore, on Monday the 4th of January 2021, I emailed my report on ivermectin to Mr. Hancock, Mr. Ashworth, Mr. Rees Mogg (my MP based on my home address) and Mrs. Wera Hobhouse (my MP based on my business address). I titled the email 'URGENT - Ivermectin

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Year	Ivermectin	Aspirin	Remdesivir	Tocilizumab	COVID-19 vaccine	Tetanus vaccine	Hydroxychloroquine	Artemisinin
2025	60	2,153	38	317	2,003	73	302	3
2024	541	14,789	1,250	8,168	500,331	916	2,657	1
2023	533	12,580	1,661	8,078	462,840	928	2,295	2
2022	1,041	10,840	1,949	8,428	1,930,754	520	2,410	1
2021	1,275	12,830	3,101	6,892	2,876,812	533	3,812	2
2020	1,441	16,083	5,092	6,129	2,385	483	7,067	2
2019	548	18,274	2	7,657	114	569	4,481	5
2018	759	16,819	1	12,153	48	567	5,189	4
2017	560	17,305		5,093	5	605	2,674	1
2016	288	15,524		4,487	4	380	2,411	2
2015	214	13,711		3,083	3	558	1,508	1
Total	8,049	226,717	13,094	78,933	5,775,299	17,653	41,193	24
		227,077						
		360						

Accessed: 2025-01-27 - 5:34am (Mountain Time)
https://www.vigiaccess.org/

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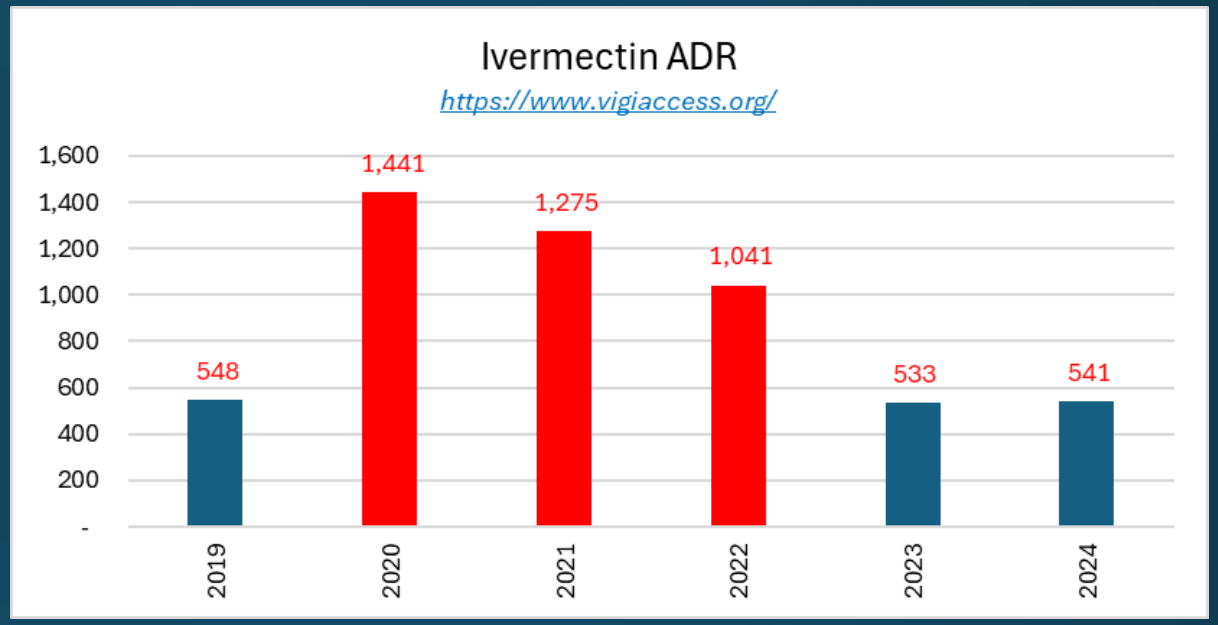

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Chapter 6: Testing

1. RT-PCR represents an excellent high-sensitivity test to aid in accurate diagnoses of symptomatic people – if they are used for the intended purpose and at optimal Ct values (vs. Ct values at "high positive" cut-offs).
2. Rapid tests with reasonable accuracy should not be used for screening the general population but could be used as an additional diagnostic tool, where clinically indicated.
3. We recommend that future pandemic responses prioritize minimizing severe disease and mortality over extensive case detection. Specifically, Alberta should focus on developing a screening tool to help estimate individual risk. This approach will optimize resource use by directing testing capacity, which can be appropriately directed by evidence-based practices, such as testing symptomatic individuals, those whose management may be influenced by test results, and for specific surveillance scenarios.

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4. We recommend that levels of immunity be gauged using a multi-antibody serological and/or mucosal assay that accounts for both pre-existing immunity as well as the presence of immune cells with the potential for cross-protection.
5. All tests should also be professionally administered and sufficiently sensitive to detect low antibody levels while sufficiently specific to distinguish between target and non-target antibodies. This also applies to laboratory tests used to identify specific respiratory viruses. Individual risk estimates can then be used to inform individual needs for protection either through the use of personal protective measures and/or vaccination.
6. Without being linked to a set of standardized clinical criteria, we recommend against the use of PCR tests as the sole criteria for a case definition. A confirmed case should include a pre-determined profile of signs and/or symptoms AND a positive test for the infection of concern PLUS any relevant patient history and confirmed epidemiological information.
7. Ensure that local surveillance data are used and interpreted when determining strategy and policy.

LIES, DAMNED LIES AND SADISTICS

WITH DAVID DICKSON

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Cover-ups and Crimes

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Dr. Jay Bhattacharya

Ingram Case

Great Barrington Declaration

Sweden

Isolation

Vaccination

(caregivers and elderly)

NIH

https://canlii.ca/t/jzf4k

FILED
JULY 31, 2023
JUDICIAL CENTRE OF CALGARY
CLERK OF THE COURT

Court of King's Bench of Alberta

Citation: Ingram v Alberta (Chief Medical Officer of Health), 2023 ABKB 453

Date:
Docket: 2001 14300
Registry: Calgary

Between:

Rebecca Marie Ingram, Heights Baptist Church, Northside Baptist Church, Erin Blacklaws and Torry Tanner

Applicants

- and -

Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health

Respondents

"[189] **Dr. Bhattacharya** is a professor in the School of Medicine at Stanford University, lately in the Department of Health Policy. **He is one of three authors of the Great Barrington Declaration**, an article released in September 2020, that is based on the premise that there is a steep age gradient in the risk profile for Covid-19 **such that older people face much higher risk of severe disease and death upon infection with Covid-19**, relative to younger people. **The Great Barrington Declaration calls for a lifting of restrictions as a general matter so that younger people can live lives as close to normal as possible**, and then a **focussed approach to protecting older people from the disease**, with more resources and **more ingenuity put into protecting older people from exposure to the virus, followed by prioritization for vaccination once vaccines are available**"

"[196] However, he has changed his opinion about **asymptomatic spread since the advent of the Omicron variant**, and **now thinks it very likely that asymptomatic spread of the virus is more important with that strain of the virus than it had been before**."

