

Exhibit 9

CDC FREEDOM OF INFORMATION ACT APPEAL

SUBMITTED VIA EMAIL

March 22, 2023

Deputy Agency Chief FOIA Officer
Office of the Assistant Secretary for Public Affairs
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue
Suite 729H
Washington, D.C. 20201
FOIARequest@psc.hhs.gov

Re: *Appeal of FOIA Request #22-00298-FOIA (IR#0610)*

Dear Sir or Madam:

This firm represents Informed Consent Action Network (“**ICAN**”). On behalf of ICAN, on November 5, 2021, we submitted a request for records (“**FOIA Request**”) from the files of the Centers for Disease Control and Prevention (“**CDC**”) pursuant to the Freedom of Information Act (5 U.S.C. § 552, as amended) (“**FOIA**”). On December 28, 2022, Roger Andoh, CDC/ATSDR FOIA Officer, responded to the FOIA Request (“**Final Response**”). ICAN writes now to appeal the Final Response.

A. FOIA Request #22-00298-FOIA (IR#0610)

On November 5, 2021, ICAN submitted a request to CDC for the following documents:

A copy of the analysis plan, including any drafts, amendments, and the final version, for the study titled “Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19- Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity – Nine States, January – September 2021” published in the Morbidity and Mortality Weekly Report dated October 29, 2021, available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w%20[].

(Attachment 1.)¹

¹ All “Attachments” referenced herein are appended to this letter.

On November 9, 2021, CDC sent an acknowledgment letter which assigned the request number 22-00298-FOIA.

(Attachment 2.)

B. CDC's Final Response

On December 28, 2022, CDC issued a Final Response letter. The letter stated in part,

A search of our records failed to reveal any documents pertaining to your request. Furthermore, the National Center for Immunization and Respiratory Diseases (NCIRD) relayed the following:

The analysis plan for the referenced MMWR was drafted and maintained by a contractor and was discussed with CDC over teleconference; SMEs did not receive copies of the analysis plan.

(Attachment 3.)

C. Argument

CDC has failed to conduct an adequate search of the requested records. An agency's search is adequate only if it is "reasonably calculated to uncover all relevant documents." *Zemansky v. E.P.A.*, 767 F.2d 569, 571 (9th Cir. 1985) (quoting *Weisberg v. U.S. Dep't. of Justice*, 745 F.2d 1476, 1485 (D.C. Cir. 1984)) (internal quotation marks omitted). "An agency fulfills its obligations under FOIA if it can demonstrate *beyond material doubt* that its search was reasonably calculated to uncover all relevant documents." *Defs. of Wildlife v. United States Border Patrol*, 623 F. Supp. 2d 83, 91 (D.D.C. 2009) (quoting *Valencia-Lucena v. U.S. Coast Guard*, 180 F.3d 321, 325 (D.C. Cir. 1999)) (emphasis added). To satisfy its FOIA obligations, an agency needs to adequately describe the scope and methods of its searches, which can reasonably be expected to uncover the records sought and demonstrate that the places most likely to contain responsive materials were searched. *Davidson v. E.P.A.*, 121 F. Supp. 2d 38, 39 (D.D.C. 2000). At minimum, the agency must specify "what records were searched, by whom, and through what process." *Steinberg v. U.S. Dep't. of Justice*, 23 F.3d 548, 552 (D.C. Cir. 1994).

A court must evaluate the reasonableness of an agency's search based on what the agency knew at its conclusion rather than what the agency speculated at its inception. *Campbell v. United States DOJ*, 164 F.3d 20, 28 (D.C. Cir. 1998). An agency is required to "revise its assessment of what is reasonable . . . to account for leads that emerge during its inquiry." *Id.* An "agency may [not] ignore what it cannot help but know." *Kowalczyk v. DOJ*, 73 F.3d 386, 389 (D.C. Cir. 1996). While there is no requirement that an agency search every location or record system, the agency cannot limit its search to only one record system if there are others that are likely to turn up the information requested. *Wallick v. Agric. Mktg. Serv.*, 281 F. Supp. 3d 56, 73 (D.C.D. 2017). FOIA demands a reasonable search tailored to the nature of a particular request. *Campbell v. United States DOJ*, 164 F.3d 20, 28 (D.C. Cir. 1998). Agencies must perform more than "perfunctory

searches” and “follow through on obvious leads to discover requested documents.” *Valencia-Lucena*, 180 F.3d at 325.

If agency records are “maintained for an agency by an entity under Government contract, for the purposes of records management,” those records remain subject to the FOIA. 5 U.S.C. § 552 (f)(2). Whether a record maintained by a government contractor is considered an agency record for the purposes of FOIA, is predicated on the degree of control an agency has over the records. *Burka v. HHS*, 87 F.3d 508, 515 (D.C. Cir. 1996). The degree of control an agency has over a record is determined by “(1) the intent of the document’s creator to retain or relinquish control over the records; (2) the ability of the agency to use and dispose of the record as it sees fit; (3) the extent to which agency personnel have read or relied upon the document; and (4) the degree to which the document was integrated into the agency’s record system or files.” *Tax Analysts v. Dep’t of Justice*, 845 F.2d 1060, 1069 (D.C. Cir. 1988). Furthermore, records that are “neither created by agency employees” nor “currently located on agency property,” may still be considered agency records so long as the contractor “acted on behalf of [the agency] in creating the” records. *Burka*, 87 F.3d at 515.

