Central District Board of Health Meeting | Agenda AMD1
707 N. Armstrong Pl, Boise, ID 83704
Friday, May 9, 2025 | Immediately Following Budget Committee Meeting at 10:00 a.m.*

The meeting will also be live on YouTube (see below) and available on our website for later viewing. Public comment will be accepted as noted on the agenda. People wishing to speak will have a maximum of two (2) minutes and must sign in before the meeting starts.

	A = Board Action Required		I = Information Item
10:15*	I	Call board meeting to order and roll call	Dr. Greg Ferch, Chair
10:20	A	Call for changes to the agenda; vote to approve the amended agenda	Dr. Greg Ferch, Chair
10:25	A	Discuss and vote on April 18, 2025, Board of Health minutes	Dr. Greg Ferch, Chair
10:30	I	Public Comment. Limited to two (2) minutes. Additional time at the discretion of the chair	Dr. Greg Ferch, Chair
10:50	I	Meridian Anti-Drug Coalition Volunteer of the Year	Russ Duke, District Director Kati Chauvin, Staff
11:05	A	Discuss and vote on whether CDH should continue to offer the COVID-19 Vaccine	Dr. Greg Ferch, Chair Sandy Mudge, MD, Savannah Klinginsmith, FNP-BC, Sky Blue, MD, Staff
12:05	I	Provide and review FY-2025 financial report	Laurel Gearhart, Staff
12:15	A	Review and vote on CDH Fee Policy and FY-2026 Fee Schedule	Laurel Gearhart, Staff
12:30	A	Discuss and vote on Board elected positions to include Chair, Vice-Chair, Trustee, and Executive Council Member*	Dr. Greg Ferch, Chair
12:45	I	Adjournment	Dr. Greg Ferch, Chair

Note: The board will take a break as needed.
***Amended Agenda Item**

Next Meeting: Friday, August 15, 2025

♦♦♦♦♦♦

Public Comments and Viewing

Submit Written Comments: If your comments are in response to an agenda item for a specific meeting date, please note that comments must be received 24-hours in advance of the applicable meeting to allow for routing and board member review. All messages will be shared with the Board and included in public record. Email: boh@cdh.idaho.gov; or Mail to: CDH Board of Health, Attn: Russ Duke, 707 N. Armstrong Place, Boise, ID 83704. ***View meetings live at: https://www.youtube.com/channel/UC4LJ1BM5Jv3zczecnYkXarw/***

CENTRAL DISTRICT HEALTH BOARD OF HEALTH REGULAR MEETING | MINUTES - DRAFT
707 N. Armstrong Place, Boise, ID 83704 | Syringa Conference Room
Friday, April 18, 2025, 8:30 a.m.

View meetings live at youtube.com/channel/UC4LJ1BM5Jv3zczecnYkXarw/

Call board meeting to order and roll call – *Dr. Greg Ferch, Chair*

Dr. Greg Ferch, Board Chair, called the Central District Health (CDH) Board of Health meeting to order at 8:30 A.M. The board members were identified by roll call: Comr. Katlin Caldwell, Valley County; Dr. Jane Young, Ada County; Betty Ann Nettleton, Elmore County; Dr. Greg Ferch, Ada County; Comr. Crystal Rodgers, Elmore County; Dr. Ryan Cole, Ada County; Comr. Clay Tucker, Boise County;

Guests and Staff in attendance were Russ Duke, District Director; Cory Kennedy, Recorder; Laurel Gearhart, Support Services Division Administrator; Curtis Loveless, Community & Environmental Health Division Administrator; Beth Bolen, Family & Clinic Services Division Administrator; Stephanie Borders, Communications & Marketing Manager; Emily Waddoups, Staff;

Call for changes to agenda; vote to approve of agenda – *Dr. Greg Ferch, Chair*

Chair Greg Ferch called for any changes to the agenda as presented; no changes were brought up, and the agenda was approved.

Discuss and vote on March 28, 2025, Board of Health minutes – *Dr. Greg Ferch, Chair*

Chair Greg Ferch called for any changes to the March 28, 2025, Board of Health minutes; no changes were brought up, and the March 28, 2025, Board of Health minutes were approved.

Provide and review FY-2025 financial report – *Laurel Gearhart, Staff*

Laurel provided an overview of the current FY-2025 Budget to Actual report. We are approximately 75% through FY-2025. The FY-2025 Cash Balance Statement reflected a total cash balance of $12,503,930, comprised of $6,415,443 in total reserve fund designations, $3,847,788 in total restricted funds, and $2,240,700 in cash balance undesignated/unrestricted.

WIC Program Overview – *Emily Waddoups, Staff*

Emily provided the Board with an overview of the WIC program and the services the program provides to our four counties. The CDH WIC team has twelve regularly scheduled clinic locations and five mobile sites. Participants in the WIC program are provided with nutrition education, given a monthly benefit for nutritious foods, and educated on other resources and health care services available. One WIC appointment can supply up to three months of WIC benefits. The WIC program helps to lower premature birth rates, decrease the number of fetal and infant deaths, improve diet quality, and increase access to regular health care, among numerous other benefits.

Review and Vote on the FY-2026 Proposed Budget – *Russ Duke, District Director*

Russ presented the proposed FY-2026 budget, including a 3% increase to county contribution, and addressed the Board's comments and inquiries.

Chair Greg Ferch called for a motion to approve the FY-2026 Proposed Budget as presented.

Motion: Betty Ann Nettleton motioned to approve the FY-2026 Proposed Budget as presented, seconded by Dr. Ryan Cole; the motion was put to a vote and was carried unanimously.

Director's Report – *Russ Duke, District Director*

Russ shared several laws recently passed in the Idaho Legislature that could potentially impact the way Central District Health provides its services. If there are any additional updates on the impact of these laws, Russ will share those updates with the Board.

Russ will meet with the Boards of Commissioners from our four counties over the coming weeks to present the proposed FY-2026 budget and data sheets with information on the services CDH provided in their counties in FY-2024. Russ provided the Board members with copies of the data sheets he will present to the County Commissioners.

The pre-budget meetings are scheduled for the following dates:

- Valley County - 04.21.2025 – at 10:00 a.m.
- Boise County – 04.22.2025 – at 9:30 a.m.
- Ada County – 05.01.2025 – at 1:30 p.m.
- Elmore County – 05.02.2025 – at 1:30 p.m.

Public Comment – *Dr. Greg Ferch, Chair*

No public comments were brought before the board.

Adjournment – *Dr. Greg Ferch, Chair*

The next Board of Health meeting will be on Friday, May 9, 2025, following the annual Budget Committee meeting, starting at 10:00 a.m. at our Boise Office. The board adjourned at 10:20 A.M.

Attest:

_____	_____
Dr. Greg Ferch Board Chair	Russell A. Duke, District Director Secretary to the Board of Health

Date approved: _____

Misuse/abuse of the PREP Act and "EUA Countermeasures"

Sasha Latypova,
sashalatypova.substack.com

1

EUA Countermeasures ≠ Regulated Medicines

FDA's "Normal" Regulatory Pathways for Market Approval

1. FDA Approved Investigational Drug (Marketed)

OR

2. Investigational Drug in Clinical Trias

3. "Expanded Access Use" Product (21CFR 312.300):

HHS-Declared Emergency

"EUA Countermeasure under PHE" § 564 of FD&C Act

Pharma cGxP regulations not applicable/not enforced!

No IRB, no informed consent required

PREP Act immunity from liability.

2

EUA Countermeasures ≠ Regulated Medicines

Covid vaccines' legal status is EUA Countermeasures under PREP Act emergency declaration (21USC 360bbb):

- The only venue for injury compensation is Countermeasures Injury Compensation Program (CICP)
- Courts have adjudicated PREP Act liability shield for manufacturers (therefore affirming that ALL covid shots are EUA Countermeasures).
- Peter Marks testified in court that because of a theoretical self-asserted possibility for Pfizer and Moderna to make "FDA compliant" batches, vaccine administrators were instructed to not provide informed consent, and thus the EUA versions were pushed with mandates.
- No IRB, no informed consent rules apply; not subject to the US FDA evidentiary standards for safety and efficacy
- Only "maybe effective" opinion of HHS Scy applies. Opinion is non-reviewable by either the Congress or the courts! "Maybe effective" is not a regulatory standard = "maybe toxic", too!
- No mechanism for recall from market until PREP Act declaration is terminated

Absence of enforceable consumer safeguards in relation to these products makes them potential poisons with no mechanisms to rectify the harm while they remain in circulation.

3

PREP Act was NOT meant to ship billions of doses of consumer/childhood vaccines for a decade!