"202] Dr. Bhattacharya **supported vaccination as a good public health policy**, particularly **giving priority to elderly people,** which Alberta did in January 2021."

"[226] **Dr. Bhattacharya had referred to Sweden** as an **example of good policy in his written report. When faced with data that indicates that, during a similar period, Alberta's death rate was about 15.2% of Sweden's death rate** when relevant populations were taken into account, he testified that it was important to adjust for the age of the population, **suggesting that the high death rate in Sweden was caused by the initial exposure of nursing homes to the virus without any measures for protection.**"

***Sweden Locked Down Care Homes** with **NO access by family for 8 full months**. It **wasn't the virus** killing them, **it was the protocols they used**.*

avoidabledeathawareness.com

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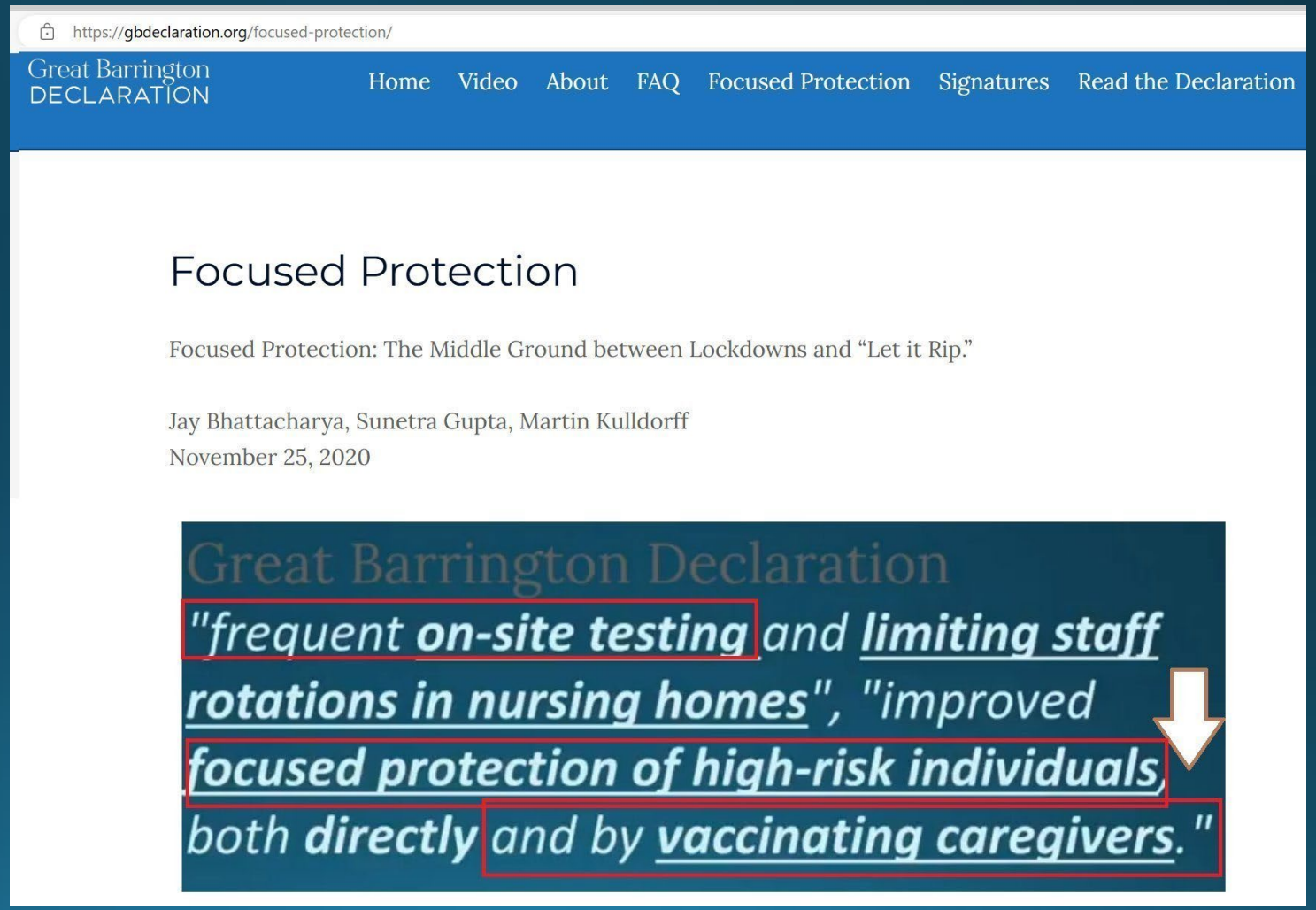
Great Barrington Declaration



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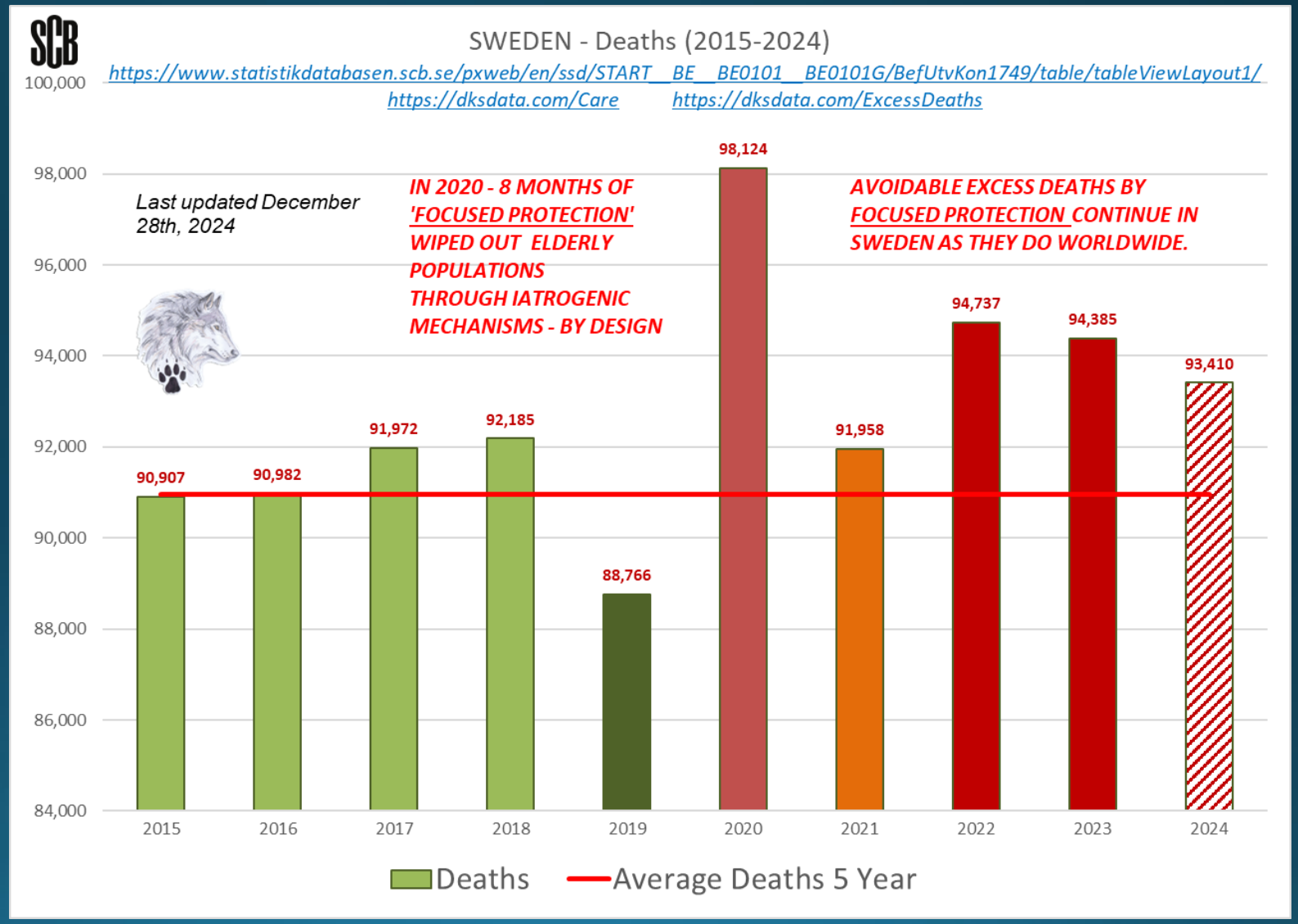