CDC’s search was likely inadequate for at least two reasons. First, CDC’s Final Response provided minimal information regarding the adequacy of its search. Instead of providing the specificity required under FOIA, CDC’s Final Response states,

A search of our records failed to reveal any documents pertaining to your request. Furthermore, the National Center for Immunization and Respiratory Diseases (NCIRD) relayed the following:

The analysis plan for the referenced MMWR was drafted and maintained by a contractor and was discussed with CDC over teleconference; SMEs did not receive copies of the analysis plan.

(Attachment 3.)

Beyond indicating the files of NCIRD were searched, CDC’s Final Response failed to adequately describe the scope and methods of its searches. Without specifying what records were searched, by whom, and through what process, ICAN cannot assume that CDC’s search was adequate. *Steinberg*, 23 F.3d at 552. The lack of detail in CDC’s Final Response regarding its search suggests it likely could not demonstrate beyond material doubt that its search was reasonably calculated to uncover all relevant documents. *Valencia-Lucena*, 180 F.3d at 325.

Second, CDC appears to have failed to “follow through on obvious leads” as required under FOIA. *Valencia-Lucena*, 180 F.3d at 325. CDC’s Final Response states “the analysis plan for the referenced MMWR was drafted and maintained by a contractor and was discussed with CDC over teleconference.” **(Attachment 3.)** However, that the analysis plan was drafted and maintained by a contractor does not automatically release the agency from its obligation to produce the requested records. *Burka*, 87 F.3d at 515. Instead, to determine whether the records are subject to disclosure, courts examine the degree of control the agency exercises over the requested records. *Tax Analysts*, 845 F.2d at 1069 (“*Tax Analysts*”).

Based on the factors described in *Tax Analysts*, courts would very likely determine the analysis plan is an agency record. For example, for the first factor, although CDC asserts the document's creator didn't physically relinquish control of the analysis plan, its contents were discussed thoroughly enough for a group of scientists to conduct a scientific study that was published by CDC. Thus, even if taking CDC's assertion as true, the document's creator effectively relinquished control of the contents of the document.

For the second factor, it appears CDC had full ability to use or dispose of the records as it saw fit. The combination of CDC's funding of the study, as well as the 17 CDC employees identified as authors of the published study, provides little doubt that CDC had substantial control over whether to use, modify, or dispose of the analysis plan initially discussed at the teleconference.²

For the third factor, based on the 17 CDC employees who shared authorship for the published study, it can be reasonably assumed that agency personnel have read or substantially relied upon the analysis plan. Such reliance on the analysis plan would have likely occurred when conducting and analyzing the research for the study, as well as when evaluating the claims made based upon the research of the study. Surely, CDC would not publish data without knowing how the data was collected and analyzed.

Finally, for the fourth factor, CDC's Final Response letter attempts to argue that the analysis plan was not integrated into the agency's records systems or files. However, due to its failure to reasonably describe the search, there is a substantial material doubt of whether CDC searched the files of the 17 employees who shared authorship for the published study. It would be very unlikely that none of the CDC authors ever possessed a copy of the analysis plan. Thus, adding to the evidence of CDC's failure to follow obvious leads. *Valencia-Lucena*, 180 F.3d at 325. Furthermore, it would be even more unlikely, that if a copy of the analysis plan was not distributed, that none of the 17 CDC authors took detailed notes during the initial discussion of the analysis plan at the teleconference. Under the Federal Records Act, those notes should have been integrated into the agency's record system or files. For either of these scenarios, it's likely the analysis plan has been integrated into the records system or files of CDC. However, this factor is not dispositive of the overall analysis, even if the analysis plan was never integrated into the agency's record system or files. *Burka*, 87 F.3d at 515.

Therefore, when weighing the factors above, courts would very likely determine the analysis plan is an agency record subject to the obligations of FOIA. *Tax Analysts*, 845 F.2d at 1069. For these reasons, CDC's search was not adequate.

D. Appellate Request

Given the foregoing, ICAN hereby appeals and requests that the documents responsive to the FOIA Request be produced within 20 days of this appeal. Thank you for your time and attention to this matter. If you require any additional information, please contact us at (212) 532-1091 or through email at foia@sirillp.com.

² See https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w;https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w#contribAff.

Very truly yours,

/s/ Aaron Siri

Aaron Siri, Esq.

Elizabeth A. Brehm, Esq.

Colin M. Farnsworth, Esq.

Enclosures

Attachment 1

FREEDOM OF INFORMATION ACT REQUEST

VIA ONLINE PORTAL

November 5, 2021

Roger Andoh
Freedom of Information Officer
Centers for Disease Control and Prevention
1600 Clifton Road, N.E., Building 57, Room MS D-54
Atlanta, Georgia 30333

Re: Analysis Plans for Study Comparing Infection-Induced and Vaccine-Induced Immunity (IR#0610)

Dear Sir or Madam:

This firm represents the Informed Consent Action Network (“ICAN”). On behalf of ICAN, please provide the following records to foia@sirillp.com in electronic form:

A copy of the analysis plan, including any drafts, amendments, and the final version, for the study titled “Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity – Nine States, January – September 2021” published in the Morbidity and Mortality Weekly Report dated October 29, 2021, available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w and attached hereto as Exhibit A.

We ask that you waive any and all fees or charges pursuant to 5 U.S.C. § 552(a)(4)(A)(iii). ICAN is a not-for-profit 501(c)(3) organization whose mission is to raise public awareness about vaccine safety and to provide the public with information to give informed consent. As part of its mission, ICAN actively investigates and disseminates information regarding vaccine safety issues, including through its website, and through press events and releases. ICAN is seeking the information in this FOIA request to allow it to contribute to the public understanding of the government’s vaccine safety programs, including the government’s efforts to promote vaccine safety. The information ICAN is requesting will not contribute to any commercial activities.