1. Constitutional Violations: The Act undermines the First, Fifth, Seventh, Ninth, and Tenth Amendments. Every American has the right to due process, free speech, and a jury trial — especially during a declared emergency.
2. Unchecked Executive Powers: The PREP Act gives the Secretary of Health and Human Services enormous unchecked authority to declare emergency (no justification required) and issue EUAs. This authority is non-reviewable by Legislature or Judicial branch. Preempts ALL state laws!
3. Abuse of Emergency Powers: Emergency declarations should never become permanent loopholes for immunity and overreach.
4. Blanket Legal Immunity: The PREP Act shields pharmaceutical companies, hospitals, and officials from liability — even if their products cause harm or death - on condition of "following HHS orders".
5. Failed Compensation Program: The PREP Act took away fundamental and unalienable rights and did not provide an adequate remedy. The Countermeasures Injury Compensation Program (CICP) has compensated only a tiny fraction of claims, leaving injured men, women and children without access to their Constitutionally protected property rights.

Source: 2005.12.21-congressional-record-prep-act-discussion-s14241-to-14254-chemerinsky.pdf

4

Appendix

5

FOOD AND DRUG ADMINISTRATION (FDA) Center for Biologics Evaluation and Research (CBER) 161st Vaccines and Related Biological Products Advisory Committee (VRBPAC) Meeting, Transcript, October 22, 2020.

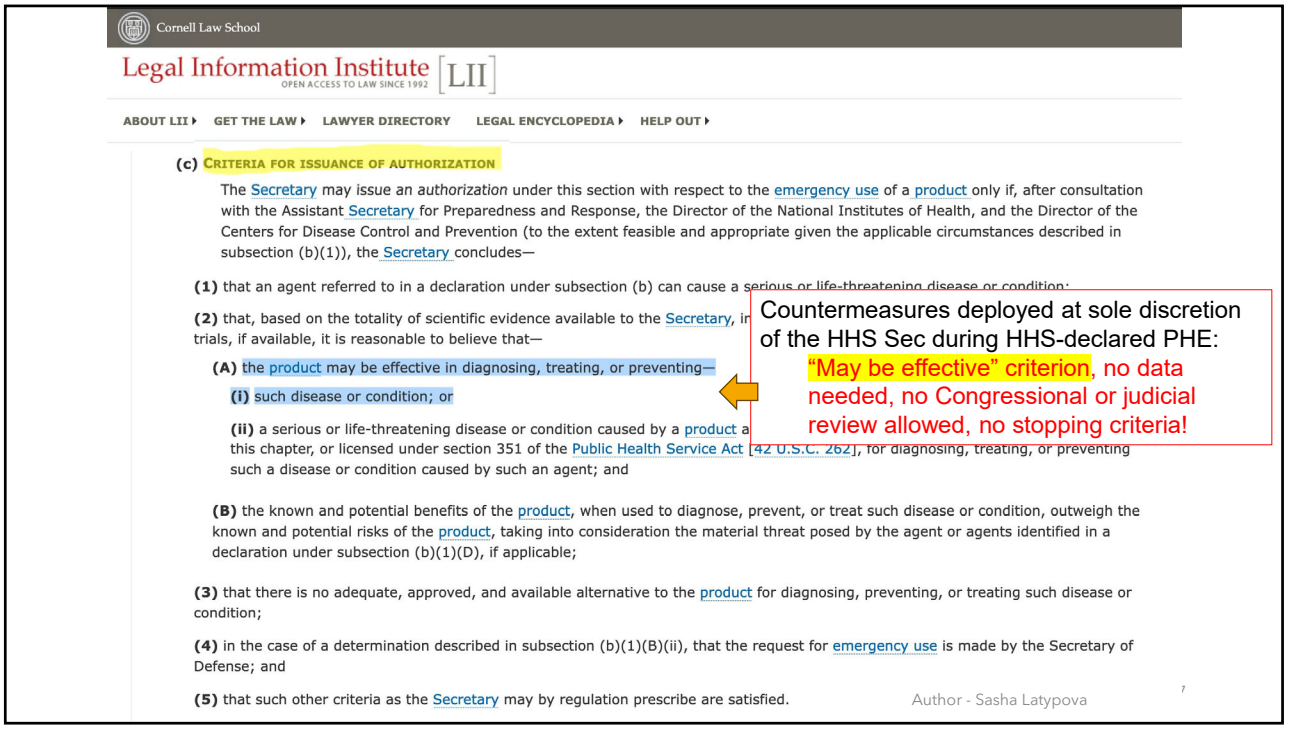
"Expanded Access Use" vs. Non-investigational EUA Pathway

https://www.fda.gov/media/143982/download

- P201/408 of transcript:
- *"DR. KURILLA: And then for Doran [FINK], did you consider at all the possibility of an expanded access protocol for those specific groups that you would issue the indication for the EUA instead of an EUA?*
- *P203 Dr. FINK: Yeah. So to answer your question about an expanded access protocol, that is another regulatory mechanism for providing access to investigational vaccine. I think if we were to consider an expanded access protocol of the same size and scope as what is being considered for an Emergency Use Authorization, then the benefit/risk considerations and the data to inform those benefit/risk considerations and allow that type of use would be highly similar. The differences between expanded access use and Emergency Use Authorization are that expanded access use is done -- or is carried out under FDA's investigational new drug regulations. So among many other things, those regulations require use of an institutional review board and also obtaining informed consent from recipients of the investigational vaccine according to regulations for clinical investigations -- research use of investigational vaccines. And so operationally speaking, an expanded access protocol would add some complexity, and that is why Emergency Use Authorization is being considered primarily as the mechanism for addressing the public health emergency that has been declared."*

6

6



7

With respect to whether or not the typical cGMP regulations in manufacturing apply to COVID shots:

- https://uscode.house.gov/view.xhtml?req=(title:21%20section:360bbb-3a%20edition:prelim)

(c) Current good manufacturing practice

(1) In general

The Secretary may, when the circumstances of a domestic, military, or public health emergency or material threat described in subsection (a)(1)(C) so warrant, authorize, with respect to an eligible product, deviations from current good manufacturing practice requirements otherwise applicable to the manufacture, processing, packing, or holding of products subject to regulation under this chapter, including requirements under section 351 or 360j(f)(1) of this title or applicable conditions prescribed with respect to the eligible product by an order under section 360j(f)(2) of this title.

(2) Effect

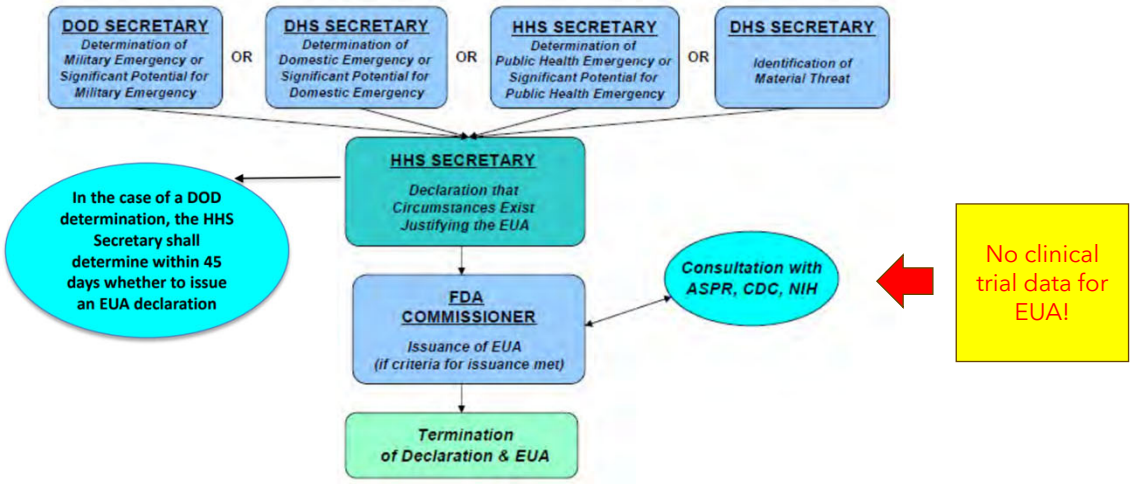
Notwithstanding any other provision of this chapter or the Public Health Service Act [42 U.S.C. 201 et seq.], an eligible product shall not be considered an unapproved product (as defined in section 360bbb–3(a)(2)(A) of this title) and **shall not be deemed adulterated or misbranded** under this chapter because, with respect to such product, the Secretary has authorized deviations from current good manufacturing practices under paragraph (1).

=There are no required standards for quality-control in manufacturing; no inspections of manufacturing procedures; no prohibition on wide variability among lots; no prohibition on adulteration; and no required compliance with Current Good Manufacturing Practices. EUA products, even though unregulated and non-standardized, "shall not be deemed adulterated or misbranded." 21 USC 360bbb-3a(c). 2013.

Author - Sasha Latypova 8

8

Summary of Process for EUA Issuance



https://public4.pagefreezer.com/browse/FDA/15-09-2022T08:43/https://www.fda.gov//media/154536/download

9

Why are legal/regulatory mechanisms for emergency use of MCMs needed?

They knew they needed to violate the law to put mRNA on the market!

