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Attorneys for Defendants
THE REGENTS OF THE UNIVERSITY OF CALIFORNIA and MICHAEL V. DRAKE

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

AARON KHERIATY, M.D.,

Plaintiff,

v.

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA, a corporation, and MICHAEL V. DRAKE, in his official capacity as President of the UNIVERSITY OF CALIFORNIA,

Defendants.

Case No. 8:21-cv-01367-JVS-KES

DECLARATION OF ARTHUR L. REINGOLD, M.D. IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION

Date: September 27, 2021
Time: 1:30 P.M.
Place: Courtroom 10 C
Judge: Hon. James V. Selna

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Attorneys for Defendants
THE REGENTS OF THE UNIVERSITY OF CALIFORNIA AND MICHAEL V. DRAKE

I, Arthur L. Reingold, M.D., declare as follows:

1. I provide this declaration in support of Defendants The Regents of the University of California and President Michael V. Drake's ("Defendants") Opposition to Plaintiff's Motion for Preliminary Injunction. I base this declaration on my expertise as outlined below and facts within my personal knowledge, to which I could and would testify competently if called upon to do so.

2. I am the Division Head of Epidemiology at the University of California, Berkeley, School of Public Health. I have worked on the prevention and control of infectious diseases in the United States, including eight years at the U.S. Centers for Disease Control and Prevention (CDC), and with numerous developing countries around the world for over forty years. Since its inception in 1994, I have directed or co-directed the CDC-funded California Emerging Infections Program. I am a member of the Society for Epidemiologic Research and elected member of the American Epidemiological Society; an elected Fellow of the Infectious Disease Society of America and of the American Association for the Advancement of Science; and an elected member of the Institute of Medicine of the National Academy of Sciences. I was previously the President of both the Society for Epidemiologic Research and the American Epidemiological Society. I have served on the editorial boards of the following journals: American Journal of Epidemiology, Epidemiology, and Global Public Health, and currently serve as Associate Editor for the journal Vaccine.

3. I received my A.B. in biology from the University of Chicago in 1970, and my M.D. from the University of Chicago in 1976. Among other things, I completed a residency in internal medicine and a preventive medicine residency with the CDC. I retain an active medical license in California and board certification in internal medicine.

4. My career in public health has been in the area of infectious diseases and epidemiology. Following my positions at the CDC (1979-1987), I joined the

faculty of the School of Public Health at the University of California, Berkeley as a Professor of Epidemiology (1987-present), the faculty of the Department of Epidemiology and Biostatistics at the University of California, San Francisco (UCSF) (1989-2005), and as a Clinical Professor in the Department of Medicine at UCSF (1991-2005). From 1990-1994, I was the Head of the Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California, Berkeley; from 1994-2000, I was the Head of the Division of Public Health Biology and Epidemiology, University of California, Berkeley; from 2000 continuing through the present, I have been the Head of the Division of Epidemiology, School of Public Health, University of California, Berkeley.

5. My research focuses on emerging and re-emerging infections in the United States and in developing countries; respiratory infections and vaccine-preventable diseases in the United States and in developing countries; and disease surveillance, outbreak detection, and outbreak response. I have published almost 400 research articles on these topics, including multiple articles about Coronavirus Disease 2019 (COVID-19).

6. I have been and am currently involved in multiple research studies of SARS-CoV-2, the novel coronavirus that causes COVID-19 and of COVID-19. I am also serving on COVID-19 advisory groups for multiple organizations, including UC Berkeley, the University of California system, and the City and County of San Francisco, among others. In addition, as an elected member of the National Academy of Medicine, I have served on two committees related to COVID-19: the National Academies of Science, Engineering, and Medicine's Committee on Equitable Allocation of Vaccines for the Novel Coronavirus and the National Academies of Sciences, Engineering, and Medicine's Workshop on Airborne Transmission of SARS-CoV-2. I also currently chair the Western States Scientific Safety Review Workshop to review the safety and efficacy of all COVID-19 vaccines being introduced in the U.S.

