Citywide Administrative Services

Dawn M. Pinnock
Commissioner

Civil Service and Labor Committee Hearing: Pay Equity in the Municipal Workforce

Introduction

Good afternoon, Chair De La Rosa and members of the committee on Civil Service and Labor and committee on Civil and Human Rights. I am Barbara Dannenberg, Deputy Commissioner for Human Capital at the Department of Citywide Administrative Services (DCAS.) I am joined today by my colleagues Silvia Montalban, DCAS's Chief Citywide Equity and Inclusion (CEI) Officer, Jeanne Victor, Executive Director of the Equal Employment Practices Commission, and Daniel Pollak, First Deputy Commissioner of the Office of Labor Relations (OLR).

Thank you for the opportunity to meet with you all and delve into the work we are doing to enhance pay equity within the municipal workforce.

In city government, it's our responsibility to ensure everyone has equitable access to opportunities. That includes fair compensation regardless of their sex, age, religion, disability, race, sexual orientation, and/or any other protected classification.

Among our agency's core values is our commitment to equity by way of providing services that help city government uplift and empower all New Yorkers. To achieve this goal, DCAS established the office of Citywide Equity and Inclusion, known as CEI, helmed by my colleague Silvia Montalban. Together, CEI and Human Capital collaborate and provide guidance to agency Equal Employment Opportunity (EEO) officers and Agency Personnel Officers (APOs) to improve service delivery, increase compliance with EEO and civil service policies, and increase access to employment and promotion opportunities. This work is central to our identity as an agency and to the advancement of our city.

In 2020, the City Council published its first report on pay equity. The report's findings revealed that when looking at gender, the adjusted pay gap is relatively small, with female employees earning 0.4% less than male counterparts. Similarly, when examining race and ethnicity, people of color make less than white employees, but the gap is progressively closing. In fact, Black employees earn $0.986 on the dollar compared to white employees; Hispanic or Latine employees earn $0.989 on the dollar compared to white employees; and Asian employees earn $0.993 on the dollar compared to white employees. New York City is faring better than the national average

Our strongest tool to combat pay inequity, is rooted in the continued reliance of our civil service system where together with salaries set through collective bargaining, we ensure that employees in the same title are treated equitably. This work happens in

close collaboration with the Office of Labor Relations as they represent the City in collective bargaining negotiations with municipal unions and work to reach agreements that are acceptable to both the City and unions and their members.

In addition to pay equity, we are also addressing occupational segregation to enhance diverse recruitment in titles and EEO job categories that are highly paid but predominantly white and/or male. Over the past years, DCAS has developed a multi-pronged approach towards addressing these disparities.

Please allow me to thank you all for your time and for your commitment to increasing pay equity. We recognize that there are opportunities for improvement and to combat occupational segregation and look forward to working closely with the City Council to accomplish these goals. Thanks again, and at this time I am happy to answer any questions.

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Introduction

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Thank you for the opportunity to meet with you all and delve into the work we are doing to enhance pay equity within the municipal workforce.

I've spent more than 20 years serving in city government, and throughout that time I've witnessed firsthand why equity matters, why access matters, and why the work we do in supporting City agencies to recruit, hire, and retain world-class talent is so critical. Equity is the civil service process in action; it's removing barriers to career pathways and developing an individualized approach rooted in fairness for every candidate. Equity is about building a workforce as diverse as the city we serve and doing so with the intention of maximizing access and providing opportunities for all New Yorkers.

As a woman and a civil servant, I am especially keyed into the sensitivities of the pay equity gap. Despite this harsh reality, I would be remiss not to acknowledge the vital role that civil service has played in ensuring fairness and equity, and the effort DCAS and the City has put into closing the gap and ensuring that when we level the playing field we are doing so with all players in mind. In city government, it's our responsibility to ensure everyone has equitable access to opportunities. That includes fair compensation regardless of their sex, age, religion, disability, race, sexual orientation, and/or any other protected classification.