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David Karen Dickson
September 12, 2020 ·

Now 'they' are admitting they knew about the virus in November and that it was widespread months before the lockdowns... (something many of us knew at the beginning). Where are all the bodies from BEFORE the lockdown? (Trick question, there are none).

[Edit for clarity and anyone wanting the source to do their own research and stay informed]

I having been tracking this for many months the most reliable source for data has morphed over time and depends on the area of focus. I look at ECDC, CDC, Government health websites (country, province, state etc.).

So the table stats, they come from the European arm of the CDC which is the current gold standard for these figures.

https://www.ecdc.europa.eu/.../download-todays-data...

These figures have been cross referenced with John Hopkins, CDC Canada Health and more. The ECDC just tracks the data worldwide in a form easy to pull down and put into a chart. There are some slight daily variances when looking between say the Canada Health and Alberta Health pages but that is due to a lag on reporting. These balance out over a few days and are minimal.

For Canada, the "They" would be the Health Minister who admitted yesterday that "they" knew about the virus being here in December at the latest. The "they" for Alberta would be Deena Hinshaw yesterday who admitted that government testing on blood samples has shown the virus was widespread in November. The 'They" worldwide would be WHO, CDC and Governments (referenced yesterday by Deena Hinshaw) who are admitting the virus was widespread months before the lockdown.

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Day Zero to 9/11/2020 = 300 days.						
The spread of virus	First Positive Case	First Recorded Death	Lockdown day	Reported Deaths Lockdown	Reported Deaths 9/11/2020	Reported Deaths After Lockdown
United States	2020-01-22	2020-02-06	2020-03-26	1,050	196,412	195,362
Canada	2020-01-25	2020-03-10	2020-03-18	8	9,163	9,155
France	2019/12/27	2020-02-15	2020-03-17	148	30,813	30,665
Italy	2020-01-31	2020-02-23	2020-02-23	2	35,597	35,595
United Kingdom	2020-01-31	2020-03-06	2020-03-23	281	41,608	41,327
Sweden	2020-02-01	2020-03-12			5,846	5,846
Belgium	2020-02-04	2020-03-12	2020-03-18	5	9,917	9,912
Germany	2020-01-27	2020-03-09	2020-03-22	45	9,423	9,378
Switzerland	2020-02-26	2020-03-06	2020-03-13	4	2,020	2,016
Norway	2020-02-27	2020-03-13	2020-03-12	-	265	265
Denmark	2020-02-27	2020-03-16	2020-03-11	-	629	629

Day Zero to 9/11/2020 = 300 days.						
Days Past	Days before first case	Days before first Death	Days before Lockdown	Days from Lockdown to 9/11/2020	Reported Deaths in days BEFORE Lockdown	Reported Deaths in days AFTER Lockdown
United States	67	82	131	169	1,050	195,362
Canada	70	115	123	177	8	9,155
France	41	91	122	178	148	30,665
Italy	76	99	99	201	2	35,595
United Kingdom	76	111	128	172	281	41,327
Sweden	77	117				5,846
Belgium	80	117	123	177	5	9,912
Germany	72	114	127	173	45	9,378
Switzerland	102	111	118	182	4	2,016
Norway	103	118	117	183	-	265
Denmark	103	121	116	184	-	629