Without these mechanisms, certain preparedness and response activities could otherwise violate provisions of the Federal Food, Drug, and Cosmetic (FD&C) Act:

- Some MCMs needed for a response might not be approved, licensed, or cleared by FDA
- Some MCMs needed for a response might be approved by FDA, but not for the emergency use (e.g., for a new indication)
- Some might be approved for the emergency use, but mass dispensed without individual prescriptions, with special instructions, or beyond expiry their dates
- Also, to ensure any available HHS Public Readiness and Emergency Preparedness (PREP) Act protections apply

https://public4.pagefreezer.com/browse/FDA/15-09-2022T08:43/https://www.fda.gov//media/154536/download 5

10

No Mechanism to Take Dangerous Adulterated EUA Countermeasure Off Market

FDA Responds After Being Urged to Recall Pfizer's Vaccine Over DNA Fragments, October 31, 2023 The Epoch Times

The U.S. Food and Drug Administration (FDA) is refusing to recall Pfizer's COVID-19 vaccine, even though they recognize the dangerous contamination with the DNA plasmids.

The FDA is not required to take Pfizer's COVID-19 vaccine, or other COVID-19 shots, off the market, an agency spokeswoman told The Epoch Times via email.

FDA: "With over a billion doses of the mRNA vaccines administered, no safety concerns related to the sequence of, or amount of, residual DNA have been identified. With regard to the FDA-approved mRNA vaccines, available scientific evidence supports the conclusion that they are safe and effective"

https://www.theepochtimes.com/article/fda-responds-after-being-urged-to-recall-pfizers-vaccine-over-dna-fragments-5519632

11

Absence of true and enforceable consumer safeguards in relation to these products makes them potential poisons with no lawful mechanisms to rectify the harm while they remain in circulation.

12

EUA Countermeasures including covid vaccines and other EUA drugs and devices pose severe risk of harm to the public due to absence of any enforceable pharmaceutical regulations.

Pursuant to Section 564 of the FD&C Act, as amended by PAHPRA, 2013, and the Supremacy Clause of the United States Constitution (Article VI, Clause 2), medical countermeasures have been exempted from testing using Good Laboratory Practices, Good Clinical Practices, including informed consent.

Under federal law, FDA must formally approve any new investigational drug product prior to a manufacturer introducing it into interstate commerce.[1] This process requires manufacturer to open an Investigational New Drug application and obtain an exemption from the FDA for its use in regulated clinical research (trials). This regulated process is therefore referred to as an "investigational" regulatory pathway. It requires a manufacturer to conduct regulated clinical research (trials) under the IND, obtaining Institutional Review Board's (IRB) approval for clinical trial protocols, independent safety monitoring oversight, and informed consent from clinical trial volunteers. In addition, manufacture of the drugs and biologics subject to the investigational status is regulated by the current Good Manufacturing practices (cGMP)[2]

EUA Medical Countermeasures are radically different, ***non-investigational*** drugs, biologics and devices deployed under FDA's authorization power known as the "Emergency Use Authorization" (EUA) process[3].

The EUA pathway is used only when the United States Secretary of Health and Human Services declares an emergency[4].

By law, the EUA status is non-investigational[5]: while the manufacturers may choose and FDA may ask to undertake some of the activities typically expected from an investigational clinical trial and manufacturing validation process, none of the typical pharmaceutical regulatory standards are applicable in an enforceable way.

FDA has the discretion to issue an EUA if, in the sole opinion of the HHS secretary, the product "may be effective" in treating the relevant disease or condition[6]. No other criteria for approval apply in an enforceable way. There is no strict requirement to conduct clinical trials prior to authorization. In addition, due to the unenforceability of

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[1] See, e.g., 21 U.S.C. § 355 (drugs); 42 U.S.C. § 262 (biologics).

[2] CFR Title 21, including sections in parts 1-99, 200-299, 300-499, 600-799, and 800-1299.

[3] Section 564 FD&C Act. Note that the EUA pathway should not be confused with the "Expanded Access Use" regulatory pathway which is often colloquially referred to as an "emergency use". The expanded access is an investigational pathway and is regulated in the same manner as all normal drug approvals. (21 CFR 312.310-320)

[4] 21 U.S.C. § 360bbb-3(a)(1), (b).

[5] 21 USC 360bbb-3(k): If a product is the subject of an authorization under this section, the use of such product within the scope of the authorization shall not be considered to constitute a clinical investigation for purposes of section 355(i), 360b(j), or 360j(g) of this title or any other provision of this chapter or section 351 of the Public Health Service Act [42 U.S.C. 262].

[6] 21 U.S.C. § 360bbb-3(c)(2)(A)

the pharmaceutical regulations and non-investigational status of the product, regulated human clinical trials are not legally possible, as none of the clinical trial human subject protections can be ensured.

FDA will approve EUA products on incomplete/non-existent information based on an opinion that "known and potential benefit of the product" may "outweigh[s] the known and potential risks"[7] and considers it unlikely that "comprehensive effectiveness data" will be available before an EUA grant. In contrast, for an investigational drug (under normal regulatory approval process) the FDA "shall" deny approval if the applicant "do[es] not show that such drug is safe."[8]

Therefore, the EUA status of a medical countermeasure precludes collection of the regulated clinical trial data and thus precludes reliable, valid scientific knowledge of risks and benefits associated with the EUA Countermeasure while it remains non-investigational.

There is no strict requirement for an Investigational New Drug exemption (IND), nor institutional review board (IRB) approval of a clinical trial protocol and informed consent forms. Thus, the EUA process makes it impossible to obtain meaningful informed consent from the recipients of the product.

Congress mandated that FDA directly inform health care professionals and product recipients of any "significant known and potential benefits and risks."[9] However, given that formal regulated clinical trials are neither required nor possible for a non-investigational EUA product, there is no effective way to collect and collate reliable and scientifically valid information on risks and benefits of an EUA, thus making the informed consent mandated by Congress meaningless.

Furthermore, there are no required standards for quality-control in manufacturing; no inspections of manufacturing procedures; no lot-release testing and no prohibition on wide variability among lots; no prohibition on adulteration; and no required compliance with Current Good Manufacturing Practices. EUA products, even though unregulated and non-standardized, "shall not be deemed adulterated or misbranded."[10]

In summary, the process by which the EUA products enter interstate commerce and claims about their safety, efficacy or contents are based solely on the HHS Secretary's opinion, which requires no supporting scientific evidence. Misrepresentations of safety, efficacy or contents of EUA products are allowed by federal law. Thus, claims provided by the federal health authorities or manufacturers cannot be considered reliable sources of information.

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[7] 21 U.S.C. § 360bbb3(c)(2)(B)
[8] 21 U.S.C. § 355(d)(2); See also 42 U.S.C. § 262(a)(2)(RB) (biologic approved only if it actually "is . . . safe").
[9] 21 U.S.C. § 360bbb-3(e)(1)(A)(II)
[10] 21 USC 360bbb-3a(c).

References:

References Emergency Use Authorization of Medical Products and Related Authorities, Guidance for Industry and Other Stakeholders, January 2017 Procedural OMB Control No. 0910- 0595 Expiration Date 09/30/202, Emergency Use Authorization of Medical Products and Related Authorities | FDA or direct link at www.fda.gov/media/97321/download , particularly pages 15, 22-25, 27,28, 33, and 39-41. Risk Evaluation and Mitigation Strategies, https://www.fda.gov/regulatory-information/search-fda-guidance-documents/fdas-application- statutory-factors- determining-when-rems-necessary; direct link at https://www.fda.gov/media/100307/download . Power point briefings on Section 564 of the FD&C Act, https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-andpolicy-framework/mcm-related-legal-and-policy-presentations-publications-and-qas : 1) August 25th-27, 2020 FDA – CDC Joint Learning Session, Regulatory Updates on Use of Medical Countermeasures Preparedness Summit ; 2) February 10, 2021 PHEP Connects Webinar; 3) March 1, 2021, The American Bar Association Health Law Section; Overview of FDAs EUA Authority and COVID-19 Response; 4) March 18, 2021, The Council of State and Territorial Epidemiologists, Public Health Law Webinar; 5) April 21, 2021, Overview from FDA: 2021 Preparedness Summit; 6) May 15, 2021 PMDA (The Pennsylvania Society for Post- Acute and Long-Term Care Medicine), Spring Symposium; and 7) November 21, 2021, FDA's EUA Authorities, BARDA (Biomedical Advanced Research and Development Authority) Industry Day. Direct links at 1) 2022-09-15 08:43 | Archive of FDA (pagefreezer.com) 2) 202111_CDC PHEP Connect Webinar.pdf 3) 202103_ABA Health Law Section.EUA_.Overview.FDA_.3.1.21.pdf 4) 202103_CSTE_FDA_3_18_21.final__0.pdf 5) Ross Overview_2021_Preparedness_Summit_508KH.pdf 6) J_Ross_20210515_FDAsEUAs_Other_Related_Authorities_508_KH.pdf 7) 202111_FDAs_Emergency_Use_Authorities.pdf

Idaho Central District Health Board Of Health Meeting
Tuesday 05/09/2025
Christina Parks, Ph.D, Testifies:
Why Genetic Vaccine Technology Is NOT Safe

1

The Need For Informed Consent

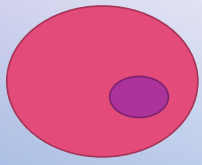
We need to be asking whether our health care professionals have the information they need to adequately understand and explain the risks versus benefits of this new genetic technology to patients.