Among our agency's core values is our commitment to equity by way of providing services that help city government uplift and empower all New Yorkers. To achieve this goal, DCAS established the office of Citywide Equity and Inclusion, known as CEI, helmed by my colleague Silvia Montalban. Together, CEI and Human Capital collaborate and provide guidance to agency Equal Employment Opportunity (EEO) officers and Agency Personnel Officers (APOs) to improve service delivery, increase compliance with EEO and civil service policies, and increase access to employment and promotion opportunities. This work is central to our identity as an agency and to the advancement of our city.

DCAS guides and encourages cross-collaboration between EEO Officers and Agency Personnel Officers across over 80 City agencies (mayoral and non-mayoral) on application of the citywide EEO policy, related laws, executive orders, processes, initiatives and best practices designed to prevent workplace discrimination. In order to promote equitable workplace practices, DCAS has undertaken many initiatives, including but not limited to:

a) Updating and releasing in 2021 the citywide EEO policy (which includes 23 protected status categories)
b) Maintaining frequent engagement with agencies by hosting best practice meetings
c) Implementing mandates and local laws into large scale initiatives, such as launching the Citywide Workplace Climate Survey (Local Law 101) to gauge awareness of EEO rights and resources and to inform future diversity, equity and inclusion (DEI) initiatives, trainings, and programs.

Pay Equity

In 2020, the City Council published its first report on pay equity. The report's findings revealed that when looking at gender, the adjusted pay gap is relatively small, with female employees earning 0.4% less than male counterparts. Similarly, when examining race and ethnicity, people of color make less than white employees, but the gap is progressively closing. In fact, Black employees earn $0.986 on the dollar compared to white employees; Hispanic or Latine employees earn $0.989 on the dollar compared to white employees; and Asian employees earn $0.993 on the dollar compared to white employees. New York City is faring better than the national average. According to the U.S. Bureau of Labor Statistics, the median weekly earning of a white man is $1,161 compared to weekly median earnings of $885 for Black and men and women, and $812 for Hispanic or Latine men and women.

Our strongest tool to combat pay inequity, is rooted in the continued reliance of our civil service system where together with salaries set through collective bargaining, we ensure that employees in the same title are treated equitably. This work happens in close collaboration with the Office of Labor Relations as they represent the City in collective bargaining negotiations with municipal unions and work to reach agreements that are acceptable to both the City and unions and their members.

In addition to pay equity, we are also addressing occupational segregation to enhance diverse recruitment in titles and EEO job categories that are highly paid but predominantly white and/or male. Over the past years, DCAS has developed a multi-pronged approach towards addressing these disparities. I would now like to share some of DCAS's efforts since the introduction of Local Law 18 of 2019.

Pay Equity Cabinet

In November 2020, in response to the New York City Council's Pay Equity in NYC report findings, the City's Taskforce on Racial Inclusion and Equity (TRIE) and the Commission on Gender Equity (CGE) established a pay equity workgroup. This group, led by DCAS, was tasked with providing recommendations that help address the gender and racial pay disparity within the City's workforce. One of the main recommendations by the workgroup was the

creation of a permanent Pay Equity Cabinet to build a sustainable pay equity structure for the City.

In October 2021, the Pay Equity Cabinet was formally established to address race and gender-based pay disparities in New York City by Executive Order 84. Established with senior leadership support at the Deputy Mayor level and key oversight agencies, including DCAS, TRIE and CGE, the Pay Equity Cabinet uses the intersections of gender, race, and tenure to address the factors contributing to pay inequity across the City and make recommendations for immediate and long-term strategies to tackle wage disparity.

The Pay Equity Cabinet collaborates with DCAS in the development and implementation of pay, employment, and retention plans to address inequities. The Commissioner of DCAS, Dawn M. Pinnock, serves as co-chair.

Under the Adams administration, we have an opportunity to reassess the effectiveness of the pay equity cabinet and implement new strategies to help close the gap.