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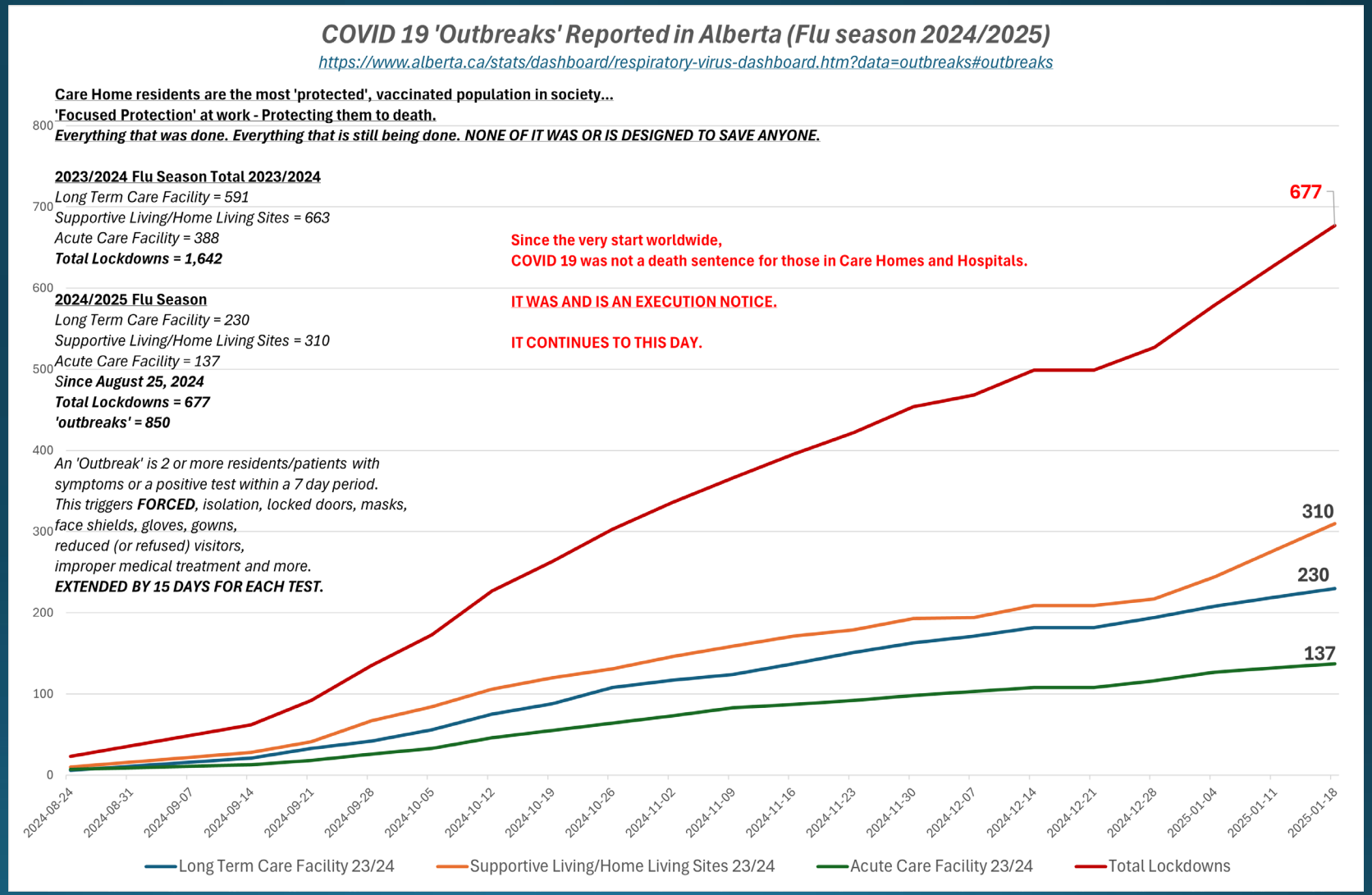

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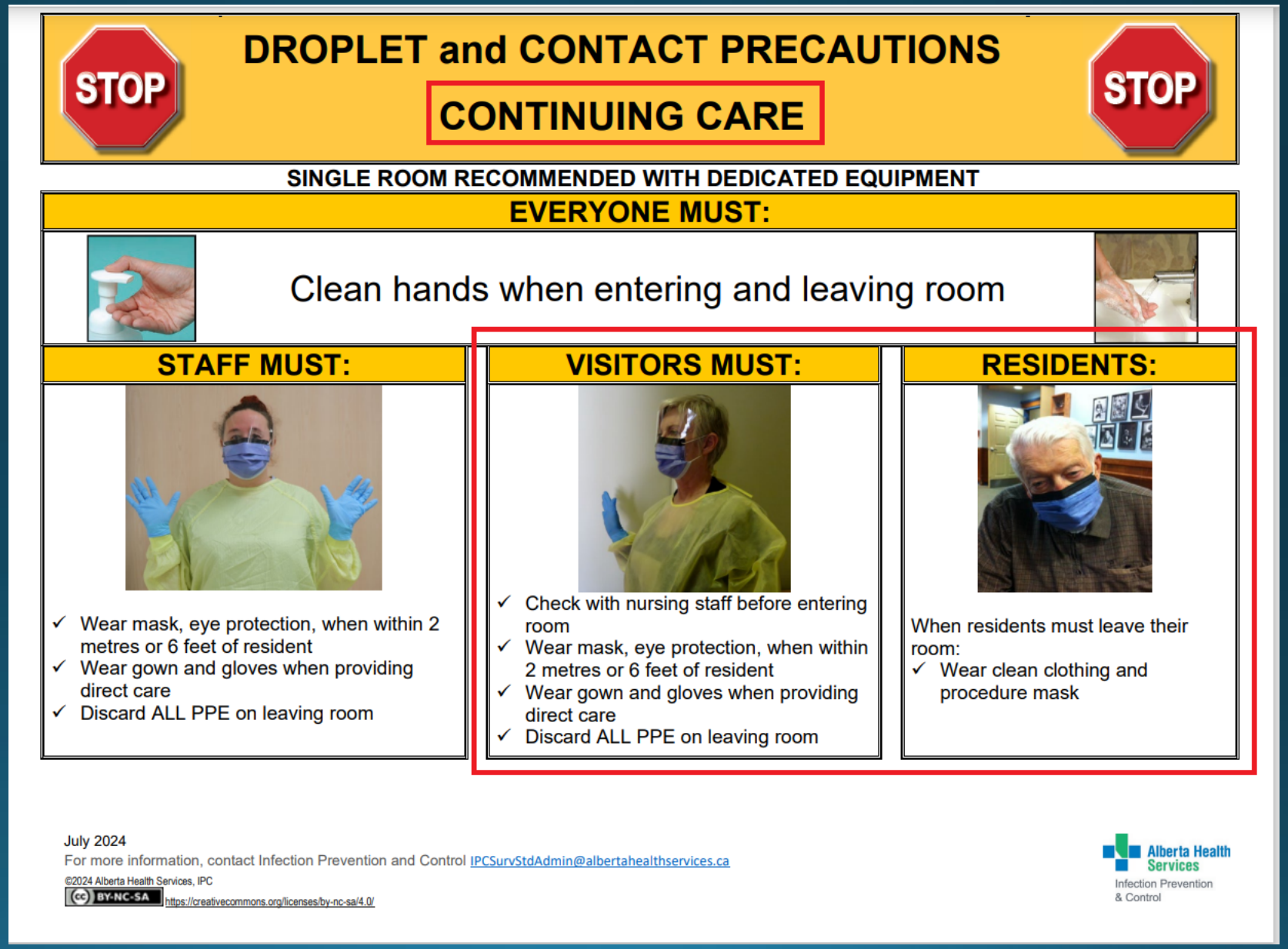