2

Traditional Vaccines Do NOT Force Cells to Make Viral Proteins

Traditional Vaccine

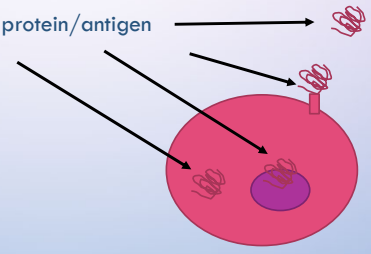
Viral protein/antigen



viral protein is NOT inside of the cells

"Gene Therapy" Vaccine

Viral protein/antigen



Body WILL attack cells making viral protein

3

The goals of gene-therapy technology are to:

- Get the target genetic material into as many of the cells of interest as possible
- Have the mRNA for the gene expressed for as long as possible
- Have a much of the target protein expressed for as long as possible

None of these are necessary for the efficacy of a vaccine!!

4

The Known Risks of Gene-Therapy Technologies are:

- Cancer
- Hyperinflammation
- Immune System Dysregulation (Autoimmune Disorders)
- Genomic Integration (changes to the germ line)

Regulatory Guidelines for Gene-Therapy Technologies require:

- 10-20 years surveillance to pick up signals for cancer and autoimmunity
- Careful screening for genomic integration into the germ line (sex cells)
- Careful screening for increased prevalence of blood disorders and cancers, such as leukemia and lymphoma

5

Genetic vaccine technology causes the body to attack itself because the cells are making a viral, foreign protein.

Thus, this technology is NOT proven safe for general use.

Long-term (20 yr) safety studies and manufacturer liability are a MUST!!

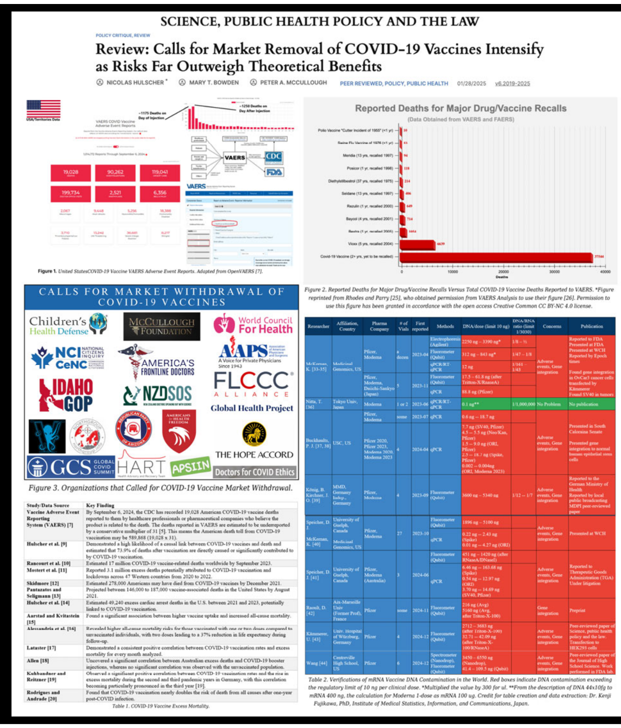
6

This technology forces the cells of the body to take up genetic information and make a foreign, viral protein rather than a human protein.

1. The spike protein is the inflammatory, toxic part of the SARS CoV-2 virus.
2. Your cells are making a foreign protein, which results in your immune system attacking the cells which are making the protein.
3. Chronic production of foreign protein results in chronic immune activation and eventually dysregulation of the immune system.
4. All of this promotes runaway inflammation, which is a major driver of disease.

7

Abundant Evidence Supports Immediate Market Withdrawal of COVID-19 Vaccines



1

A total of **450 peer-reviewed studies** demonstrate that COVID-19 vaccines are fundamentally harmful due to the widespread biodistribution, persistence, and pathogenicity of modified mRNA, the resulting Spike protein (*n* = 320 studies, detected 709 days after injection), and their lipid nanoparticle (LNP) delivery system.

SARS-CoV2 spike protein pathogenicity research collection

Sass, Erik

Compiled by Dr. Martin Wucher, MSC Dent Sc (eq DDS), Erik Sass, et al.

Doi: **10.5281/zenodo.14559644**

Version 2, last updated December 26, 2024. Corresponding author: eriksass@gmail.com

Originally part of the outer coat of the SARS-CoV2 virus, where it functions as a "key" to "unlock" (infect) cells, spike proteins are also produced in large amounts by the mRNA "vaccines," triggering a short-lived immune response in the form of antibodies. However, a growing body of evidence has shown that the spike protein is harmful by itself, independent of the rest of the virus.

The following (I. Alphabetical List) collects over 300 (**n=320**) peer-reviewed scientific studies confirming that the spike protein is highly pathogenic on its own; most *in vitro* studies cited here used recombinant spike proteins or spike proteins in pseudoviral vectors, and produced pathological effects not reliant on the SARS-CoV2 viral machinery.

The second section (II. Categories) organizes the research into broad categories including affected tissues and organ systems, mechanisms, and evidence from clinical pathology. Because these areas overlap, many articles appear more than once in the second section.

mRNA "vaccine" biodistribution, persistence, and adjuvant toxicity library

Sass, Erik (Contact person)

Compiled by Dr. Martin Wucher, MSC Dent Sc (eq DDS), Dr. Byram Bridle, PhD, Erik Sass, et al.

Doi: **10.5281/zenodo.14559625**

Last updated December 26, 2024. Corresponding author: eriksass@gmail.com

Originally part of the outer coat of the SARS-CoV2 virus, where it functions as a "key" to "unlock" (infect) cells, spike proteins are also produced in large amounts by the mRNA "vaccines," triggering a short-lived immune response in the form of antibodies. However, a growing body of evidence has shown that the spike protein is harmful by itself (see: "Spike protein pathogenicity research library," https://zenodo.org/records/14559644). Furthermore, research has demonstrated that:

1) Both the "vaccine" mRNA encoding for the spike protein antigen and the spike protein itself can penetrate distant tissues, causing systemic harms.

2) "Vaccine" mRNA and the spike protein antigen persist in the tissues of human vaccine recipients and animal test subjects far longer than claimed by public health officials, while viral spike proteins have been shown to persist even longer.

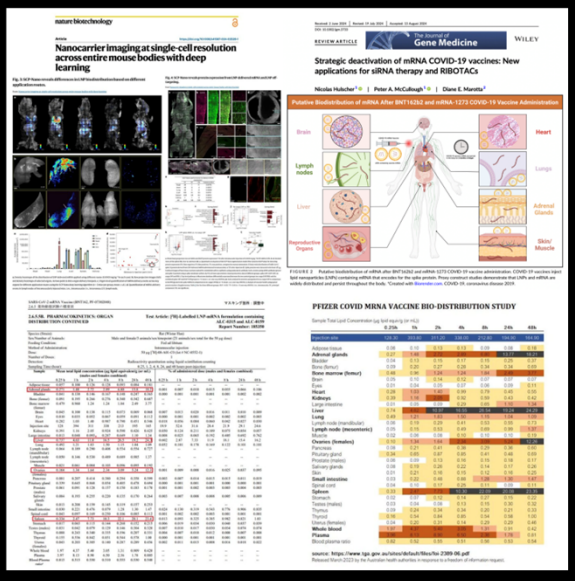
3) The ionizable lipid nanoparticles (LNPs) used in the experimental mRNA injections are highly inflammatory on their own, including their polyethylene glycol (PEG) component, an established cause of anaphylaxis (an extreme allergic reaction).

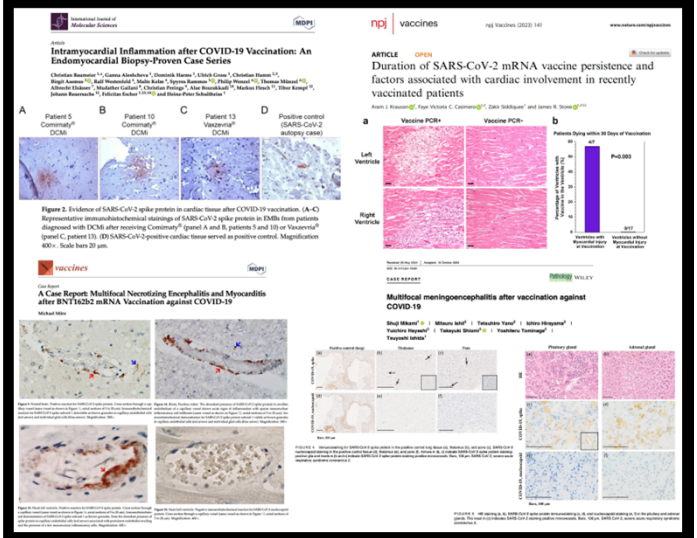
The following research collection presents over 100 peer-reviewed studies (**n=130**) documenting I) the wide distribution and II) persistence of "vaccine" mRNA and the encoded spike protein, as well as III) the potential harms of the LNP delivery system (some studies with overlapping findings appear in more than one category). Taken together with evidence of the spike protein's pathogenicity (https://zenodo.org/records/14559644), these findings suggest that the mRNA "vaccines" can distribute harmful, long-lasting spike protein uncontrollably throughout the body, causing injuries and death by various means.