7. Attached hereto as **Exhibit A** and incorporated by reference to this declaration is a copy of my curriculum vitae.

COVID-19 Pandemic and the SARS-CoV-2 Virus

8. The disease COVID-19 is caused by infection with the novel coronavirus, SARS-CoV-2. Chinese health officials reported the first cluster of cases of COVID-19 on December 31, 2019 in persons associated with a seafood and live animal market in the City of Wuhan, Hubei Province. On January 7, 2020, Chinese health officials confirmed the role of SARS-CoV-2 in these cases. The earliest date of onset of symptoms in the report from China was December 1, 2019. Studies of the SARS-CoV-2 virus show that it is closely related to coronaviruses found in bats and pangolins and that the first human infections likely occurred in November, 2019. While the consensus is that the initial human infection was the result of a "spillover event" (i.e., direct animal to human transmission), some experts believe it could have resulted from escape of the virus from a laboratory in Wuhan.

9. Whatever the original source of the SAR-CoV-2 virus, it is a novel coronavirus that is not known to have infected the human population before its emergence in China in the latter part of 2019. As a result, when the COVID-19 pandemic began, few, if any people anywhere in the world had either acquired or innate immunity to it – i.e., the entire population, including that of the U.S., was susceptible to infection with the SARS-CoV-2 virus.

10. SARS-CoV-2 is a single stranded RNA virus that is capable of mutating frequently. As a result of this process, multiple variants of the virus have developed in various geographic locations and spread widely, including what are classified as variants of interest and variants of concern. Currently, one of the variants of concern, the Delta variant, is responsible for a high proportion of SARS-CoV-2 infections in the U.S. and elsewhere. Evidence suggests that the Delta variant is more readily transmitted from person-to-person and also produces, on

average, more severe illness.

11. SARS-CoV-2 is spread from person-to-person via respiratory droplets, including small droplets sometimes referred to as aerosols. Human activities that can lead to transmission of the SARS-CoV-2 virus include coughing, sneezing, singing, and talking. Infection is often asymptomatic, and transmission of the virus can occur from individuals who are symptomatic and from individuals who do not have symptoms, including those who never go on to develop symptoms and those who subsequently do develop symptoms.

12. Among those infected with SARS-CoV-2, the elderly, especially the frail elderly, and those with a variety of immunosuppressive conditions are at greatest risk of severe illness, hospitalization, the need for mechanical ventilation, and death. However, severe illnesses and deaths due to COVID-19 can occur in individuals of all ages, including previously healthy individuals. Among children and adolescents, a severe illness called Multisystem Inflammatory Syndrome in Children (MISC) can result from COVID-19, as can a similar illness in adults, Multisystem Inflammatory Syndrome in Adults (MISA). In addition, many individuals with COVID-19, including those with mild cases, go on to have persistent sequelae, so-called long COVID or long-haul COVID, the frequency, duration, and severity of which remain to be characterized.

13. As of August 28, 2021, almost 216,000,000 COVID-19 cases and over 4,500,000 COVID-19 deaths have been reported worldwide, including almost 39,000,000 cases and over 637,000 deaths in the U.S.[1] These numbers of reported cases and reported deaths, however, are widely understood to substantially underestimate the numbers of SARS-CoV-2 infections and the numbers of COVID-

[1] For current numbers of reported COVID-19 cases and deaths worldwide, see The New York Times "Coronavirus World Map: Tracking the Global Outbreak," available at https://www.nytimes.com/interactive/2021/world/covid-cases.html. For current numbers of reported COVID-19 cases and deaths in the United States, see The New York Times "Coronavirus in the U.S.: Latest Map and Case Count," available at https://www.nytimes.com/interactive/2021/us/covid-cases.html.

19 cases and deaths, for a variety of reasons. The U.S. experienced a relatively small peak in COVID-19 cases, hospitalizations, and deaths in the summer of 2020 and a much larger peak in the 2020-2021 winter months. After the numbers of cases, hospitalizations, and deaths in the U.S. declined sharply in the spring and early summer, the numbers began to climb again in July, 2021, including in California , and many parts of the United States are currently experiencing sharp increases in infections, hospitalizations, and deaths. These trends over time undoubtedly reflect the influence of diverse factors (e.g., human behavior change, such as social distancing and use of masks and other facial coverings; introduction of COVID-19 vaccines; seasonal changes in temperature and humidity; and changes in the SARS-CoV-2 variants that predominate, among others), making it difficult to predict future trends, including in the fall of 2021, when many universities and colleges are resuming in-person instruction of millions of individuals. In the United States during the 2020-21 academic year, over 70 universities and colleges experienced outbreaks of >2,000 cases of COVID-19, including many large public universities.