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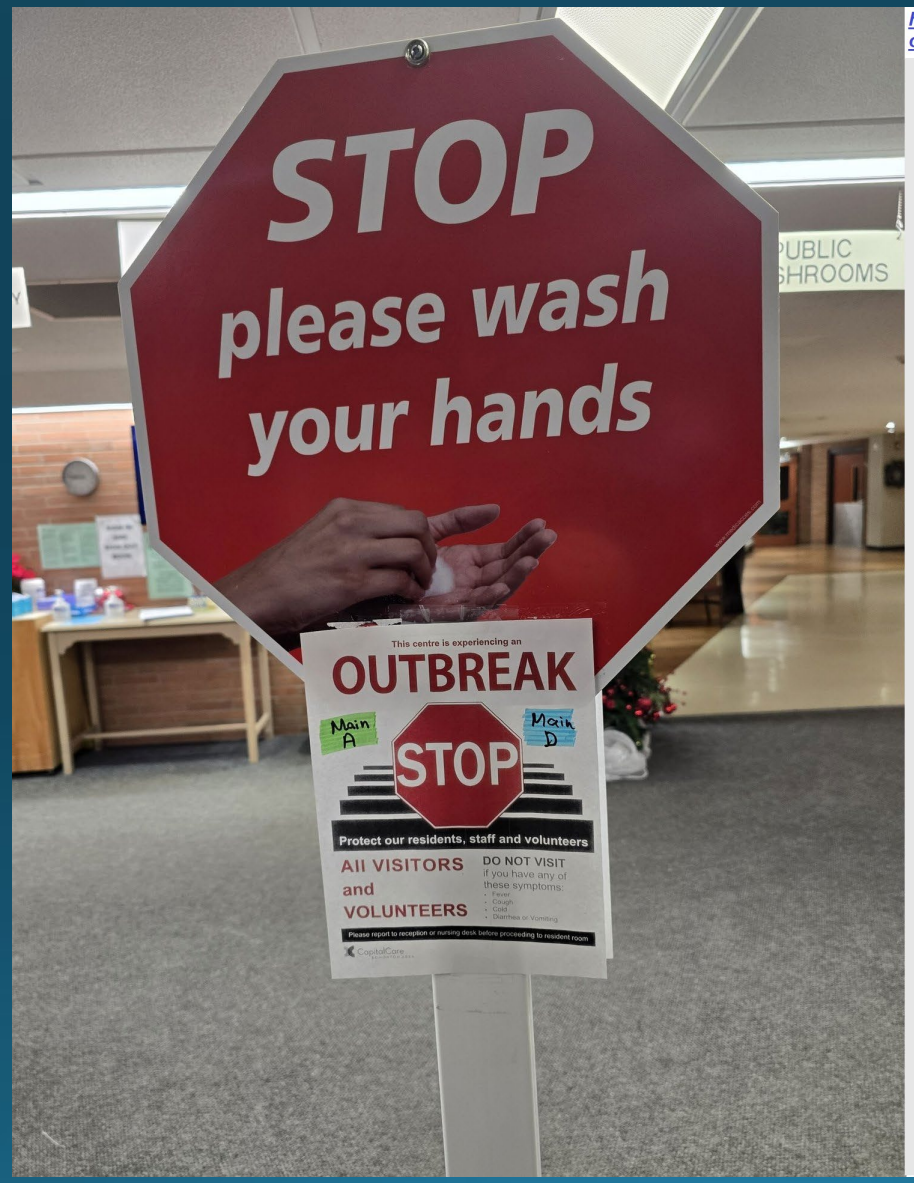

https://www.albertahealthservices.ca/assets/info/hp/cdc/if-hp-cdc-ob-guide-for-outbreak-prevention-and-control-in-continuing-care-homes.pdf

Appendix C: Case and outbreak definitions

Case and outbreak definitions are set by Alberta Health and are used to open and report outbreaks.

COVID-19	
Case Definition	A person with the virus (SARS-CoV-2) that causes COVID-19 by: • A positive result on a molecular test [that is Nucleic acid amplification test (NAATs) such as polymerase chain reaction (PCR)], loop-mediated isothermal amplification (LAMP) or rapid molecular test] that is Health Canada approved or approved by the lab accreditation body of the jurisdiction in which the test was performed. **OR** • A positive result on a Health Canada approved rapid/point-of-care (POC) antigen test in a person with clinical illness[10] **OR** • Two positive results on a Health Canada approved rapid/POC antigen test completed not less than 24 hours of each other in an asymptomatic person.
Outbreak Definition	Two or more confirmed COVID-19 cases in residents within a seven-day period, with a common epidemiological link[11].
Outbreak Duration[12]	14 days (two incubation periods). The outbreak ends on the 15th day following symptom onset of the last resident case.

[10] Clinical illness - any one or more of the following: new or worsening cough, shortness of breath (SOB), sore throat, loss or altered sense of taste/smell, runny nose/nasal congestion, fever/chills, fatigue (significant and unusual), muscle ache/joint pain, headache, nausea/diarrhea).
[11] Epidemiological link means the cases need to have been in the setting (same facility/same unit) during their incubation period or communicable period.
[12] Day zero is the first day of symptoms Day one is the first full day after symptoms develop.
If the person tested is asymptomatic, use date of specimen collection as day zero.

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Table of Alberta Immunization Policy (AIP) Updates

Revision Date: October 4, 2024

The updates are listed in chronological order, and date back to August 25, 2016. For up-to-date biological product start and end dates and historical program notes prior to August 25, 2016, see Alberta Immunization Program History.

The 'Date' in the third column refers to when an update is made to the AIP (e.g., implementation date, policy revision date).

Section	Updates	Date
History of Immunization in Alberta – **Alberta Immunization Program Changes**	• End date added for Novavax Nuvaxovid XBB.1.5 • Start dates added for Moderna Spikevax KP.2 and Pfizer BioNTech KP.2 • Start date added for Abrysvo™, Respiratory Syncytial Virus (RSV) • Start date added for Influenza Inactivated Quadrivalent: Flucelvax®	October 1, 2024
Biological Products – COVID-19 – **Moderna Spikevax**	• September 17, 2024 – Licensed for use in Canada. • October 2024 – Implemented in Alberta.	October 1, 2024
Biological Products – COVID-19 – **Pfizer BioNTech**	• September 24, 2024 – Licensed for use in Canada. • October 2024 – Implemented in Alberta.	October 1, 2024
Special Situations for Immunization – Immunization recommendations for transplant candidates and recipients – **Adult HSCT**	• Addition of use of high-dose influenza and RSV vaccine.	September 30, 2024
Special Situations for Immunization – Immunization recommendations for transplant candidates and recipients – **Adult SOT**	• Addition of use of high-dose influenza and RSV vaccine.	September 30, 2024
Biological Products – Influenza (Flu) – **Influenza Vaccine Quadrivalent Inactivated high Dose**	• Updated to include off license use in pregnant HSCT, CAR T-cell therapy recipients and SOT candidates and recipients.	September 30, 2024
Special Situations for Immunization – **Immunization Recommendations for Specific Populations (Immunosuppressed and Chronic Health Conditions)**	• Addition of recommendations for childhood cancer survivors.	September 30, 2024