Anti-Discrimination Statement

On March 29, 2022, DCAS issued an updated employer diversity statement citywide. It was revamped to reaffirm the City's commitment to diversity, equity, and inclusivity. The prior EEO statement read: *"The City of New York is an Equal Opportunity Employer."* The new employer diversity statement expounds on what that means and entails: "*The City of New York is an inclusive equal opportunity employer committed to recruiting and retaining a diverse workforce and providing a work environment that is free from discrimination and harassment based upon any legally protected status or protected characteristic, including but not limited to an individual's sex, race, color, ethnicity, national origin, age, religion, disability, sexual orientation, veteran status, gender identity, or pregnancy."*

The updated statement reinforces the City's non-discrimination protections and provides standard language that will be used consistently across all City agencies on job postings and on internal and external agency websites. DCAS has automatically added the updated language to all job postings on the City's career page at nyc.gov/jobs.

Compliance with EO21

Executive Order 21 (EO21) removes the reliance of pay history in the calculation of salary offers to applicants and is intended to promote pay equity by limiting the impact of pay disparities. One impact of EO21 is that agencies no longer make salary offers as a fixed percentage of an applicant's previous salary. Agencies were required to remove all references to salary or fixed percentages from employment documents. This EO removes a barrier to advancement for employees who may have entered the workforce at a relatively lower salary and ensures their career progression is no longer limited by their previous position, but rather on the value of the role to which they are appointed. In an ongoing effort to reinforce the changes introduced in EO21, DCAS sent agencies a reminder of their obligation under EO21 most recently on July 18, 2022. We also

work with the Office of Management and Budget as they review and approve personnel action requests that comply with EO21.

Local Law 14 of 2019 Report

DCAS contributed to other Citywide assessments on equity through the Local Law 14 of 2019 (LL14) report. LL14 amended the New York City Charter to require DCAS to review and report annually the activities of DCAS and City agencies, "to provide fair and effective affirmative employment practices to ensure equal employment opportunity (EEO) for minority group members and women who are employed by, or who seek employment with, City agencies." It also requires DCAS to provide an analysis of the applicants for City employment, except where a civil service exam was the basis of the appointment. This report concentrates on aggregated citywide data and information, including programs and initiatives that illustrate the work that City agencies have undertaken to enhance equity in recruitment, hiring, and creating a diverse and inclusive workplace. DCAS produced two such reports, the 2020 report, published in October 2021, and the 2021 report, published in December 2021. The report indicated that minority groups' promotions cumulatively exceed promotion of self-identified white employees in each job category, except for Officials and administrator where it was equal. Additionally, in general, representation of minorities is increasing throughout the workforce, as evidenced by the fact that minority groups cumulatively have a higher representation than self-identified white new hires in all, but one EEO-4 job category.

Workforce Data

One of the key components to examining trends and developing new strategies to close the pay equity gap is data. DCAS collects demographic information during the application, onboarding, and employee background investigation processes. These data points are used in compliance reports, the annual Workforce Profile Report, and in ad hoc reports.

DCAS prepares the federally mandated bi-annual EEO-4 report, which is mandated from all state and local governments with 100 or more employees by Title VII of the Civil Rights Act of 1964, as amended. The report provides a summary of a jurisdiction's workforce composition by agency function, job category, salary, race/ethnicity, and gender. The City's 2021 report submitted in January 2022 shows– among other things – that the share of minority and women officials and administrators increased from approximately 35% in 2011 to 45% in 2021. That's a 10% increase in 10 years, and a strong indicator that the needle is moving in the right direction. We expect the release of the 2023 report in January 2024.

DCAS also provides agencies with quarterly charter-mandated reports that focus on characteristics of the workforce by agency, including job group, civil service title, race/ethnicity and gender, civil service status, pay class (fulltime or part time), new hires, promotions, separations, and utilization. These reports compare the representation of the incumbent workforce to the available workforce in the labor market, helping to identify overutilization (or overrepresentation) and underutilization (or underrepresentation) of demographic groups within agencies and job groups.