Please note that a small number of studies in section I) investigate the ability of viral spike protein resulting from infection to cross important physiological barriers on its own, while some studies in section II) demonstrate the long persistence of viral-derived spike protein in the absence of viable virus, bolstering concerns about the identical "vaccine" spike.

2

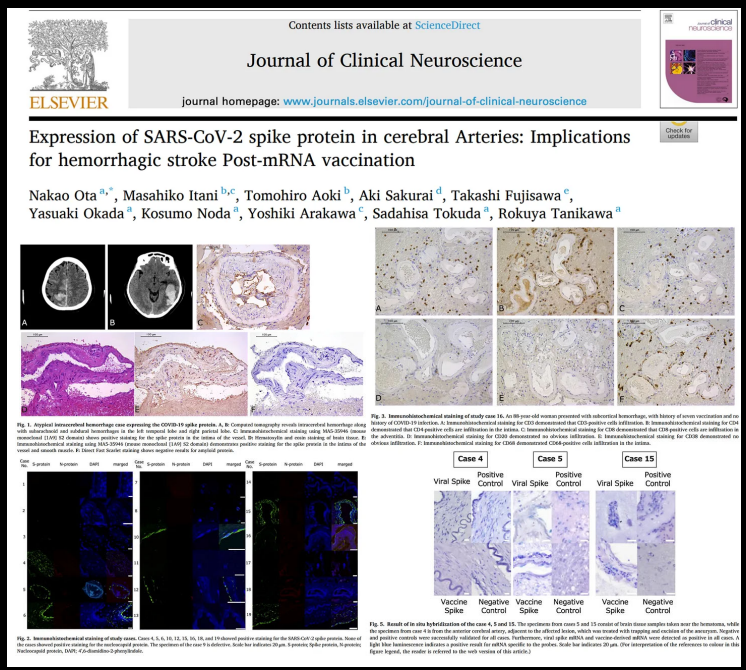
Lipid nanoparticles (LNPs) carrying modified mRNA travel to **all organ systems**, instructing them to become toxic full-length, prefusion-stabilized Spike protein factories. Product mRNA and resulting Spike protein are found **directly in affected tissues** at autopsy.





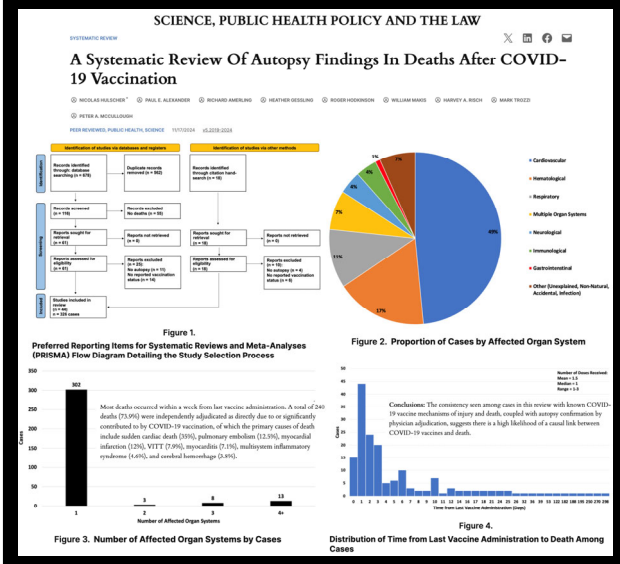
3

Recently, Ota et al found COVID-19 mRNA vaccine Spike protein expression in the cerebral arteries of hemorrhagic stroke patients 17 months after vaccination.



4

Post-mortem analyses of **325** peer-reviewed **autopsy reports** indicate a **high likelihood of a causal link between COVID-19 vaccination and death** involving multiple organ systems.


SCIENCE, PUBLIC HEALTH POLICY AND THE LAW

SYSTEMATIC REVIEW

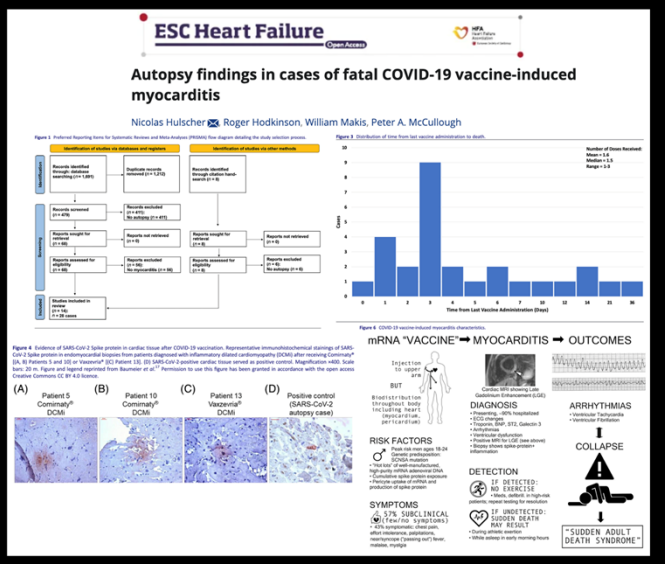
A Systematic Review Of Autopsy Findings In Deaths After COVID-19 Vaccination

Figure 1.
Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Flow Diagram Detailing the Study Selection Process

Figure 2. Proportion of Cases by Affected Organ System

Figure 3. Number of Affected Organ Systems by Cases

Figure 4.
Distribution of Time from Last Vaccine Administration to Death Among Cases


ESC Heart Failure

Autopsy findings in cases of fatal COVID-19 vaccine-induced myocarditis

Nicolas Hulscher, Roger Hodkinson, William Makis, Peter A. McCullough

mRNA "VACCINE" ➡ MYOCARDITIS ➡ OUTCOMES

Excess Mortality

Along with VAERS, >**12 studies** demonstrate that mass COVID-19 vaccination has led to increased mortality.

The total number of COVID-19 vaccine deaths worldwide may be greater than **17 million**.

Study/Data Source	Key Finding
Vaccine Adverse Event Reporting System (VAERS) [7]	By September 6, 2024, the CDC has recorded 19,028 American COVID-19 vaccine deaths reported to them by healthcare professionals or pharmaceutical companies who believe the product is related to the death. The deaths reported in VAERS are estimated to be underreported by a conservative multiplier of 31 [5]. This means the American death toll from COVID-19 vaccination may be 589,868 (19,028 x 31).
Hulscher et al. [9]	Demonstrated a high likelihood of a causal link between COVID-19 vaccines and death and estimated that 73.9% of deaths after vaccination are directly caused or significantly contributed to by COVID-19 vaccination.
Rancourt et al. [10]	Estimated 17 million COVID-19 vaccine-related deaths worldwide by September 2023.
Mostert et al. [11]	Reported 3.1 million excess deaths potentially attributed to COVID-19 vaccination and lockdowns across 47 Western countries from 2020 to 2022.
Skidmore [12]	Estimated 278,000 Americans may have died from COVID-19 vaccines by December 2021.
Pantazatos and Seligmann [13]	Projected between 146,000 to 187,000 vaccine-associated deaths in the United States by August 2021.
Hulscher et al. [14]	Estimated 49,240 excess cardiac arrest deaths in the U.S. between 2021 and 2023, potentially linked to COVID-19 vaccination.
Aarstad and Kvitastein [15]	Found a significant association between higher vaccine uptake and increased all-cause mortality.
Alessandria et al. [16]	Revealed higher all-cause mortality risks for those vaccinated with one or two doses compared to unvaccinated individuals, with two doses leading to a 37% reduction in life expectancy during follow-up.
Lataster [17]	Demonstrated a consistent positive correlation between COVID-19 vaccination rates and excess mortality for every month analyzed.
Allen [18]	Uncovered a significant correlation between Australian excess deaths and COVID-19 booster injections, whereas no significant correlation was observed with the unvaccinated population.
Kuhbandner and Reitzner [19]	Observed a significant positive correlation between COVID-19 vaccination rates and the rise in excess mortality during the second and third pandemic years in Germany, with this correlation becoming particularly pronounced in the third year [19].
Rodrigues and Andrade [20]	Found that COVID-19 vaccination nearly doubles the risk of death from all causes after one-year post-COVID infection.

Table 1. COVID-19 Vaccine Excess Mortality.