14. Before the development, approval, and introduction of safe and effective COVID-19 vaccines, the only interventions available for reducing the spread of SARS-CoV-2 were so-called nonpharmaceutical interventions. Among these interventions were (and are) travel restrictions and bans; closures of schools, restaurants, bars, and other establishments; tele-working; use of masks and other facial coverings; screening in various settings of individuals for fever, other symptoms, possible exposures to others with COVID-19, or the presence of SARS-CoV-2 in the nose or throat; contact tracing and quarantine; improved hand hygiene; and decontamination of surfaces. Some of these interventions (e.g., decontamination of surfaces) most likely had no impact on the transmission of SARS-CoV-2, while for others (e.g., closing of restaurants and implementation of mask mandates), evidence suggests there was an impact. Where available,

improved indoor ventilation is also considered to be an effective means of reducing transmission of SARS-CoV-2 inside buildings. All of these non-pharmaceutical interventions combined, however, provide less than complete protection against transmission of SARS-CoV-2 in a population, especially when these interventions are imperfectly implemented, as is almost invariably the case in the "real world."

COVID-19 Vaccine Development and Efficacy

15. Development of vaccines against COVID-19 began in early 2020, soon after SARS-CoV-2 was determined to be the cause of the disease. Since that time, multiple COVID-19 vaccines have been developed and tested in the U.S., Europe, China, Russia, and elsewhere. Thus far, three COVID-19 vaccines have been granted Emergency Use Authorization (EUA) by the U.S. FDA, two using an RNA approach (Pfizer/BioNTech and Moderna) and one using an adenovirus vector approach (Janssen/Johnson & Johnson), similar to COVID-19 vaccines that have been developed, tested, and approved for use in other countries. The three COVID-19 vaccines currently approved for use in the U.S. received EUA approval on December 10, 2020 (Pfizer/BioNTech), December 17, 2020 (Moderna) and January 27, 2021 (Janssen/Johnson & Johnson), respectively.[2] The mRNA COVID-19 vaccine made by Pfizer/BioNTech received full approval by the FDA on August 23, 2021.[3] All three vaccines were shown in large phase 3 trials to be highly efficacious against COVID-19 disease, particularly against COVID-19-related hospitalization and death. Since the granting of EUA status by FDA and the development of guidelines for their use by the Advisory Committee on Immunization Practices (ACIP), over 369,000,000 doses of the three vaccines had been administered in the U.S. as of August 30, 2021, with 74.1% of the U.S.

[2] FDA, COVID-19 Vaccines, available at https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/covid-19-vaccines.

[3] FDA, Comirnaty and Pfizer-BioNTech COVID-19 Vaccine, available at https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/comirnaty-and-pfizer-biontech-covid-19-vaccine.

population ≥ 18 years of age having received at least one dose.[4] Post-approval observational studies have demonstrated that the COVID-19 vaccines have a very high level of effectiveness in preventing severe illnesses, hospitalizations, and deaths from COVID-19, including cases caused by the Delta variant of SARS-CoV-2.[5] While "breakthrough" SARS-CoV-2 infections do occur among partially and fully vaccinated individuals, they are typically associated with mild illness or no symptoms, and vaccinated individuals are less likely to transmit COVID-19 compared to those who are not vaccinated.[6] As of July 31, 2021, ~97% of all hospitalizations for COVID-19 in the U.S. were among unvaccinated individuals.[7]

COVID-19 Vaccine Safety

16. In the clinical trials that led to granting of EUA status to the three COVID-19 vaccines being used in the U.S. currently, reactogenicity and various side effects were carefully monitored in the days and weeks following receipt of the various vaccines. The side effects observed (e.g., injection site pain, malaise, headache), while more common in recipients of the COVID-19 vaccines than in placebo recipients, were comparable to those seen following receipt of other vaccines commonly given to adults (e.g., vaccines against influenza, Herpes Zoster