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Schedule for individuals with certain moderate to severe immunocompromising conditions	Individuals 6 months and older: **Unimmunized/Previously received fewer than 3 doses of non-KP.2 COVID-19 vaccine:** • Immunocompromised individuals should follow the schedule below and receive the appropriate number of doses of Moderna KP.2 COVID-19 vaccine to complete a three-dose COVID-19 vaccine series. Regardless of whether they have received one or two non-KP.2 COVID-19 vaccine doses, the previous dose(s) should be counted, and the series should not be restarted. ○ Dose 1: day 0 ○ Dose 2: at least 28 days after dose 1 ○ Dose 3: 8 weeks after dose 2; however, a minimum interval of 4 weeks may be considered. **Previously received 3 or more doses of non-KP.2 COVID-19 vaccine:** • 1 dose, at least 3 months from previous COVID-19 vaccine dose, regardless of the number of doses received in the past. **Note:** • Specific immunocompromising conditions that make an individual eligible for a three-dose COVID-19 vaccine series: ○ Solid organ transplant recipients – pre-transplant and post-transplant. ○ Hematopoietic stem cell transplants recipients – pre-transplant and post-transplant while in immunosuppressed state and individuals receiving Chimeric Antigen Receptor (CAR) T-Cell therapy. See: ▪ Standard for Immunization of Transplant Candidates and Recipients ▪ Child HSCT ▪ Adult HSCT ○ Individuals with malignant hematologic disorders and non-hematologic malignant solid tumors prior to receiving or while receiving active treatment which includes chemotherapy, targeted therapies, and immunotherapy or having received previous COVID-19 vaccines while on active treatment (does not include individuals receiving solely hormonal therapy, radiation therapy or a surgical intervention). ○ Individuals with chronic kidney disease on peritoneal dialysis or hemodialysis.

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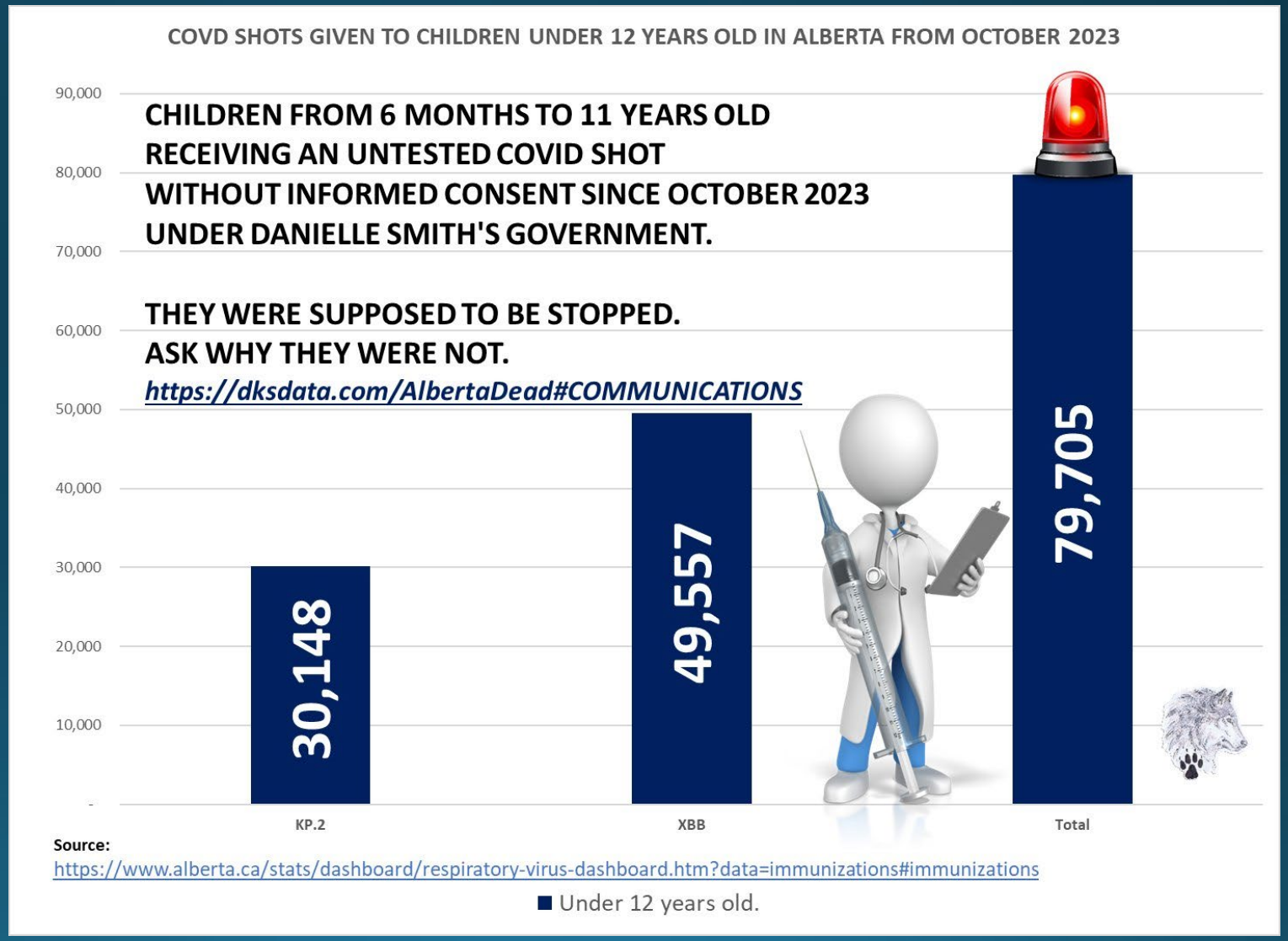

