Attending Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated this \_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2021

**NOTICE OF LIABILITY**

To:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_do not consent to myself or my recently born offspring in receiving any COVID-19 testing, or being injected with the COVID-19 Vaccine, any experimental medical procedures or treatments, any medication or injected with any vaccines without my known written consent.

I do not authorize any man or woman to unlawfully take possession or deprive me of my constitutionally protected rights or any of those of my biological property , without due process of law. Those that knowingly and willingly violate this contract and my rights shall be held accountable to the fullest extent the law shall allow. Upon such actions whereas my rights are violated, or my wishes and demands are not adhered to, you are given full notice of the liabilities for which I shall seek immediate remedy by contacting the County Sheriff followed by filing criminal and civil charges of kidnap and unlawful trespass on my rights and that of my recently born offspring in a court of proper jurisdiction for which I shall be indemnified.

It is my duty to remind you of the very first principle of the Nuremberg Code: The voluntary consent of the human subject is essential. The 4th principle states that the experiment should be so conducted as to avoid all necessary physical and mental suffering and injury. The 5th principle clearly states that no experiment should be conducted where there is a reason to believe that death or injury shall occur.

All physicians take the Hippocratic Oath and within that oath is “first, do no harm”. It specifies the principles of beneficence and non-maleficence and the rule of confidentiality.

I am fortifying your written reassurance that you acknowledge that my full written consent is required for myself or my recently born offspring to receive any COVID-19 testing, or being injected with the COVID-19 Vaccine, any experimental medical procedures, any medication or injected with any vaccines.

Hereby let it be known that you shall be held personally and professionally liable for participating in any unlawful or illegal criminal activity and or for supporting crimes against humanity. You are hereby noticed and are fully aware of this legal and lawful binding contract which allows no escape clause when you knowingly and willingly violate this contract and your commitment to humanity.

Refusing to sign this contract demonstrates a complicit consent to engage in mass child abuse, in genocide of our youth and crimes against humanity which you shall be held liable both professionally and privately. Upon refusing to sign this contract shall result in your complicit agreement until the time which you shall supply verified lawful documentation that states the contrary.

**AGREED WRITTEN AND ACKNOWLEDGED POSITION**

Signed (**Mother**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed **(Father**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed (**Hospital Administrator**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed (**Attending Physician**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed (**Attending Physician**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_