Please note that the FOIA provides that if only portions of a requested file are exempted from release, the remainder must still be released. We therefore request that we be provided with all non-exempt portions which are reasonably segregable. We further request that you describe

any deleted or withheld material in detail and specify the statutory basis for the denial as well as your reasons for believing that the alleged statutory justification applies. Please also separately state your reasons for not invoking your discretionary powers to release the requested documents in the public interest. Such statements may help to avoid unnecessary appeal and litigation. ICAN of course reserves all rights to appeal the withholding or deletion of any information.

Access to the requested records should be granted within twenty (20) business days from the date of your receipt of this letter. Failure to respond in a timely manner shall be viewed as a denial of this request and ICAN may immediately file an administrative appeal.

If you would like to discuss our requests or any issues raised in this letter, please feel free to contact me at (212) 532-1091 or foia@sirillp.com during normal business hours. Thank you for your time and attention to this matter.

Very truly yours,

/s/ Gabrielle G. Palmer
Gabrielle G. Palmer, Esq.

Exhibit A

Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021

Catherine H. Bozio, PhD¹; Shaun J. Grannis, MD^{2,3}; Allison L. Naleway, PhD⁴; Toan C. Ong, PhD⁵; Kristen A. Butterfield, MPH⁶; Malini B. DeSilva, MD⁷; Karthik Natarajan, PhD^{8,9}; Duck-Hye Yang, PhD⁶; Suchitra Rao, MBBS⁵; Nicola P. Klein, MD, PhD¹⁰; Stephanie A. Irving, MHS⁴; Brian E. Dixon, PhD^{2,11}; Kristin Dascomb, MD, PhD¹²; I-Chia Liao MPH¹³; Sue Reynolds, PhD¹; Charlene McEvoy, MD⁷; Jungmi Han⁸; Sarah E. Reese, PhD⁶; Ned Lewis, MPH¹⁰; William F. Fadel, PhD^{2,11}; Nancy Grisel, MPP¹²; Kempapura Murthy MBBS¹³; Jill Ferdinands, PhD¹; Anupam B. Kharbanda, MD¹⁴; Patrick K. Mitchell, ScD⁶; Kristin Goddard, MPH¹⁰; Peter J. Embi, MD^{3,15}; Julie Arndorfer, MPH¹²; Chandni Raiyani, MPH¹³; Palak Patel, MBBS¹; Elizabeth A. Rowley, DrPH⁶; Bruce Fireman, MA¹⁰; Nimish R. Valvi, DrPH, MBBS²; Eric P. Griggs, MPH¹; Matthew E. Levy, PhD⁶; Ousseny Zerbo, PhD¹⁰; Rachael M. Porter, MPH¹; Rebecca J. Birch, MPH⁶; Lenee Blanton, MPH¹; Sarah W. Ball, ScD⁶; Andrea Steffens, MPH¹; Natalie Olson, MPH¹; Jeremiah Williams, MPH¹; Monica Dickerson, MPH¹; Meredith McMorro, MD¹; Stephanie J. Schrag, DPhil¹; Jennifer R. Verani, MD¹; Alicia M. Fry, MD¹; Eduardo Azziz-Baumgartner, MD¹; Michelle Barron, MD⁵; Manjusha Gaglani, MBBS¹³; Mark G. Thompson, PhD¹; Edward Stenehjem, MD¹²

On October 29, 2021 this report was posted as an MMWR Early Release on the MMWR website (<https://www.cdc.gov/mmwr>).

Previous infection with SARS-CoV-2 (the virus that causes COVID-19) or COVID-19 vaccination can provide immunity and protection from subsequent SARS-CoV-2 infection and illness. CDC used data from the VISION Network* to examine hospitalizations in adults with COVID-19–like illness and compared the odds of receiving a positive SARS-CoV-2 test result, and thus having laboratory-confirmed COVID-19, between unvaccinated patients with a previous SARS-CoV-2 infection occurring 90–179 days before COVID-19–like illness hospitalization, and patients who were fully vaccinated with an mRNA COVID-19 vaccine 90–179 days before hospitalization with no previous documented SARS-CoV-2 infection. Hospitalized adults aged ≥18 years with COVID-19–like illness were included if they had received testing at least twice: once associated with a COVID-19–like illness hospitalization during January–September 2021 and at least once earlier (since February 1, 2020, and ≥14 days before that hospitalization). Among COVID-19–like illness hospitalizations in persons whose previous infection or vaccination occurred 90–179 days earlier, the odds of laboratory-confirmed COVID-19 (adjusted for sociodemographic and health characteristics) among unvaccinated, previously infected adults were higher than the odds among fully vaccinated recipients of an mRNA COVID-19 vaccine with no previous documented infection (adjusted odds ratio [aOR] = 5.49; 95% confidence interval [CI] = 2.75–10.99). These findings suggest that among hospitalized adults with COVID-19–like illness whose previous infection or vaccination occurred 90–179 days earlier, vaccine-induced immunity was more protective than infection-induced

immunity against laboratory-confirmed COVID-19. All eligible persons should be vaccinated against COVID-19 as soon as possible, including unvaccinated persons previously infected with SARS-CoV-2.

To compare the early protection against COVID-19 conferred by SARS-CoV-2 infection and by receipt of mRNA COVID-19 vaccines (i.e., 90–179 days after infection or vaccination), the VISION Network collected data from 187 hospitals across nine states during January–September 2021 (1). Eligible hospitalizations were defined as those among adults aged ≥18 years who had received SARS-CoV-2 molecular testing (from 14 days before to 72 hours after admission) and had a COVID-19–like illness discharge diagnosis[†] during January–September 2021. Eligible patients had also been tested at least once since February 1, 2020. To limit the analysis to patients with access to SARS-CoV-2 testing before hospitalization, patients who did not receive SARS-CoV-2 testing ≥14 days before hospitalization were excluded.