Since 2015, agencies have had access to quarterly interactive workforce diversity dashboards. The dashboard summarizes the data found in the quarterly charter-mandated reports in an interactive graphic format that makes it easier to communicate key indicators to agency and management leadership. To effectively address workforce utilization issues, DCAS conducts training for agency EEO officers on how to interpret quarterly reports, which detail workforce compositions and specify occupational areas where women and people of color are underutilized. The reports provide crucial data which agencies use to inform their recruitment and succession plans.

DCAS also provides other tools to allow agencies to make data-driven personnel decisions. For example, our Salary Benchmarking tools allows agencies to compare salaries for the same title across agencies of a similar size and/or function.

Annual EEO and Diversity Plans

DCAS also reviews agencies' annual DEI and EEO plans mandated by The New York City Charter (Chapter 35, Section 815[a][19]) and the EEO Policy. Such plans address recruitment, selection, promotion, training, EEO and DEI initiatives and activities to prevent employment discrimination. Agencies' progress in implementing the annual plan is captured in quarterly reports submitted to DCAS, the City Council and the Equal Employment Practices Commission. Agency leaders are also required to issue an annual EEO and Diversity statement to memorialize their commitment to equitable, fair and inclusive employment and recruitment practices.

Training

As we work to standardize our approach to EEO, diversity, equity and inclusion, DCAS has developed training programs for employees. These courses are consistent with best practices and guidance provided by civil rights enforcement agencies, like the United States Equal Employment Opportunity Commission (EEOC), NYS Division of Human Rights, and the NYC Commission on Human Rights. EEO, diversity, equity and inclusion trainings are offered year-round and are accessible to all City employees.

DCAS training efforts include:

a) Launched an updated Everybody Matters training in February of this year. Everybody Matters is a mandatory comprehensive EEO diversity and inclusion training that complies with Local Law 121. (age discrimination)
b) Updated mandatory annual Sexual Harassment Prevention Training for the entire City workforce (Local Law 92) and LGBTQI+ training. (Executive Order 16)
c) Worked with the Mayor's Office for People with Disabilities (MOPD) on the launch of the Disability Etiquette and Awareness Training this year.

We also offer more specialized trainings that educate agencies on making fair and objective hiring decisions, such as Structured Interviewing, Unconscious Bias, and Intersectionality.

DCAS provides EEO and diversity training to agency EEO and diversity and inclusion professionals citywide. We provide new EEO officers with an introductory training after being on boarded.

DCAS is also working to specifically develop the City's human resources community through the development and management of the New York City Human Resource

Academy (NYC HR Academy). This program is designed by HR practitioners and thought leaders and is especially designed and intended for the city's HR professionals. The curriculum focuses on common trends, best practices, emerging issues, and case studies for topics related to personnel management. The goal of the NYC HR Academy is to be an instrumental asset that equips agency HR professionals with resources and the network needed to align their workforce with the City's policies, structures, and initiatives. This program also includes a mandatory diverse and inclusive recruitment best practices training.

Recruitment

Inclusive recruitment and outreach are key to promoting equal employment opportunity. To increase access to municipal employment opportunities, DCAS established the Office of Citywide Recruitment (OCR) in 2015. OCR seeks to generate a pipeline for applicants with the education and experience needed to sustain operations across the City's workforce. To ensure greater diversity in the City's workforce, OCR shares information with historically underserved communities that include both unemployed and employed veterans, people with disabilities, youth, the LGBTQI+ community, and ethnic and racial groups that are underrepresented in City government. Using workforce data, OCR advises agencies on large scale recruitment strategies and promoting the vision that the City is an employer of choice that recruits and retains a very diverse workforce. DCAS liaises with networks that support underrepresented and underserved populations in the city. This includes extensive outreach to educate the public on the New York State's 55-a program for qualified applicants with disabilities.