Historical Comparisons - FDA Class I Recall Indicated

The total number of COVID-19 vaccine deaths reported to VAERS (**37,544 among all participating countries**) have **far exceeded the recall limits of past vaccine withdrawals by up to 375,340%**.

In 1955, the Cutter polio vaccine was immediately recalled after **10 death reports**.

The swine flu vaccine of 1976 was recalled after **53 reported fatalities**.

In 1999, the Rotashield vaccine was suspended after **15 cases of bowel obstruction**.

The criteria for an FDA Class I recall, which applies to products with a reasonable probability of causing serious adverse health consequences or death, have been far exceeded.

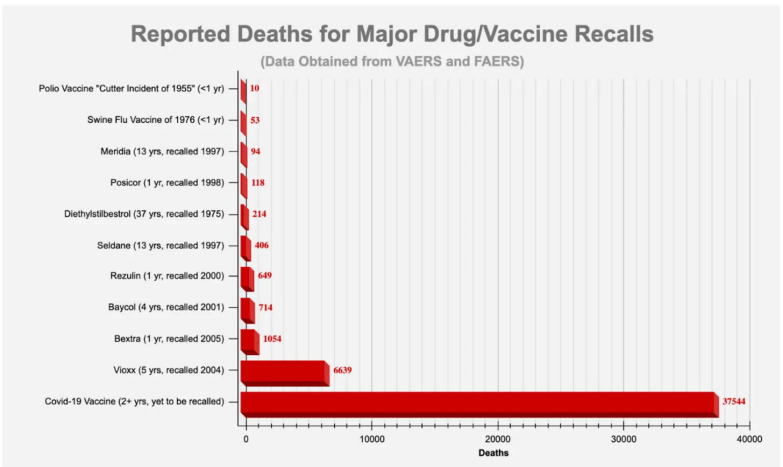


*Figure 2. Reported Deaths for Major Drug/Vaccine Recalls Versus Total COVID-19 Vaccine Deaths Reported to VAERS. *Figure reprinted from Rhodes and Parry [25], who obtained permission from VAERS Analysis to use their figure [26]. Permission to use this figure has been granted in accordance with the open access Creative Common CC BY-NC 4.0 license.*

7

Negative Efficacy

>6 studies have demonstrated that COVID-19 vaccination increases your risk of SARS-CoV-2 infection.

Shrestha et al (Cleveland Clinic) – The risk of COVID-19 increased with the number of vaccine doses received. Individuals with one prior dose had a 107% higher risk (HR = 2.07, 95% CI: 1.70–2.52), while those with more than three doses faced a 253% higher risk (HR = 3.53, 95% CI: 2.97–4.20).

Feldstein et al (CDC) – Children vaccinated with Pfizer-BioNTech without prior SARS-CoV-2 infection were 159% more likely to get infected (HR = 2.59, 95% CI: 1.27–5.28) and 257% more likely to develop symptomatic COVID-19 (HR = 3.57, 95% CI: 1.10–11.63) compared to unvaccinated children without prior infection.

Ioannou et al – Vaccine effectiveness (VE) against documented SARS-CoV-2 infection was -3.26% (95% CI, -6.78% to -0.22%), meaning vaccinated individuals had a statistically significant higher infection rate than the unvaccinated control group.

Nakatani et al – Vaccinated individuals had an 85% increased odds of infection compared to the unvaccinated (OR = 1.85, 95% CI: 1.33–2.57).

Eythorsson et al – Those who received two or more doses had a 42% higher risk of reinfection than those with one dose or less (95% CI: 1.13–1.78).

Chemaitelly et al – The effectiveness of Pfizer-BioNTech (BNT162b2) against symptomatic BA.1 and BA.2 Omicron infections dropped from 46.6% and 51.7% (1–3 months post-dose) to -17.8% and -12.1% (≥7 months). Moderna (mRNA-1273) declined from 71.0% and 35.9% to -10.2% and -20.4% over the same period.

8

DNA Contamination

>11 reports have found DNA contamination in COVID-19 vaccines, documented across multiple manufacturers, vaccine platforms, and geographic regions, with levels exceeding regulatory thresholds by up to **65,500%**.

The discovery of large amounts of residual plasmid DNA, including Spike-coding sequences and the SV40 promoter/enhancer, in COVID-19 vaccine vials raises serious concerns about **potential genome integration, prolonged Spike protein expression, and carcinogenicity.**

Researcher	Affiliation, Country	Pharma Company	# of Vials	First reported	Methods	DNA/dose (limit 10 ng)	DNA/RNA ratio (limit 1/3030)	Concerns	Publication
McKernan, K. [33-35]	Medicinal Genomics, US	Pfizer, Moderna	a dozen	2023-04	Electrophoresis (Agilent)	2250 ng – 3390 ng*	1/8 – ½	Adverse events, Gene integration	Reported to FDA Presented at FDA Presented at WCH Reported by Epoch times Found gene integration in OvCa3 cancer cells transfected by Kämmerer Found SV40 in tumors
					Fluorometer (Qubit)	312 ng – 843 ng*	1/47 – 1/8		
					qPCR/RT-qPCR	12 ng	1/161 – 1/43		
		Pfizer, Moderna, Daiichi-Sankyo (Japan)	5	2023-11	Fluorometer (Qubit)	17.5 – 61.8 ng (after Tritton-X/RnaseA)			
					qPCR	88.8 ng (Pfizer)			
Nitta, T. [36]	Tokyo Univ, Japan	Moderna	1 or 2	2023-06	qPCR/RT-qPCR	0.1 ng**	1/1,000,000	No Problem	No publication
Buckhaults, P. J. [37, 38]	USC, US	Pfizer, Moderna	some	2023-07	qPCR	0.6 ng -- 18.7 ng		Adverse events, Gene integration	Presented in South Caleraina Senate Presented gene integration to normal human epithelial stem cells
		Pfizer 2020, Pfizer 2023, Moderna 2020, Moderna 2023	4	2024-04	qPCR	7.7 ng (SV40, Pfizer) 4.5 -- 5.5 ng (Neo/Kan, Pfizer) 1.5 -- 9.0 ng (ORI Pfizer) 2.5 -- 18.7 ng (Spike, Pfizer) 0.002 -- 0.004ng (ORI, Moderna 2023)			
König, B. Kirchner, J. O. [39]	MMD, Germany Indep., Germany	Pfizer, Moderna	4	2023-09	Fluorometer (Qubit)	3600 ng – 5340 ng	1/12 -- 1/7	Adverse events, Gene integration	Reported to the German Ministry of Health Reported by local public broadcasting MDPI peer-reviewed paper
Speicher, D. J. McKernan, K. [40]	University of Guelph, Canada Medicinal Genomics, US	Pfizer, Moderna	27	2023-10	Fluorometer (Qubit)	1896 ng – 5100 ng		Adverse events, Gene integration	Presented at WCH
					qPCR	0.22 ng -- 2.43 ng (Spike) 0.01 ng -- 4.27 ng (ORI)			
Speicher, D. J. [41]	University of Guelph, Canada	Pfizer, Moderna (Australia)	3	2024-06	Fluorometer (Qubit)	451 ng – 1420 ng (after RNaseA/DNase1)		Adverse events, Gene integration	Reported to Therapeutic Goods Administration (TOA) Under litigation
					qPCR	6.46 ng -- 163.68 ng (Spike) 0.54 ng -- 12.97 ng (ORI) 3.70 ng -- 14.69 ng (SV40, Pfizer)			
Raoult, D. [42]	Aix-Marseille Univ (Former Prof), France	Pfizer	some	2024-11	Fluorometer (Qubit)	216 ng (Avg) 5160 ng (Avg, after Triton-X-100)		Gene integration	Preprint
Kämmerer, U. [43]	Univ. Hospital of Würzburg, Germany	Pfizer	4	2024-12	Fluorometer (Qubit)	2712 – 3683 ng (after Triton-X-100) 32.71 -- 42.09 ng (after Triton-X-100/RNaseA)		Adverse events, Gene integration	Peer-reviewed paper of Science, public health policy and the law. Transfection to HEK293 cells
Wang [44]	Centreville High School, US	Pfizer	6	2024-12	Spectrometer (Nanodrop), Fluorometer (Qubit)	3450 – 6550 ng (Nanodrop), 41.4 – 109.5 ng (Qubit)		Adverse events, Gene integration	Peer-reviewed paper of the Journal of High School Science. Work performed in FDA lab

*Table 2. Verifications of mRNA Vaccine DNA Contamination in the World. Red boxes indicate DNA contamination exceeding the regulatory limit of 10 ng per clinical dose. *Multiplied the value by 300 for ul. **From the description of DNA 44x10fg to mRNA 400 ng, the calculation for Moderna 1-dose as mRNA 100 ug. Credit for table creation and data extraction: Dr. Kenji Fujikawa, PhD, Institute of Medical Statistics, Information, and Communications, Japan.*

9

Widespread and Unified Calls for the Market Withdrawal of COVID-19 Vaccines

>81,000 Physicians, Scientists, Researchers, and Concerned Citizens

240 Elected Government Officials

17 Professional Public Health and Physician Organizations

17 Republican Party County Committees

6 Scientific Studies

2 State Republican Parties

All call for the market withdrawal of COVID-19 vaccines.