Two exposure groups were defined based on COVID-19 vaccination status and previous SARS-CoV-2 infection. Vaccination status was documented in electronic health records and immunization registries. Previous infection was ascertained based on SARS-CoV-2 testing from rapid antigen tests or molecular assays (e.g., real-time reverse transcription–polymerase chain reaction) performed before mRNA vaccination and ≥14 days before admission; testing performed after February 2020 was primarily within network partners' medical facilities. Adults were considered unvaccinated with a previous SARS-CoV-2 infection if no COVID-19 vaccine doses were received and if the most recent positive SARS-CoV-2 test

[†] Medical events with a discharge code consistent with COVID-19–like illness were included. COVID-19–like illness diagnoses included acute respiratory illness (e.g., COVID-19, respiratory failure, or pneumonia) or related signs or symptoms (cough, fever, dyspnea, vomiting, or diarrhea) using diagnosis codes from the *International Classification of Diseases, Ninth Revision* and *International Classification of Diseases, Tenth Revision*.

* Funded by CDC, the VISION Network includes Columbia University Irving Medical Center (New York), HealthPartners (Minnesota and Wisconsin), Intermountain Healthcare (Utah), Kaiser Permanente Northern California (California), Kaiser Permanente Northwest (Oregon and Washington), Regenstrief Institute (Indiana), and University of Colorado (Colorado).

result occurred ≥ 90 days before hospitalization. Adults were considered fully vaccinated with an mRNA COVID-19 vaccine with no previous documented infection if the second dose of Pfizer-BioNTech (BNT162b2) or Moderna (mRNA-1273) mRNA vaccine was received ≥ 14 days before the index test date[§] and if they had been tested since February 1, 2020, and had no positive test results ≥ 14 days before hospitalization. Patients were excluded if they had received 1 mRNA vaccine dose only, received the second dose < 14 days before index test date, or received the Janssen (Johnson & Johnson [Ad26.COV2]) vaccine (because of sparse data). To reduce the chance that the hospitalization was related to an ongoing SARS-CoV-2 infection, patients were also excluded from the previous infection group if their most recent previous positive test result occurred 14–89 days before hospitalization.[¶]

The outcome of laboratory-confirmed COVID-19 was defined as COVID-19–like illness and a positive SARS-CoV-2 result from molecular testing. Among patients hospitalized with COVID-19–like illness whose previous infection or completion of vaccination occurred 90–179 days earlier, the odds of laboratory-confirmed COVID-19 were compared between previously infected persons and fully vaccinated mRNA COVID-19 vaccine recipients. aORs and 95% CIs were calculated using multivariable logistic regression, adjusted for age, geographic region, calendar time (days from January 1 to hospitalization), and local virus circulation, and weighted based on propensity to be in the vaccinated category (1,2). Established methods were used to calculate weights to account for differences in sociodemographic and health characteristics between groups (3). Separate weights were calculated for each model. aORs were stratified by mRNA vaccine product and age group.

Three secondary analyses were also conducted. First, the impact of whether and how the time interval since previous infection or full vaccination was adjusted was examined. Specifically, any time since either previous infection or completion of vaccination was considered. Then, previously infected patients were limited to those with more recent infections (i.e., 90–225 days before hospitalization [the lowest two tertiles of number of days since infection]), and fully vaccinated patients were limited to those with the longest interval since completion of vaccination (i.e., receipt of second mRNA vaccine dose 45–213 days before hospitalization [the highest two tertiles of number of days since vaccination]). Then, number of days since previous infection or completion of vaccination, rather than calendar time, was adjusted in the model. For the next secondary

[§] Index test date was defined as the date of respiratory specimen collection associated with the most recent positive or negative SARS-CoV-2 test result before the hospitalization or the hospitalization date if testing only occurred after admission.

[¶] <https://www.cdc.gov/coronavirus/2019-ncov/php/invest-criteria.html>

analysis, aORs for hospitalizations that occurred before and during SARS-CoV-2 B.1.617.2 (Delta) variant predominance (June–September 2021) were compared, beginning on the date the Delta variant accounted for $> 50\%$ of sequenced isolates in each medical facility's state (2). Finally, effect modification was assessed by mRNA vaccine product or by age group; p-values < 0.2 were considered indicative of a statistically significant difference in aOR by product or age, similar to previous modeling studies of effect modification (4). All analyses were conducted using SAS (version 9.4; SAS Institute) and R (version 4.0.2; R Foundation). This study was reviewed and approved by Westat, Inc. institutional review board.**

During January 1–September 2, 2021, a total of 201,269 hospitalizations for COVID-19–like illness were identified; 139,655 (69.4%) patients were hospitalized after COVID-19 vaccines were generally available to persons in their age group within their geographic region. Molecular testing for SARS-CoV-2 was performed for 94,264 (67.5%) patients with COVID-19–like illness hospitalizations. Among these patients, 7,348 (7.8%) had at least one other SARS-CoV-2 test result ≥ 14 days before hospitalization and met criteria for either of the two exposure categories: 1,020 hospitalizations were among previously infected and unvaccinated persons, and 6,328 were among fully vaccinated and previously uninfected patients (Table 1).

Laboratory-confirmed SARS-CoV-2 infection was identified among 324 (5.1%) of 6,328 fully vaccinated persons and among 89 of 1,020 (8.7%) unvaccinated, previously infected persons. A higher proportion of previously infected than vaccinated patients were aged 18–49 years (31% versus 9%), Black (10% versus 7%), and Hispanic (19% versus 12%).