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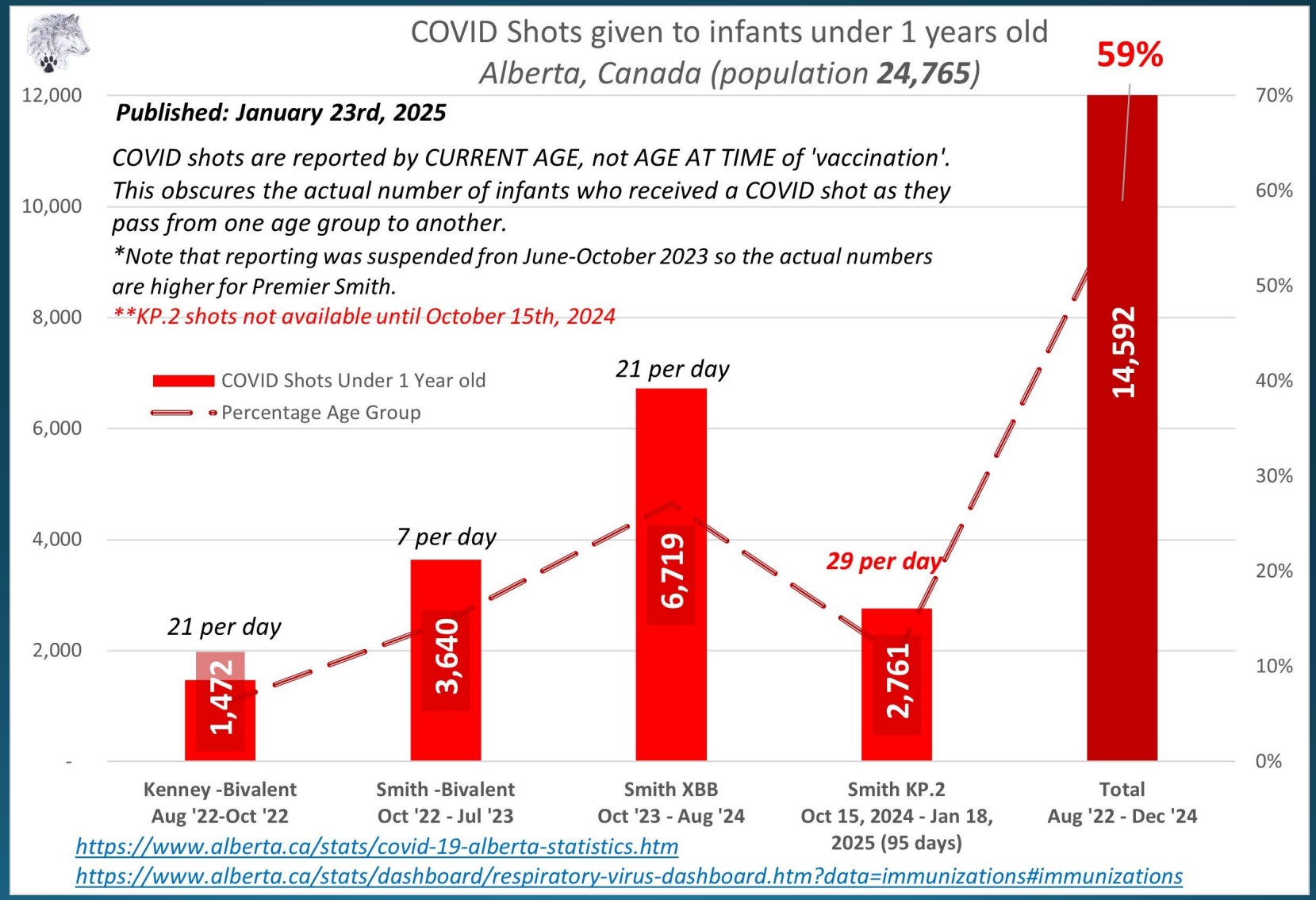

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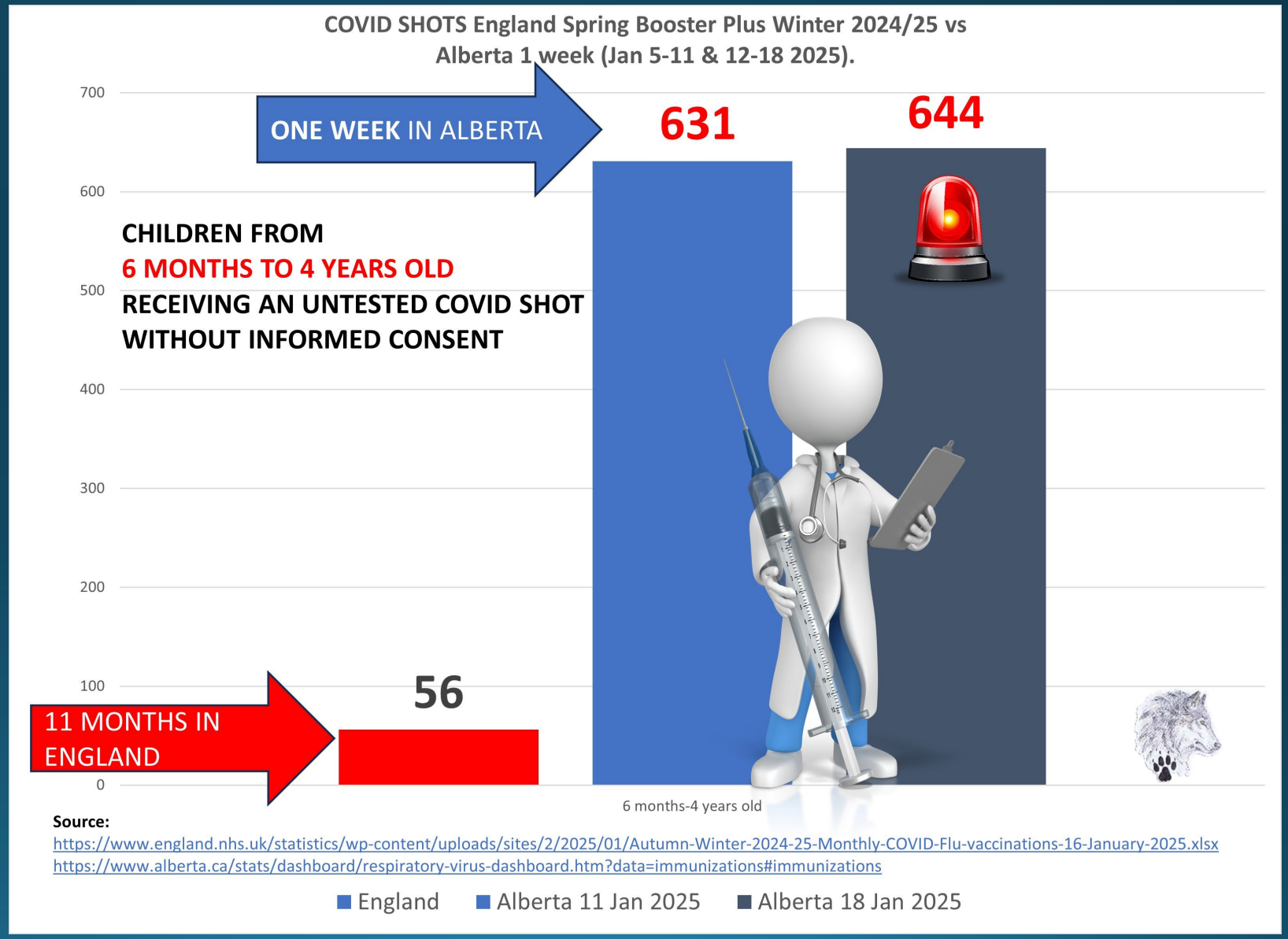