[4] CDC, COVID Data Tracker, COVID-19 Vaccination in the United States, available at https://covid.cdc.gov/covid-data-tracker/#vaccinations_vacc-total-admin-rate-pop18.
[5] International Vaccine Access Center, Johns Hopkins Bloomberg School of Public Health and World Health Organization, "Results of COVID-19 Vaccine Effectiveness Studies: An Ongoing Systematic Review," available at https://view-hub.org/sites/default/files/2021-07/COVID%2019%20VE%20Team%20Literature%20Review%20-%20Summary%20Table.pdf; FP Polack, et al. "Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine" N Engl J Med, Vol. 383, pp. 2603-2615 (efficacy of Pfizer/BioNTech vaccine), available at https://www.nejm.org/doi/full/10.1056/nejmoa2034577; LR Baden, et al., "Efficacy and Safety of the mRNA-1273 SARS-CoV-2 Vaccine" N Engl J Med, Vol. 384, pp. 403-416 (efficacy of Moderna vaccine), available at https://www.nejm.org/doi/full/10.1056/nejmoa2035389; J Sadoff, et al., "Safety and Efficacy of Single-Dose Ad26.COV2.S Vaccine against Covid-19" N Engl J Med, Vol. 384, pp. 2187-2201 (efficacy of Janssen/Johnson & Johnson vaccine), available at https://www.nejm.org/doi/full/10.1056/NEJMoa2101544.
[6] See RJ Harris, et al., "Effect of Vaccination on Household Transmission of SARS-CoV-2 in England" N Engl J Med, Letter to the Editor, Jun. 23, 2021, available at https://www.nejm.org/doi/full/10.1056/NEJMc2107717.
[7] White House, Press Briefing by White House COVID-19 Response Team and Public Health Officials, July 16, 2021, available at https://www.whitehouse.gov/briefing-room/press-briefings/2021/07/16/press-briefing-by-white-house-covid-19-response-team-and-public-health-officials-45/.

and S. pneumoniae), and were generally mild and self-limited, resolving within two to three days.[8]

17. As the three COVID-19 vaccines were introduced in the U.S., multiple systems were employed to monitor reported adverse events following immunization, including both existing and new surveillance systems. One important component of the U.S. system for monitoring and evaluating the safety of vaccines is the Vaccine Adverse Event Reporting System (VAERS), which is a collaborative effort of the FDA and the CDC.[9] This system is designed to make it easy for vaccine recipients, family members, healthcare providers, and others to report any condition or event observed at any time point following the administration of a vaccine. The system, which is passive in nature, is intended to help detect "signals" – that is, events or conditions that might be related to the receipt of a vaccine. However, the report of an illness or death in the days, weeks, months, or years following the receipt of a vaccine does not and cannot establish a causal connection between receipt of that vaccine and the illness or death reported.[10] Rather, such reports can help generate hypotheses concerning such relationships, which must then be tested using appropriate epidemiological and biostatistical studies and methods.

18. To date, data from these various systems suggest that the three COVID-19 vaccines are very safe and that their benefits far outweigh any risks associated with receipt of the vaccines. As expected, and as seen with other vaccines and medications, there is a very small risk of a severe allergic reaction (i.e., anaphylaxis) in the 15 to 30 minutes following receipt of a dose of a COVID-19 vaccine; such reactions can be reversed with appropriate medical care and are the reason vaccines should be administered at a facility equipped to promptly

[8] CDC, Possible Side Effects, available at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/expect/after.html.
[9] CDC, Vaccine Adverse Event Reporting System (VAERS), available at https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html.
[10] *Id*. ("VAERS data alone cannot determine if the vaccine caused the reported adverse event.")

recognize and treat such reactions.

19. In addition, three very rare side effects have been noted in small numbers of recipients of the COVID-19 vaccines being used in the U.S., including cases of Guillain-Barré Syndrome (GBS) and cases of Thrombosis with Thrombocytopenia Syndrome (TTS) in recipients of the Janssen/Johnson & Johnson COVID-19 vaccine and cases of myocarditis in recipients of the two mRNA COVID-19 vaccines. Based on analyses presented by CDC experts to the ACIP at its meetings on July 22, 2021 and August 30, 2021, even taking these rare adverse events following receipt of COVID-19 vaccines into account, the benefits of COVID-19 vaccination with regard to illnesses, hospitalizations, and deaths prevented far outweigh any known risks, both in men and in women and across all adult age groups, including those 18 – 29 years of age.[11]