Among COVID-19–like illness hospitalizations in persons whose previous infection or vaccination occurred 90–179 days earlier, the odds of laboratory-confirmed COVID-19 were higher among previously infected, unvaccinated patients than among fully vaccinated patients (aOR = 5.49; 95% CI = 2.75–10.99) (Table 2). In secondary analyses, the aORs that examined the impact of whether and how time since infection or vaccination was adjusted and that stratified hospitalizations before and during Delta variant predominance were all similar to the primary aOR estimate. For product- and age group–specific estimates, sparse data limited the precision of these aORs. However, an assessment of effect modification indicated the aOR of laboratory-confirmed COVID-19 was higher for previously infected patients compared with patients vaccinated with Moderna (aOR = 7.30) than compared with patients vaccinated with Pfizer-BioNTech (aOR = 5.11) during January–September ($p = 0.02$). Similarly, the interaction term for exposure group by

** 45 C.F.R. part 46; 21 C.F.R. part 56.

TABLE 1. Characteristics of COVID-19–like illness hospitalizations* among unvaccinated adults with a SARS-CoV-2 infection occurring 90–179 days before the index test date† and among adults who were fully vaccinated[§] 90–179 days before the index test date† without a previous documented SARS-CoV-2 infection — nine states,¶ January–September 2021

Characteristic	No. (column %)		Standardized mean or proportion difference**
	Unvaccinated with previous SARS-CoV-2 infection	Fully vaccinated [§] without previous documented infection	
All hospitalizations with COVID-19–like illness	1,020 (100)	6,328 (100)	NA
SARS-CoV-2 test result associated with COVID-19–like illness hospitalization			
Positive	89 (9)	324 (5)	0.14
Negative	931 (91)	6,004 (95)	
Sex			
Male	405 (40)	2,905 (46)	0.13
Female	615 (60)	3,423 (54)	
Age group, yrs			
18–49	313 (31)	560 (9)	0.74
50–64	243 (24)	865 (14)	
65–74	207 (20)	1,757 (28)	
75–84	177 (17)	2,018 (32)	
≥85	80 (8)	1,128 (18)	
Race, irrespective of ethnicity			
White	647 (63)	4,356 (69)	0.24
Black	100 (10)	452 (7)	
Other††	71 (7)	686 (11)	
Unknown	202 (20)	834 (13)	
Ethnicity, irrespective of race			
Hispanic	189 (19)	756 (12)	0.20
Non-Hispanic	695 (68)	4,458 (70)	
Unknown	136 (13)	1,114 (18)	
Month of index test date†			
January	11 (1)	0 (—)	2.10
February	41 (4)	0 (—)	
March	114 (11)	0 (—)	
April	245 (24)	6 (0)	
May	294 (29)	235 (4)	
June	184 (18)	1,300 (21)	
July	99 (10)	2,731 (43)	
August	31 (3)	2,049 (32)	
September	1 (0)	7 (0)	

See table footnotes on the next page.

age indicated that the aOR was higher for patients aged ≥65 years (aOR = 19.57) than for those aged 18–64 years (aOR = 2.57) (interaction term, $p = 0.05$).

Discussion

In this multistate analysis of hospitalizations for COVID-19–like illness among adults aged ≥18 years during January–September 2021 whose previous infection or vaccination occurred 90–179 days earlier, the adjusted odds of laboratory-confirmed COVID-19 were higher among unvaccinated and previously infected patients than among those who were fully vaccinated with 2 doses of an mRNA COVID-19 vaccine without previous documentation of a SARS-CoV-2 infection. Secondary analyses that did not adjust for time since infection or vaccination or adjusted time since infection or vaccination differently as well as before and during Delta variant predominance produced similar results. These findings are consistent with evidence that neutralizing antibody titers after

receipt of 2 doses of mRNA COVID-19 vaccine are high (5,6); however, these findings differ from those of a retrospective records-based cohort study in Israel,†† which did not find higher protection for vaccinated adults compared with those with previous infection during a period of Delta variant circulation. This variation is possibly related to differences in the outcome of interest and restrictions on the timing of vaccination. The Israeli cohort study assessed any positive SARS-CoV-2 test result, whereas this study examined laboratory-confirmed COVID-19 among hospitalized patients. The Israeli cohort study also only examined vaccinations that had occurred 6 months earlier, so the benefit of more recent vaccination was not examined. This report focused on the early protection from infection-induced and vaccine-induced immunity, though it is possible that estimates could be affected by time. Understanding infection-induced and vaccine-induced immunity over time is important, particularly for future studies to consider.

†† <https://www.medrxiv.org/content/10.1101/2021.08.24.21262415v1>

Morbidity and Mortality Weekly Report

TABLE 1. (Continued) Characteristics of COVID-19–like illness hospitalizations* among unvaccinated adults with a SARS-CoV-2 infection occurring 90–179 days before the index test date† and among adults who were fully vaccinated‡ 90–179 days before the index test date† without a previous documented SARS-CoV-2 infection — nine states,¶ January–September 2021

Characteristic	No. (column %)		Standardized mean or proportion difference**
	Unvaccinated with previous SARS-CoV-2 infection	Fully vaccinated‡ without previous documented infection	
Site			
Columbia University	53 (5)	238 (4)	0.73
HealthPartners	22 (2)	94 (1)	
Intermountain Healthcare	117 (11)	454 (7)	
Kaiser Permanente Northern California	254 (25)	3,614 (57)	
Kaiser Permanente Northwest	30 (3)	250 (4)	
Regenstrief Institute	390 (38)	1,145 (18)	
University of Colorado	154 (15)	533 (8)	
Time since either previous SARS-CoV-2 infection or full mRNA vaccination until COVID-19–like illness index test date, days			
90–119	367 (36)	3,325 (53)	0.42
120–149	353 (35)	2,101 (33)	
150–179	300 (29)	902 (14)	
COVID-19 vaccination status			
Unvaccinated	1,020 (100)	0 (—)	NA
Pfizer-BioNTech (BNT162b2)	0 (—)	3,736 (59)	
Moderna (mRNA-1273)	0 (—)	2,592 (41)	

Abbreviation: NA = not applicable.