Figure 3. Organizations that Called for COVID-19 Vaccine Market Withdrawal.

10

Conclusion

I expect that calls for an immediate moratorium on COVID-19 vaccines will continue to increase until a critical mass is reached, and the products are finally removed from the market.

Excess mortality, negative efficacy, and widespread DNA contamination associated with COVID-19 vaccines have been sufficiently demonstrated. The FDA's criteria for a Class I recall have been far exceeded.

No large-scale, conclusive, randomized, double-blind, placebo-controlled trials have demonstrated reduction in infection transmission, hospitalization, or death as primary endpoints. Thus, the COVID-19 vaccines are not proven to be effective in reducing important clinical outcomes.

A position supporting COVID-19 vaccination goes against good medical practice and violates the Hippocratic Oath to above all, do no harm.

Immediate removal of COVID-19 vaccines from the market is essential to prevent further harm to the fewer than 20% of the population still receiving booster doses.

11

FY-2025 Budget to Actual Report
July 2024 - April 2025
Fiscal Year % Elapsed 83.33%

REVENUES:	FEES			CONTRACTS			OTHER			TOTAL REVENUE		% to
	Budget	Actual	%	Budget	Actual	%	Budget	Actual	%	Budget	Actual	Budget
Administration	0	0	0%	94,300	437,257	464%	0	0	0%	94,300	437,257	464%
Support Services	0	0	0%	60,700	1,586	3%	47,900	2,401	5%	108,600	3,987	4%
Community & Environmental Health	1,289,100	1,168,680	91%	4,766,800	3,456,135	73%	778,500	1,019,761	131%	6,834,400	5,644,576	83%
Family & Clinic Services	585,300	382,797	65%	3,349,200	3,055,792	91%	14,200	266	2%	3,948,700	3,438,856	87%
DISTRICT TOTAL	**1,874,400**	**1,551,477**	**83%**	**8,271,000**	**6,950,770**	**84%**	**840,600**	**1,022,428**	**122%**	**10,986,000**	**9,524,676**	**87%**
County Contributions										5,511,800	5,702,285	103%
Interest Revenue										485,900	358,545	74%
Restrict/Reserve										364,900	0	0%
REVENUE:										**17,348,600**	**15,585,505**	**90%**
TOTAL FUNDING:										**17,348,600**	**15,585,505**	**90%**

EXPENDITURES:	PERSONNEL			OPERATING			CAPITAL			TRUSTEE & BENEFITS			TOTAL EXPENDITURES		% to
	Budget	Actual	%	Budget	Actual	%	Budget	Actual	%	Budget	Actual	%	Budget	Actual	Budget
Administration	515,300	493,731	96%	186,900	121,789	65%	0	0	0%	5,500	5,845	106%	707,700	621,364	88%
Support Services	1,789,200	1,567,031	88%	725,600	926,971	128%	464,000	153,955	33%	0	17	0%	2,978,800	2,647,974	89%
Community & Environmental Health	4,516,400	3,651,017	81%	2,424,900	1,615,635	67%	20,000	0	0%	956,800	676,125	71%	7,918,100	5,942,777	75%
Family & Clinic Services	4,770,200	3,463,418	73%	854,100	610,301	71%	0	0	0%	119,700	81,609	68%	5,744,000	4,155,328	72%
DISTRICT TOTAL	**11,591,100**	**9,175,196**	**79%**	**4,191,500**	**3,274,696**	**78%**	**484,000**	**153,955**	**32%**	**1,082,000**	**763,596**	**71%**	**17,348,600**	**13,367,443**	**77%**

FY-2025 Revenue & Expenditure Report
July 2024 - April 2025
Fiscal Year % Elapsed 83.33%

NOTES

REVENUES:

Fees:

	July - April		
	FY-2023	FY-2024	FY-2025
Community & Environmental Health			
Sewage Disposal	456,510	411,130	422,149
Land Programs - Other	67,890	62,670	72,292
Food Programs *(updated)*	651,897	626,361	610,679
Child Care Licensing	38,750	27,205	29,750
Other (incl. Vital Stat's)	49,601	44,265	33,811
Subtotal:	1,264,648	1,171,631	1,168,680
Family & Clinic Services			
Central Care	66,843	96,113	64,742
Immunizations	73,145	69,851	39,451
Reproductive Health	101,607	123,982	58,456
Child Dental Clinic	44,918	40,501	32,877
Home Visitation	91,754	89,793	186,160
Other	8,315	-	1,112
Subtotal:	386,582	420,240	382,797
TOTAL FEES:	**1,651,230**	**1,591,871**	**1,551,477**

Contracts:

Administration	-	119,829	437,257
Support Services	-	13,276	1,586
Community &Environmental Health	7,609,339	4,539,520	3,456,135
Family and Clinic Services	3,177,256	2,094,463	3,055,792
TOTAL CONTRACTS:	10,786,595	6,767,089	6,950,770

REVENUES	**Budget Total**	**Budget to Date**	**Actual to Date**	**% Over / -Under**
Fees	1,874,400	1,562,000	1,551,477	-0.7%
Contracts	8,271,000	6,892,500	6,950,770	0.8%

EXPENDITURES:

Personnel Costs:

Completed payperiods:	22/26	84.6%
Current spending:		79.2%

Budget Total	**Budget to Date**	**Actual to Date**	**-Under / Over**	**% -Under / Over**
11,591,100	9,807,854	9,175,196	-632,658	-6.5%

Operating Costs:

Budget Total	**Budget to Date**	**Actual to Date**	**-Under / Over**	**% -Under / Over**
4,191,500	3,492,917	3,274,696	-218,221	-6.2%

Trustee and Benefit Costs:

Budget Total	**Budget to Date**	**Actual to Date**	**-Under / Over**	**% -Under / Over**
1,082,000	901,667	763,596	-138,070	-15.3%

Capital Outlay:

Budget Total	**Budget to Date**	**Actual to Date**	**-Under / Over**	**% -Under / Over**
484,000	403,333	153,955	-249,378	-61.8%

FY-2025 Cash Balance Statement

For Month Ending: April 2025

Cash Balances

Fund #	Name	Location	Beginning Balance	Change	Ending Balance
N/A	Cash on Hand	CDH	3,960	(1,450)	2,510
29000	Operating	State Treasurer - General	1,449,041	(567,260)	881,781
62500	LGIP - Operating	State Treasurer - LGIP	8,688,405	3,083,545	11,771,950
62500	LGIP - Capital	State Treasurer - LGIP	1,000,000	-	1,000,000

Total Cash Balances at Month End **$ 13,656,240**

Reserve Fund Designations

Special Projects/Carryover Designation	Approved Request	Expenditure to Date	Balance
Environmental Health Systems Upgrades	$ 296,864	$ 90,117	$ 206,747
Employee Retention	$ 139,000	$ 139,000	$ -
CDH Staffing Needs	$ 299,100	$ 65,614	$ 233,486
Armstrong Bathroom Remodel	$ 100,000	$ -	$ 100,000
McCall Office Refresh	$ 50,000	$ -	$ 50,000
	$ -	$ -	$ -
	$ 884,964	$ 294,732	590,232

Personnel Reserve Fund 27th Pay Period	279,300	
Operational Reserve Funds		
$4,520,000 designated (3-month cash flow target = $4,520,000)	4,520,000	
Capital Reserve Fund for Building/Capital	1,000,000	
Total Reserve Fund Designations		**$ 6,389,532**
Total Restricted Funds		**$ 3,209,305**
Cash Balance Undesignated/Unrestricted		**$ 4,057,403**

ENVIRONMENTAL HEALTH SERVICES

Proposed FY-2026 FEES (July 1, 2025 - June 30, 2026)

Program	Description	FY-2025 Fee	Proposed FY-2026 Fee
Sewage Program-Permits			
	Individual System - New	$877.00	$878.00
	Individual System - Repair	$877.00	$878.00
	Individual System - Expansion - No Test Hole/Site Visit	$438.00	$439.00
	Individual System - Expansion - With Test Hole/Site Visit	$877.00	$878.00
	Individual System - Repair - No Test Hole/Site Visit	$438.00	$439.00
	Central /Large Soil Absorption System - New	$1,503.00	$1,505.00
	Central /Large Soil Absorption System - Repair	$1,503.00	$1,505.00
	Speculative Site Evaluation	$438.00	$439.00
	Tank only & Vault Privy	$438.00	$439.00
	Permit Renewal/Transfer	$94.00	$94.00
Sewage Program-Planning and Zoning Review			
	Office Review	$94.00	$94.00
	Field Visit Required	$438.00	$439.00
Sewage Program-Licenses			
	Installers - Standard	$125.00	$125.00
	Installers - Complex	$125.00	$125.00
	Tech. Guid. Manual - Installer	$25.00	$25.00
	Pumper Establishment	$125.00	$125.00
	Pumper Per Truck Fee	$31.00	$31.00
Mortgage Survey			
	Inspection	$129.00	$142.00
	Repeat Inspection (after 2nd inspection)	$129.00	$142.00
Land Development Subdivision Application (price per lot)			
	Served by Septic and/or Individual Wells	$301.00	$348.00
	Served by Large Soil Absorption System	$301.00	$348.00
	Central Services	$201.00	$232.00
Pool Program			
	Swimming Pool License*	$50.00	$50.00
	Swimming Pool Plan Review*	$100.00	$100.00
	Class/Video/Test	$68.00	$69.00
Child Care Inspections			
	Large Center (13+children)/Center > 25 children*	$325.00	$325.00
	Center 13-25 children*	$250.00	$250.00
	Group (7-12 children)*	$100.00	$100.00
	Family (1-6) children - Voluntary Inspection*	$100.00	$100.00
	Child Care Inspection--Boise City License	$175.00	$175.00