Use of COVID-19 Vaccines in Individuals with a Prior History of COVID-19 Illness or with Detectable SARS-CoV-2 Antibodies

20. Individuals described as having been "infected before" with SARS-CoV-2 (or COVID-19) comprise a heterogeneous group, whose level of immunity to subsequent SARS-CoV-2 infection and COVID-19 illness is equally heterogeneous. Included in this heterogeneous group might be: 1) individuals with a history of a clinical illness they or their healthcare provider believe to have been COVID-19, with no laboratory evidence that the illness was COVID-19; 2) individuals with a prior illness that is clinically compatible with COVID-19 and a contemporaneous laboratory test (e.g., PCR or antigen detection) positive for SARS-CoV-2; 3) individuals with no signs or symptoms of COVID-19 who, for whatever reason, underwent testing for SARS-CoV-2 and whose test was reported as positive; and 4) individuals with a positive result on a serological (i.e., antibody)

[11] ACIP Presentation Slides, H Rosenblum, "COVID-19 vaccines: benefits-risk discussion," (July 22, 2021), available at https://www.cdc.gov/vaccines/acip/meetings/slides-2021-07-22.html; ACIP Presentation Slides, H. Rosenblum, "Benefit-risk discussion for use of Pfizer-BioNTech COVID-19 vaccine in individuals >16 years of age (August 30, 2021), available at https://www.cdc.gov/vaccines/acip/meetings/slides-2021-08-30.html.

test, with or without a history in the past of a clinically compatible illness. To consider all such individuals as protected against future SARS-CoV-2 infection and, therefore, not in need of COVID-19 vaccination, is neither reasonable nor scientifically sound.

21. While individuals who have had a documented case of COVID-19 typically have antibodies to the SARS-CoV-2 virus detectable in their blood and are believed to have a reduced risk of getting COVID-19 again in the months that follow, neither the completeness nor the durability of protection against a second case of COVID-19 has been established. The extent to which any such immunity resulting from having had COVID-19 provides protection against new variants of SARS-CoV-2 is also unknown. Because available evidence suggests that the risk of a second episode of COVID-19 is extremely low in the 90 days following a first episode, current recommendations advise waiting for that period of time before administering COVID-19 vaccine to someone who has had COVID-19.

22. While many SARS-CoV-2 antibody tests have been authorized by the FDA, none of these tests is currently considered to provide a reliable indication of a person's level of immunity to or protection from COVID-19 in the future. Both the FDA and the CDC specifically caution against using the results of SARS-CoV-2 antibody tests to guide decisions about administration of COVID-19 vaccines. On its website, the FDA states that "…results from currently authorized SARS-CoV-2 antibody tests should not be used to evaluate a person's level of immunity or protection from COVID-19 at any time…..,"[12] while on its website, the CDC advises that "Antibody testing is NOT currently recommended to assess the need for vaccination in an unvaccinated person."[13]

[12] FDA, Antibody Testing Is Not Currently Recommended to Assess Immunity After COVID-19 Vaccination: FDA Safety Communication (May 19, 2021), available at https://www.fda.gov/medical-devices/safety-communications/antibody-testing-not-currently-recommended-assess-immunity-after-covid-19-vaccination-fda-safety.

[13] CDC, COVID-19, Antibody Testing Interim Guidelines, available at https://www.cdc.gov/coronavirus/2019-ncov/lab/resources/antibody-tests-guidelines.html.

23. Furthermore, studies suggest that administration of the COVID-19 vaccine provides enhanced neutralization of some circulating variants of SARS-CoV-2, compared with that induced by natural infection, as measured by in vitro (i.e., laboratory) studies.[14] In addition, a recently published study from Kentucky has demonstrated that among individuals who have recovered from a documented SARS-CoV-2 infection, receipt of a COVID-19 vaccine is associated with a significantly reduced risk of re-infection; in that study, those who remained unvaccinated had 2.34 times the odds of re-infection with SARS-CoV-2, compared to those who were vaccinated.[15]

24. With regard to the safety of administering COVID-19 vaccine to individuals with antibodies to SARS-CoV-2, while the available evidence suggests that such individuals may have a modestly increased incidence of some side effects in the first few days following receipt of a COVID-19 vaccine, the side effects in question (e.g., injection site pain and tenderness and fatigue) are ones that are self-limited and that improve with little or no treatment within a day or two. There is no evidence to suggest that rare side effects referred to above in paragraph 19 occur more often in individuals with either a history of prior COVID-19 or detectable antibodies to SARS-CoV-2. Furthermore, there is no evidence that administration of other commonly used vaccines (e.g., measles, hepatitis A and B, and human papilloma virus, etc.) to individuals with antibodies to those infectious agents is associated with an increased risk of serious adverse events or is otherwise unsafe.