* Medical events with a discharge code consistent with COVID-19–like illness were included. COVID-19–like illness diagnoses included acute respiratory illness (e.g., COVID-19, respiratory failure, or pneumonia) or related signs or symptoms (cough, fever, dyspnea, vomiting, or diarrhea) using diagnosis codes from the *International Classification of Diseases, Ninth Revision* and *International Classification of Diseases, Tenth Revision*. Clinician-ordered molecular assays (e.g., real-time reverse transcription–polymerase chain reaction) for SARS-CoV-2 occurring ≤ 14 days before to < 72 hours after hospital admission were included.

† Index test date was defined as the date of respiratory specimen collection associated with the most recent positive or negative SARS-CoV-2 test result before the hospitalization or the hospitalization date if testing only occurred after the admission.

‡ Full vaccination was defined as receipt of the second dose of Pfizer-BioNTech or Moderna mRNA vaccine ≥ 14 days before the index test date.

¶ Partners contributing hospitalizations were in California, Colorado, Indiana, Minnesota and Wisconsin, Oregon and Washington, Utah, and New York.

** In comparing characteristics between unvaccinated adults with a previous infection and fully vaccinated adults without a previous documented infection, a standardized mean or proportion difference > 0.2 was considered noteworthy. After balancing characteristics that differed between the two comparison groups, the standardized mean or proportion differences were ≤ 0.06 .

†† Other race includes Asian, Hawaiian or Other Pacific islander, American Indian or Alaskan Native, Other not listed, and multiple races.

In this study, the benefit of vaccination compared with infection without vaccination appeared to be higher for recipients of Moderna than Pfizer-BioNTech vaccine, which is consistent with a recent study that found higher vaccine effectiveness against COVID-19 hospitalizations for Moderna vaccine recipients than for Pfizer-BioNTech vaccine recipients (7). In this study, the protective effect of vaccination also trended higher for adults aged ≥ 65 years than for those aged 18–64 years. However, considering the limited data by both product type and age, additional research is needed on the relative protection of vaccination versus infection without vaccination across demographic groups and vaccine products, as well as vaccination in previously infected persons.

The findings in this report are subject to at least seven limitations. First, although this analysis was designed to compare two groups with different sources of immunity, patients might have been misclassified. If SARS-CoV-2 testing occurred outside of network partners' medical facilities or if vaccinated persons are less likely to seek testing, some positive SARS-CoV-2 test results might have been missed and thus some patients classified as vaccinated and previously uninfected might also have been infected. In addition, despite the high specificity of COVID-19

vaccination status from these data sources, misclassification is possible. Second, the aOR could not be further stratified by time since infection or vaccination because of sparse data and limited ability to control for residual confounding that could be magnified within shorter intervals. The aOR that did not adjust for time might also be subject to residual confounding, particularly related to waning of both types of immunity. Third, selection bias might be possible if vaccination status influences likelihood of testing and if previous infection influences the likelihood of vaccination. Previous work from the VISION network did not identify systematic bias in testing by vaccination status, based on data through May 2021 (1). Fourth, residual confounding might exist because the study did not measure or adjust for behavioral differences between the comparison groups that could modify the risk of the outcome. Fifth, these results might not be generalizable to nonhospitalized patients who have different access to medical care or different health care-seeking behaviors, particularly outside of the nine states covered. Sixth, the statistical model incorporated the use of a weighted propensity score method which is subject to biases in estimates or standard errors if the propensity score model is misspecified. Numerous techniques were used to reduce

Morbidity and Mortality Weekly Report

TABLE 2. Adjusted odds ratios* of laboratory-confirmed COVID-19 among hospitalizations in adults with COVID-19–like illness comparing unvaccinated adults with a SARS-CoV-2 infection occurring 90–179 days before the index test date and adults who were fully vaccinated 90–179 days before the index test date without a previous documented SARS-CoV-2 infection — nine states, January–September 2021