Program	Description	FY-2025 Fee	Proposed FY-2026 Fee
Food License Fees			
	Temp, Interm & Mobile (No Commissary)*	$80.00	$80.00
	Mobile with Commissary*	$100.00	$100.00
	Other, Regular*	$200.00	$200.00
	Other >2 licenses on single premises w/ one owner*	$250.00	$250.00
	Temp 1 Day Event*	$35.00	$35.00
	Temp 2-3 Day Single Event*	$45.00	$45.00
	Temp 4 Day Single OR Mult. Events*	$80.00	$80.00
	Late Fee Jan 1-15*	$35.00	$35.00
	Late Fee Jan 16*	$70.00	$70.00
	Food License Reinstatement*	$18.00	$18.00
	Request for Variance (per hour fee)*	$50.00	$50.00
	Compliance Conference (per hour fee)*	$100.00	$100.00
	Enforcement and Legal Fees (per hour fee)*	$150.00	$150.00
	Federal School Inspection*	$200.00	$200.00
	Plan Review/Preoperational inspection*	$100.00	$100.00
Classes			
	Serv-Safe Managers Certificate	$128.00	$131.00
	Retakes	$65.00	$73.00
Other Services			
	Consultation - hourly rate	$65.00	$73.00
	Drinking Water Sample Collection	$130.00	$145.00
	Shallow Injection Wells*	$75.00	$75.00

*Fee set by law or statute

FAMILY & CLINIC SERVICES

Proposed FY-2026 FEES (July 1, 2025 - June 30, 2026)

HCPCS Code		FY-2025 Fee	Proposed FY-2026 Fee
36415	Insertion of needle into vein for collection of blood sample	$15.42	$15.90
36416	Puncture of skin for collection of blood sample	$6.00	$6.00
80053	Blood test, comprehensive group of blood chemicals	$19.00	$19.00
81002	Urinalysis, manual test	$6.26	$6.26
81025	Urine pregnancy test	$15.50	$15.50
86580	Tb intradermal test	$20.82	$21.56
86701	Analysis for antibody to HIV -1 virus	$16.00	$16.00
86780	Analysis for antibody, Treponema pallidum	$23.84	$23.84
87210	Smear for infectious agents	$10.48	$10.48
87491	Detection test by nucleic acid for chlamydia trachomatis, amplified probe technique	$63.16	$63.16
87591	Detection test by nucleic acid for Neisseria gonorrhoeae (gonorrhoeae bacteria), amplified probe technique	$63.16	$63.16
87661	Infectious agent detection by nucleic acid (dna or rna); trichomonas vaginalis, amplified probe technique	$63.16	$63.16
90471	Immunization admin	$41.63	$44.55
90472	Immunization admin each add	$29.55	$31.61
90480	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]) vaccine, single dose	$80.00	$80.00
90619	Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier	$229.44	$229.44
90620	Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B	$298.12	$298.12
90633	Hepatitis A vaccine pediatric or adolescent dosage	$50.30	$50.30

90651	Human Papillomavirus vaccine types 6, 11, 16, 18, 31, 33, 45, 52, 58, nonavalent	$433.62	$433.62
90661	Influenza vaccine, trivalent derived from cell cultures	$40.12	$40.12
90674	Influenza vaccine, quadrivalent derived from cell cultures, preservative and antibiotic free	$58.10	$61.50
90677	Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use	$510.70	$519.60
90696	Diphtheria, tetanus, acellular pertussis, and polio vaccine	$0.00	$0.00
90700	Diphtheria, tetanus, and acellular pertussis vaccine (younger than 7 years)	$35.16	$35.16
90707	Measles, mumps, and rubella vaccine	$140.38	$140.38
90710	Measles, mumps, rubella, and varicella vaccine	$199.26	$199.26
90713	Poliovirus vaccine	$53.04	$53.04
90715	Diphtheria, tetanus, and acellular pertussis vaccine (7 years or older)	$67.50	$68.94
90716	Varicella vaccine	$154.66	$154.66
90746	Hepatitis B vaccine, adult dosage (3 dose schedule)	$126.68	$126.68
90834	Psytx w pt 45 minutes	$89.00	$89.00
90837	Psytx w pt 60 minutes	$105.00	$105.00
91322	Severe acute respiratory syndrome coronavirus 2 (sarscov-2) (coronavirus disease [covid-19]) vaccine, mrnalnp, 50 mcg/0.5 ml dosage, for intramuscular use	$291.84	$262.66
96127	Brief emotional/behav assmt	$9.40	$10.06
96372	Ther/proph/diag inj sc/im	$28.87	$30.90
99203	Office o/p new low 30 min	$224.95	$242.13
99213	Office o/p est low 20 min	$183.32	$197.59
99214	Office o/p est mod 30 min	$258.53	$278.06
J1050	Injection, medroxyprogesterone acetate, 1 mg	$1.02	$1.02
S4993	Contraceptive pills for birth control	$13.22	$13.22

CDH FEE POLICY

DEFINITIONS

CPT – A uniform language for coding medical services and procedures to streamline reporting, increase accuracy and efficiency.

wRVU – For every patient examination or procedure performed, a certain amount of work RVUs is assigned to a CPT code, wRVUs are determined by looking at three components:

1. The work of the provider.
2. Expenses incurred by the practice.
3. The cost of malpractice insurance premiums.

POLICY

All fees for services performed in Central District Health's (CDH) clinic and clinic programs and environmental health programs are approved by the CDH Board of Health using the methodology described below. Changes to the fee setting methodology must be approved by the Board of Health (BOH). Fees will be reviewed annually at the May Board of Health meeting.

Family & Clinic Services Fees (FCS)

Procedure:
The methodology for determining fees billed for clinic services is as follows:

1. CDH will use the Non-Facility RVUs as provided by the Centers for Medicare & Medicaid services (CMS) to determine fees, understanding that CMS occasionally makes additions, deletions, and small changes in the RVUs. Most medical procedures or CPT codes have a set RVU.
2. In addition, CDH has established, the use of Blue Cross of Idaho's conversion factor as CDH's conversion factor. Fees are determined by multiplying the RVU by the conversion factor.
   (Conversion factor) x (RVU)
3. For procedures without an RVU, fees will be 200% of the current Medicaid allowable. When no Medicaid rates are available, allowable amounts from larger third-party payers are reviewed and are used to determine fees.
4. CDH will review the conversion factor every two years, and the review will occur in odd calendar years.
5. All FCS fees will be set using the above methodology; during the annual review, the top forty most frequently performed services will be presented to the Board for review.
6. CDH shall establish behavioral health services fees that are structured to remain affordable for patients with limited financial means.

Community & Environmental Health Fees (CEH)

Procedure:
The methodology for determining fees billed for environmental health services is as follows:

1. Fees set in rule or statute are set and CDH has no authority to determine or alter these fees.
2. Other environmental health fees are based on an hourly rate multiplied by the average number of hours to complete each service, as determined by CDH subject matter experts.
3. Hourly rates are determined by calculating the total cost of delivering the service (personnel, operating, indirect) and dividing it by the total number of hours charged to the project code.
4. The indirect rate is determined by calculating the average rate of the previous 10 fiscal years. This helps account for sharp fluctuations in indirect rate changes.
5. ServSafe class fees are determined by calculating the total cost of administering the class divided by the number of enrolled students over a fiscal year to determine a per student cost.
6. Consultation rate is determined by averaging the hourly rate of each unique service.
7. Because these fees for service are predictive, and do not account for inflation, or increases in staff pay that occur year over year, fees will not decrease year over year. (If there is a predicted drop in cost of greater than 10% for any singular fee, CDH will review that fee with the BOH and may adjust downward.)

Contact:	*District Director*
Original:	*08-17-23*
Reviewed/Revised:	*05-09-24;05-05-25;*
Procedure(s):	*None*
Appendix(ices):	*None*
Form(s):	*None*
Additional Reference(s):	*None*

CDH Fee Policy approved:

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Dr. Greg Ferch, Board Chair Date