Support for UC's COVID-19 Vaccine Policy

25. All of the available evidence strongly suggests that SARS-CoV-2, the virus that causes COVID-19, will continue to circulate and cause infections, illnesses, hospitalizations, and deaths globally, throughout the U.S., and in every

[14] Stamatatos L, Czartoski J, Wan YH, et al., mRNA vaccination boosts cross-variant neutralizing antibodies elicited by SARS-CoV-2 infection. Science. Epub March 27, 2021.
[15] Cavanaugh AM, Spicer KB, Thoroughman D, Glick C and Winter K, Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination-Kentucky. May-June 2021, MMWR 70(32); pages 1081-83; August 13, 2021.

county in California for the foreseeable future, including the highly transmissible Delta variant. It is also likely that new variants of SARS-CoV-2 will arise as a result of mutation of the virus, with unpredictable consequences. As university and college campuses re-open to in-person activities, the opportunities for transmission of SARS-CoV-2 will increase substantially, both on the campuses and in surrounding communities. Evidence from the 2020-21 academic year demonstrates that university and college campuses are highly unlikely to be able to prevent or control outbreaks of COVID-19 solely through the application of non-pharmaceutical interventions.[16] Available COVID-19 vaccines have an excellent safety and efficacy profile, and the benefits of COVID-19 vaccination far outweigh any known risks. COVID-19 vaccination of all students, faculty, and staff without a valid contra-indication or exemption is the single most effective intervention available to prevent cases and outbreaks of COVID-19, both among those who are vaccinated and those who cannot be vaccinated.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 1st day of September 2021 at Berkeley, CA

Arthur L. Reingold, M.D.

[16] B Romain, et al., "Prevalence of COVID-19 in adolescents and youth compared with older adults in states experiencing surges" PLoS One, 2021 March 10 (finding that prevalence of COVID-19 for adolescents and for youth was significantly greater than for older adults), available at https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0242587.

EXHIBIT A

June, 2021

CURRICULUM VITAE
Arthur Lawrence Reingold

PRESENT POSITION:	Professor of Epidemiology Division Head, Epidemiology School of Public Health University of California, Berkeley		
EDUCATION:	1966 - 70	A.B.	University of Chicago
	1970 - 76	M.D.	University of Chicago
POSTGRADUATE TRAINING:	1976 - 78	Internal Medicine Resident, Mount Auburn Hospital Cambridge, Massachusetts	
	1980 - 82	Preventive Medicine Resident, Centers for Disease Control (CDC) - Atlanta, Georgia	
POSITIONS HELD:	1979 - 80	Epidemic Intelligence Service Officer, State of Connecticut - Department of Health Services Hartford, Connecticut	
	1980 - 81	Epidemic Intelligence Service Officer, Special Pathogens Branch - Bacterial Diseases Division Centers for Disease Control (CDC) - Atlanta, Georgia	
	1981 - 85	Assistant Chief, Respiratory & Special Pathogens Epidemiology Branch, Center for Infectious Diseases Centers for Disease Control (CDC) - Atlanta, Georgia	
	1985 - 87	CDC Liaison Officer, Office of the Director Centers for Disease Control - Atlanta, Georgia	
FACULTY APPOINTMENTS:	1979 - 80	Instructor, Department of Medicine (Epidemiology) University of Connecticut - Hartford, Connecticut	
	1985 - 87	Visiting Lecturer, Department of Biomedical and Environmental Health Sciences (Epidemiology) University of California, Berkeley	
	1987 -	Professor of Epidemiology, School of Public Health, University of California, Berkeley	
	1989 - 2014	Professor, Department of Epidemiology and Biostatistics - University of California, San Francisco	