Outcome	Total no.	No. (row %) of SARS-CoV-2 positive test results	Adjusted odds ratio (95% CI)
All adults (aged ≥18 years), any COVID-19 mRNA vaccine			
Any mRNA vaccine			
Fully vaccinated [†] without previous documented infection	6,328	324 (5.1)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	1,020	89 (8.7)	5.49 (2.75–10.99)
Any mRNA vaccine, no restriction of time since previous infection or completion of vaccination			
Fully vaccinated [†] without previous documented infection (range of time since vaccination = 0–213 days before hospitalization)	18,397	542 (3.0)	Ref
Unvaccinated with a previous SARS-CoV-2 infection (range of time since previous infection = 90–494 days before hospitalization)	2,085	130 (6.2)	2.75 (1.90–3.98)
Any mRNA vaccine, examining the potential influence of time since previous infection or completion of vaccination			
Fully vaccinated [†] without previous documented infection, limited to those with longest period since vaccination (range of time since vaccination = 45–213 days before hospitalization)	12,231	458 (3.7)	Ref
Unvaccinated with a previous SARS-CoV-2 infection, limited to those with more recent infections (range of time since previous infection = 90–225 days before hospitalization)	1,389	107 (7.7)	3.98 (2.49–6.35)
Any mRNA vaccine, adjusting for time since previous infection or completion of vaccination in model			
Fully vaccinated [†] without previous documented infection	6,328	324 (5.1)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	1,020	89 (8.7)	3.22 (1.68–6.20)
By time relative to SARS-CoV-2 B.1.617.2 (Delta) variant predominance			
Before Delta predominance (January–June 2021)			
Fully vaccinated [†] without previous documented infection	1,115	18 (1.6)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	831	70 (8.4)	6.11 (2.83–13.16)
During Delta predominance (June–September 2021)**			
Fully vaccinated [†] without previous documented infection	5,213	306 (5.9)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	189	19 (10.1)	7.55 (3.45–16.52)
By mRNA vaccine product[§]			
Pfizer-BioNTech (BNT162b2)			
Fully vaccinated [†] without previous documented infection	3,736	215 (5.8)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	1,020	89 (8.7)	5.11 (2.53–10.29)
Moderna (mRNA-1273)			
Fully vaccinated [†] without previous documented infection	2,592	109 (4.2)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	1,020	89 (8.7)	7.30 (3.40–15.60)
By age group, yrs[¶]			
18–64			
Fully vaccinated [†] without previous documented infection	1,425	71 (5.0)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	556	49 (8.8)	2.57 (1.42–4.65)
≥65			
Fully vaccinated [†] without previous documented infection	4,903	253 (5.2)	Ref
Unvaccinated with a previous SARS-CoV-2 infection	464	40 (8.6)	19.57 (8.34–45.91)

Abbreviations: CI = confidence interval; ref = referent group.

* Odds ratios were adjusted for age, geographic region, calendar time (days since January 1, 2021), and local virus circulation (percentage of SARS-CoV-2 positive results from testing within the counties surrounding the facility on the date of the hospitalization) and balanced using inverse weights on characteristics that differed between the two groups (calculated separately for each odds ratio model) using facility characteristics, sociodemographic characteristics, and underlying medical conditions. Cardiovascular disease was also adjusted in the main model and in the model for Pfizer-BioNTech. Any likely immunosuppression was also included in the model for Moderna. Neuromuscular and respiratory conditions were also adjusted in the model for adults aged ≥65 years. Number of days since previous infection or completion of vaccination, instead of calendar time, was adjusted in the model within the stated secondary analysis.

[†] Full vaccination was defined as receipt of the second dose of Pfizer-BioNTech or Moderna mRNA vaccine ≥14 days before the index test date.

[§] P-value from assessment of effect modification by mRNA product was 0.02.

[¶] P-value for interaction term for exposure group by age group was 0.05.

** SARS-CoV-2 B.1.617.2 (Delta) variant predominance began on the date the Delta variant accounted for >50% of sequenced isolates in each medical facility's state. <https://doi.org/10.15585/mmwr.mm7037e2>

potential suboptimal specification of the model, including but not limited to including a large set of covariates for machine learning estimation of propensity scores, including covariates in both regression and propensity models, ensuring large sample sizes and checking stability of weights, and conducting secondary analyses to assess robustness of results. Finally, the study

assessed COVID-19 mRNA vaccines only; findings should not be generalized to the Janssen vaccine.

In this U.S.-based epidemiologic analysis of patients hospitalized with COVID-19–like illness whose previous infection or vaccination occurred 90–179 days earlier, vaccine-induced immunity was more protective than infection-induced immunity

against laboratory-confirmed COVID-19, including during a period of Delta variant predominance. All eligible persons should be vaccinated against COVID-19 as soon as possible, including unvaccinated persons previously infected with SARS-CoV-2.

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All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. Stephanie A. Irving reports support from Westat to Kaiser Permanente Northwest Center for Health Research. Nicola P. Klein reports support from Pfizer to Kaiser Permanente, Northern California for COVID-19 vaccine clinical trials, and institutional support from Merck, GlaxoSmithKline, and Sanofi Pasteur outside the current study. Charlene McEvoy reports support from AstraZeneca to HealthPartners Institute for COVID-19 vaccine trials. Allison L. Naleway reports Pfizer Research funding to Kaiser Permanente Northwest for unrelated study of meningococcal B vaccine safety during pregnancy. Suchitra Rao reports grants from GlaxoSmithKline and Biofire Diagnostics. No other potential conflicts of interest were disclosed.

Summary

What is already known about this topic?

Previous infection with SARS-CoV-2 or COVID-19 vaccination can provide immunity and protection against subsequent SARS-CoV-2 infection and illness.

What is added by this report?

Among COVID-19–like illness hospitalizations among adults aged ≥ 18 years whose previous infection or vaccination occurred 90–179 days earlier, the adjusted odds of laboratory-confirmed COVID-19 among unvaccinated adults with previous SARS-CoV-2 infection were 5.49-fold higher than the odds among fully vaccinated recipients of an mRNA COVID-19 vaccine who had no previous documented infection (95% confidence interval = 2.75–10.99).

What are the implications for public health practice?

All eligible persons should be vaccinated against COVID-19 as soon as possible, including unvaccinated persons previously infected with SARS-CoV-2.

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Attachment 2



Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

November 09, 2021

SENT VIA EMAIL

Elizabeth Brehm
Attorney
Siri & Glimstad
200 Park Avenue, 17th Floor
New York, New York 10166
foia@sirillp.com

1st Letter Subject: Acknowledgement Letter

Dear Ms. Brehm:

The Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) received your November 05, 2021, Freedom of Information Act (FOIA) request on November 05, 2021, seeking:

“A copy of the analysis plan, including any drafts, amendments, and the final version, for the study titled “Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity – Nine States, January – September 2021” published in the Morbidity and Mortality Weekly Report dated October 29, 2021, available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w”

Your FOIA request number is #22-00298-FOIA, and it has been placed in our complex processing queue.