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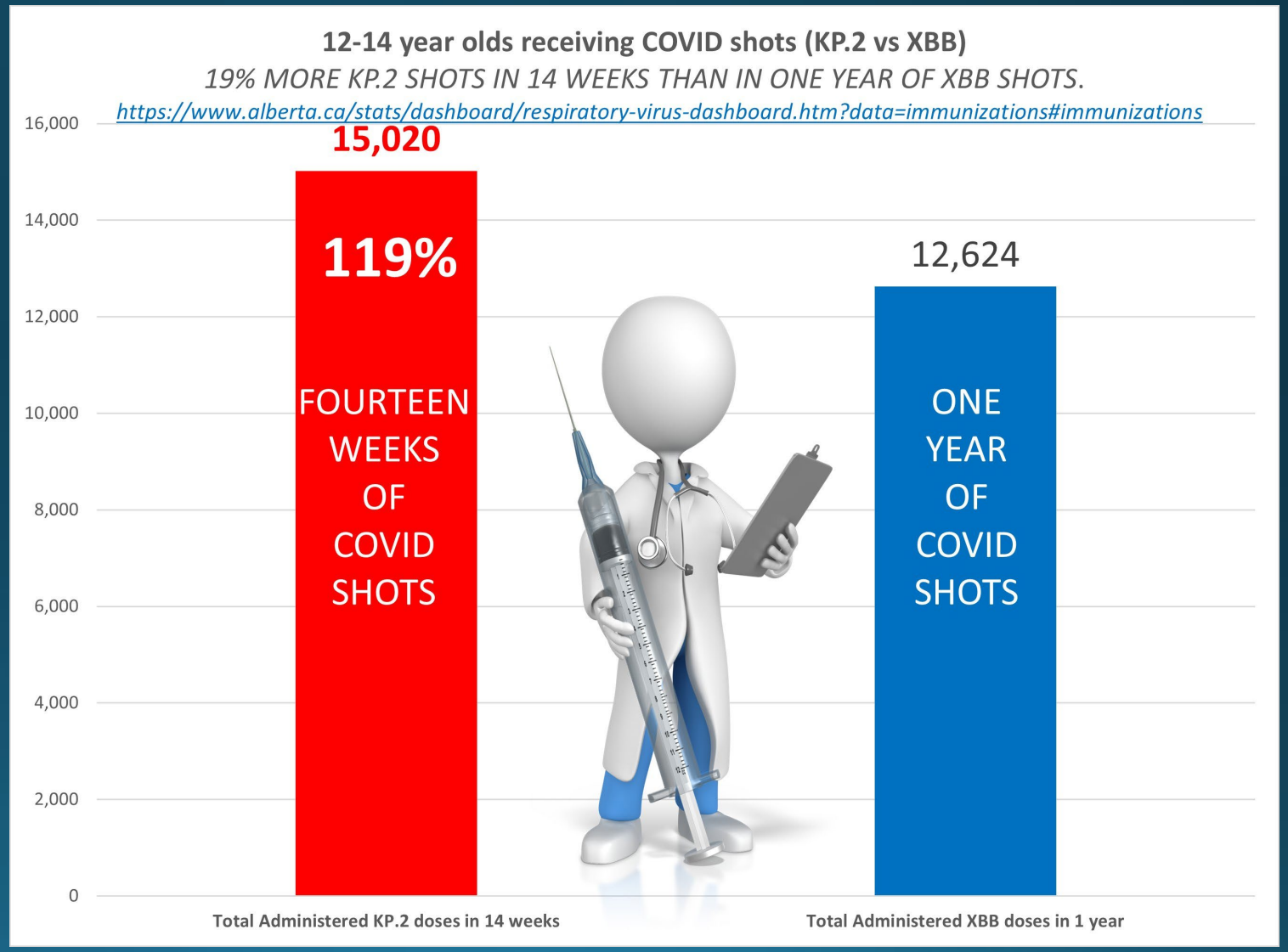

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2,320,910 COVID doses given in Alberta October 10th, 2022 - January 18th, 2025

AZ	Janssen	Moderna	Novavax	Pfizer	XBB	KP.2	Total
1,420	4,720	215,840	547	602,833	855,891	639,659	2,320,910

Danielle Smith - Premier of Alberta since October 2022

April 2021

"There will be a reckoning after this. No wonder the pharma companies were shielded from liability"

October 2021

"I'll reprint the best advice here, because it is the simplest way to get the shot in the meantime "

November 2021

"Johnson & Johnson, the one I took, is not recommended for women under the age of 50 because of a higher incidence of blood clots. "

October 11th 2022

Speaking about Canadians that have not taken a COVID vaccine.

"They have been the most discriminated against group that I've ever witnessed in my lifetime,"

January 18th, 2025 *$17-35$ a shot for Pharmacies (Plus admin fees)* **No shots to be given Aug 30-Oct 15, 2024**

COVID-19 vaccine first dose administered and coverage by age group and provider, 2023-2024

August 24th, 2024 total =854,407. 2023/24 Year End = 855,891. Missing 1,484.

XBB total: 855,891 KP.2 Total: 639,659 Population Manipulation:Infant population doubled (Aug 24-Sept 14) then halved Dec 5.

Age group	AHS	Pharmacies	Other	Total Administered KP.2	Total Administered XBB	KP.2 Percentage	Population	XBB/KP.2 Actual Coverage (%)	Increase in KP.2 shots this week
6m-11m	2,748	0	13	2,761	6,719	11.1%	24,765	52%	220
01-04	13,504	0	51	13,555	16,399	6.5%	209,827	7.82%	424
05-11	4,929	9,637	51	14,617	26,439	4.8%	302,916	10%-14%	141
12-14	1,401	13,533	86	15,020	12,624	4.9%	305,137	9%-16%	126
15-19	731	12,697	95	13,523	18,363	4.5%	299,958	6.12%	129
20-24	1,287	10,643	194	12,124	15,875	3.9%	309,865	5.12%	183
25-29	2,660	13,934	319	16,913	21,762	4.9%	343,556	6.33%	201
30-34	6,065	18,616	350	25,031	32,486	6.5%	385,721	8.42%	265
35-39	8,940	21,466	396	30,802	39,211	7.7%	399,050	9.83%	308
40-44	6,117	24,225	402	30,744	39,219	8.1%	377,948	10.38%	275
45-49	3,493	25,246	370	29,109	39,189	9.1%	321,389	12.19%	245
50-54	2,942	29,728	479	33,149	46,127	11.5%	288,285	16.00%	267
55-59	3,011	37,484	490	40,985	59,043	15.3%	268,492	21.99%	363
60-64	3,280	58,331	570	62,181	86,204	21.7%	286,101	30.13%	582
65-69	3,119	76,772	527	80,418	109,358	31.5%	255,277	42.84%	719
70-74	2,437	72,970	516	75,923	99,163	39.7%	191,213	51.86%	654
75-79	2,042	59,203	618	61,863	78,338	45.5%	136,106	57.56%	474
80-84	1,381	38,082	630	40,093	52,310	49.0%	81,742	63.99%	259
85-89	941	22,363	766	24,070	34,012	51.3%	46,904	72.51%	108
90+	957	14,602	1,219	16,778	25,982	56.9%	29,469	88.17%	58
Unknown	0	0	0	0	1				
All ages	71,985	559,532	8,142	639,659	858,826	13.2%	4,863,721	17.66%	6,001
Percentage	11.3%	87.5%	1.3%		Reported Pop Total		4,888,735	25,014 discrepancy	

https://www.alberta.ca/stats/dashboard/respiratory-virus-dashboard.htm?data=immunizations#immunizations

https://web.archive.org/web/20240920163411/https://www.alberta.ca/stats/dashboard/respiratory-virus-dashboard.htm?data=immunizations#immunizations