Arthur Lawrence Reingold

FACULTY APPOINTMENTS (CONTINUED)	1990 - 94	Head, Epidemiology Program, Department of Biomedical and Environmental Health Sciences, University of California, Berkeley
	1991 -	Clinical Professor, Department of Medicine University of California, San Francisco
	1994 - 2000	Head, Division of Public Health Biology and Epidemiology University of California, Berkeley
	2008 - 2014	Associate Dean for Research, School of Public Health, University of California, Berkeley
	2009 - 2014	Edward Penhoet Distinguished Chair for Global Health and Infectious Disease
	2000 - 2018	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley
	2018 - 2020	Head, Division of Epidemiology & Biostatistics, School of Public Health University of California, Berkeley
	2020 -	Head, Division of Epidemiology, School of Public Health, University of California, Berkeley

MEDICAL LICENSURE:		California
BOARD CERTIFICATION:	1980	American Board of Internal Medicine
AWARDS:	1970 - 74	Medical Scientist Training Program
	1985	Commendation Medal, U.S. Public Health Service
	1986	Charles Shepard Award, Centers for Disease Control (CDC)
MEMBERSHIPS:	1970	Sigma Xi
	1978	American College of Physicians
	1983	American Society for Microbiology
	1984	Society for Epidemiologic Research
	1986	Infectious Disease Society of America (Fellow)
	1988	American Epidemiological Society
	1991	American College of Epidemiology (Fellow)
	1994	AAAS (Fellow)
	2003	Institute of Medicine, National Academy of Medicine (Member)

PROFESSIONAL ACTIVITIES

SELECTED CONSULTATIONS:	1981	Institute of Medicine: Toxic-shock syndrome
	1981	Food and Drug Administration: Toxic-shock syndrome
	1982	United States Agency for International Development: Control of meningococcal meningitis in West Africa

CONSULTATIONS (CONTINUED)	1983	World Health Organization (WHO): Control of meningococcal meningitis in Nepal
	1983	East-West Center, University of Hawaii: Role of indoor air pollution in acute respiratory infections in developing countries
	1984	Institute of Medicine: Meningococcal vaccines
	1986	World Health Organization (WHO): Control of meningococcal meningitis in South Asia
	1987 - 1993	Center for Child Survival, University of Indonesia: Control of Acute Respiratory Infections
	1988	Evaluation of the Combating Communicable Childhood Disease Program, Ivory Coast
	1994	Evaluation of National Epidemiology Board Program, Rockefeller Foundation
	1995	Planning of a School-based Acute Rheumatic Fever Prevention Project - New Zealand Heart Foundation
	1995	Vaccines Advisory Committee, Food & Drug Administration Approval of accellular pertussis vaccine
	1996	External Reviewer, NIAID Group B Streptococcus Research Contract with Harvard University
	1996 - 2000	U.S. Food and Drug Administration; Consultant to the Vaccines Advisory Committee
	1996	World Health Organization, Consultation on Control of Meningococcal Meningitis in Africa
	1998 – 2002	Advisor to the INCLEN "Indiaclen" project
	2002 – 2003	Evaluation of a School-based Acute Rheumatic Fever Prevention Project – New Zealand Heart Association
SELECTED ADVISORY BOARDS AND PANELS:	1988 - 1989	Member, Advisory Committee on Ground Water and Reproductive Outcomes, State of California Department of Health Services
	1989 - 1990	AIDS Advisory Committee, Alameda County Board of Supervisors
	1989 - 1993	Advisory Committee, Birth Defects Monitoring Program, State of California Department of Health Services
	1993 - 1995	Centers for Disease Control (CDC): Public Health Service Advisory Panel on the Case Definition for Lyme Disease
	1992 - 1994	World Health Organization (WHO): Task Force on Strengthening Epidemiologic Capacity; Childhood Vaccine Initiative
	1996 - 2000	Armed Forces Epidemiological Board

Arthur Lawrence Reingold

ADVISORY BOARDS AND PANELS (CONTINUED)