In unusual circumstances, an agency can extend the twenty-working-day limit to respond to a FOIA request. We will require more than thirty working days to respond to your request because:

- We reasonably expect that two or more CDC centers, institutes, and offices (C/I/Os) may have responsive records.
- We reasonably expect to consult with two or more C/I/O/s, or another HHS operating division or another federal agency about your request.

To process your request promptly, please consider narrowing the scope of your request to limit the number of responsive records. If you have any questions or wish to discuss reformulation or an alternative time frame for the processing of your request, you may contact the analyst handling your request, Carolyn Okpewho, at 770-488-6332 or our FOIA Public Liaison, Roger Andoh, at 770-488-6277. Additionally, you may contact the Office of Government Services (OGIS) to inquire about the FOIA mediation services they offer. The contact information for OGIS is as follows: Office of Government Information Services; National Archives and Records Administration; 8601 Adelphi Road-OGIS; College Park, Maryland 20740-6001; e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

Page 2 – Elizabeth Brehm

You requested that we waive fees associated with processing your request, your request is denied because it doesn't meet the following criteria:

- The disclosure of the records will not contribute significantly to public understanding of the operations or activities of the government.
- You have failed to demonstrate that you disseminate information to the public.
- You have failed to provide enough information to warrant a waiver of fees.

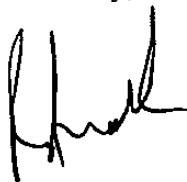
Because Informed Consent Action Network (ICAN) is considered an "All Other requester" you are entitled to two hours of free search time, and up to 100 pages of duplication (or the cost equivalent of other media) without charge, and you will not be charged for review time. We may charge for search time beyond the first two hours and for duplication beyond the first 100 pages. (10 cents/page).

Since you did provide us with a date range for your request, the search cut-off date for your request will be the date provided.

You have the right to appeal the agency's fee waiver response to your request. You may mail your appeal to the Deputy Agency Chief FOIA Officer, Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Suite 729H, Washington, D.C. 20201. You may also transmit your appeal via email to FOIARequest@psc.hhs.gov. Your appeal must be postmarked or electronically transmitted by February 07, 2022.

You may check on the status of your case on our FOIA webpage <https://foia.cdc.gov/app/Home.aspx> and entering your assigned request number.

Sincerely,



Roger Andoh
CDC/ATSDR FOIA Officer
Office of the Chief Operating Officer
Phone: (770) 488-6399
Fax: (404) 235-1852

#22-00298-FOIA

Attachment 3

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333**SENT VIA EMAIL**

December 28, 2022

Elizabeth Brehm
Attorney
Siri & Glimstad
200 Park Avenue, 17th Floor
New York, New York 10166
foia@sirillp.com**2nd Letter Subject: Final Response Letter**

Dear Ms. Brehm:

The Centers for Disease Control and Prevention and Agency for Toxic Substances and Disease Registry (CDC/ATSDR) received your November 05, 2021, Freedom of Information Act (FOIA) request on November 05, 2021, seeking:

“A copy of the analysis plan, including any drafts, amendments, and the final version, for the study titled “Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity – Nine States, January – September 2021” published in the Morbidity and Mortality Weekly Report dated October 29, 2021, available at https://www.cdc.gov/mmwr/volumes/70/wr/mm7044e1.htm?s_cid=mm7044e1_w”

A search of our records failed to reveal any documents pertaining to your request. Furthermore, the National Center for Immunization and Respiratory Diseases (NCIRD) relayed the following:

The analysis plan for the referenced MMWR was drafted and maintained by a contractor and was discussed with CDC over teleconference; SMEs did not receive copies of the analysis plan.

The analytical methods used in the referenced MMWR are described in detail in the publication and Supplemental Appendices linked below:

Publication:

<https://www.nejm.org/doi/full/10.1056/nejmoa2110362>

Supplemental Appendices:

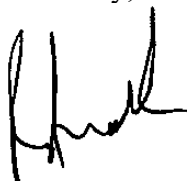
https://www.nejm.org/doi/suppl/10.1056/NEJMoa2110362/suppl_file/nejmoa2110362_appendix.pdf

You may contact our FOIA Public Liaison at 770-488-6277 for any further assistance and to discuss any aspect of your request. Additionally, you may contact the Office of Government Information Services (OGIS) at the National Archives and Records Administration to inquire about the FOIA mediation services they offer. The contact information for OGIS is as follows: Office of Government Information Services, National Archives and Records Administration, 8601 Adelphi Road-OGIS, College Park, Maryland 20740-6001, e-mail at ogis@nara.gov; telephone at 202-741-5770; toll free at 1-877-684-6448; or facsimile at 202-741-5769.

Page 2 – Elizabeth Brehm

If you are not satisfied with the response to this request, you may administratively appeal by writing to the Deputy Agency Chief FOIA Officer, Office of the Assistant Secretary for Public Affairs, U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, Suite 729H, Washington, D.C. 20201. You may also transmit your appeal via email to FOIARequest@psc.hhs.gov. Please mark both your appeal letter and envelope “FOIA Appeal.” Your appeal must be postmarked or electronically transmitted by March 28, 2023.

Sincerely,

A handwritten signature in black ink, appearing to read 'Roger Andoh', with a stylized flourish at the end.

Roger Andoh
CDC/ATSDR FOIA Officer
Office of the Chief Operating Officer
Phone: (770) 488-6399
Fax: (404) 235-1852

#22-00298-FOIA