1997 - 2012	University of California, San Francisco AIDS Research Institute Steering Committee
1998 - 2003	Emerging Infections Committee of the Infectious Diseases Society of America
1998 – 2000	Panelist, Howard Hughes Medical Institute Predoctoral Fellowship
2001 - 2006	Technical expert, Sub-Committee on the Protection of Public Health; California State Strategic Committee on Terrorism
2003 - 2008	Advisory Board, Chinese University of Hong Kong – Centre for Emerging AND Infectious Diseases
2004 -	Advisory Board, University of California, Berkeley Clinical Research Center
2004 - 2008	Advisory Board, New York University School of Medicine Fellowship in Medicine and Public Health Research
2004 - 2005	Institute of Medicine Committee on Measures to Enhance the Effectiveness of CDC Quarantine Station Plan for U.S. Ports of Entry
2005 - 2012	Strategic Advisory Group of Experts (SAGE) for Vaccine Policy, World Health Organization (WHO) (Deputy Chairman, 2010-2012)
2005 -	Data and Safety Monitoring Committee; F.I. Proctor Foundation, University of California, San Francisco (UCSF)
2007 - 2012	NIH Fogarty International Center External Advisory Board
2007 - 2009	Chair, Working Group on Pneumococcal Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
2008 - 2012	Working Group on H5N1 Influenza Vaccines, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
2008 - 2011	Chair, Leptospirosis Burden Epidemiology Reference Group, World Health Organization (WHO)
2008 - 2012	National Biosurveillance Advisory Subcommittee of the Advisory Committee to The Director, Centers for Disease Control and Prevention (CDC)
2008 - 2009	Institute of Medicine Committee on the Review of Priorities in the National Vaccine Plan
2009 - 2012	Chair, Working Group on Hepatitis A Vaccine, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
2011 - 2013	Member, Institute of Medicine Committee on Vaccine Priorities
2011 - 2014	Member, Working Group on Vaccine Hesitancy, Strategic Advisory Group of Experts (SAGE), World Health Organization (WHO)
2012 - 2014	Chair, Review of the Heterologous Effects of Childhood Vaccines, World Health Organization (WHO)
2012 - 2014	Chair, External Review of the Measles Rubella Initiative (of WHO, CDC, UNICEF, American Red Cross, and United Nations Foundation)

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ADVISORY BOARDS AND PANELS (CONTINUED)

2013 - 2018	Advisory Committee on Immunization Practices (ACIP), U.S. Department of Health and Human Services
2016 - 2017	Member, Institute of Medicine Committee on a National Strategy for the Elimination of Hepatitis B and C
2018 - 2019	Member, Independent Review Committee, Global Alliance for Vaccines and Immunizations (GAVI)
2018 -	Member, Strategic Advisory Group, Partnership for Influenza Vaccination Introduction
2020	Member, Organizing Committee, National Academics of Science, Engineering, and Medicine (NASEM) Workshop on Airborne Transmission of SARS-CoV-2
2020	Member, National Academies of Science, Engineering, and Medicine (NASEM) Committee on Equitable Allocation of Vaccines for the Novel Coronavirus
2020 -	Chair, Western States Scientific Safety Review Workgroup on COVID-19 Vaccines

LEADERSHIP POSITIONS:

1997 - 2012	Secretary-Treasurer, American Epidemiological Society
2009 - 2010	President, Society for Epidemiologic Research
2015 – 2016	President, American Epidemiological Society (AES)

EDITORIAL BOARDS:

1995 - 2000	Board of Editors, American Journal of Epidemiology
2001 - 2005	Board of Editors, Epidemiology
2005 -	Editorial Advisory Board, Global Public Health
2009 - 2010	Editorial Advisory Board, American Journal of Epidemiology

ASSOCIATE EDITORSHIPS:

2017 - 2019	Current Epidemiology Reports
2018 -	Vaccine

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PUBLICATIONS:

1. Hayes RV, Pottenger LA, Reingold AL, Getz GS, Wissler RW. Degradation of I^{125} - labeled serum low density lipoprotein in normal and estrogen-treated male rats. Biochem Biophys Res Comm 1971;44:1471-1477.

2. Reingold AL, Kane MA, Murphy BL, Checko P, Francis DP, Maynard JE. Transmission of hepatitis B by an oral surgeon. J Infect Dis 1982;145:262-268.

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4. Bartlett P, Reingold AL, Graham DR, et al. Toxic-shock syndrome associated with surgical wound infections. JAMA 1982;247:1448-1450.

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