OCR reviews gender distribution and the ethnic composition of the workforce, along with the civil service exam schedule, to focus its recruitment efforts. Since its establishment, OCR has participated in approximately 1696 events, reaching over 83,000 participants. OCR builds partnerships with educational institutions (middle and high schools/trade schools and colleges/universities), community-based organizations, faith-based institutions, and elected officials to conduct Civil Service 101 sessions – a training program developed by the OCR team to simplify the civil service process, promote the civil service exams, and highlight the benefits of working for the City.

OCR partners with the Department of Education (middle and high school), including their career and technical education (CTE) programs, to expose students to City jobs and internships in their field of interest. Additionally, in response to Local Law 173 of 2018, DCAS provides the DOE with the list of upcoming civil service exams that are open to high school graduates. These activities support the objectives in bill 527 regarding dissemination of civil service examination related information to high school students.

Similar to our partnership with DOE, we also have several internship and fellowship opportunities including the Civil Service Pathways Fellowship (CSPF). The CSPF, a DCAS/CUNY partnership, is a two-year fellowship that provides recent CUNY graduates with pathways to permanent civil service employment.

More broadly, OCR also partners with agencies to host agency spotlight events and *CityTalk* panel discussions. Through these events, OCR spotlights hard to recruit titles and include women in non-traditional careers (IT, engineering, construction, etc.), LGBTQI+ employees, veterans, employees with disabilities, and ethnic groups that are

underrepresented in City government, while promoting the many different City agencies, their service to the community, and the work employees perform.

These efforts have been complemented by other diversity events including partnering with the Mayor's Office for People with Disabilities to host diversity career fairs targeting job seekers with disabilities and symposia for HR and EEO professionals, which focus on disability etiquette and the 55-a Program.

Conclusion

Please allow me to thank you all for your time and for your commitment to increasing pay equity. It is a commitment that I too share. While pay and compensation are critical aspects of employment, they do not tell the full story. In spirit we are aligned with Intros 515, 527, and 541 but we also believe we have adequate foundations, including the existing charter mandate that we can build from to close the gap and usher in new opportunities for underserved populations. Through our collaboration with the pay equity cabinet, transparency in the dissemination of workforce data, close collaboration with our fellow oversight agencies, requirement for City agencies to produce an annual diversity and EEO plan, and aggressive recruitment that is inclusive of all New Yorkers, we are confident that we can continue to make our city government more equitable. We recognize that there are opportunities for improvement and to combat occupational segregation and look forward to working closely with the City Council to accomplish these goals. Thanks again, and at this time I am happy to answer any questions.

NYC
Equal Employment
Practices Commission

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September 22, 2022

Int. No. 515

Testimony of the Equal Employment Practices Commission (EEPC)
Jeanne M. Victor, Executive Director of the EEPC

Good afternoon, Speaker Adams and Members of the Committee on Civil Service and Labor and the Committee on Civil and Human Rights:

My name is Jeanne Victor and I am the Executive Director of the Equal Employment Practices Commission. At the outset, I want to applaud City Council for taking up the fight for equal and fair compensation for all City employees, particularly women and minorities and for the remediation of occupational segregation in the City's workforce. According to Indeed, the job search website, some of the top reasons why people leave their jobs include the need for more of a challenge, looking for a higher salary, wanting to feel valued, and searching for job growth and career advancement. It is natural for workers to feel uninspired and dissatisfied if they are paid less than their counterparts or if their career opportunities and salaries are limited. The EEPC recently submitted a report on the underutilization of women and minorities in the City's workforce and in our report pointed out some instances of occupational segregation in the City's workforce and submitted a recommendation to remediate it, which I will address shortly.

But first, for those who are not familiar with the work of the Equal Employment Practices Commission or the EEPC, its main charge, as set forth in the City Charter is to review, evaluate, and monitor the employment procedures, practices and programs of City agencies to ensure they maintain an effective affirmative employment program of equal employment opportunity for women and minority group members who are employed by or who seek employment with the City. We accomplish this mandate by auditing approximately 142 City agencies, entities, and offices of elected officials once

every 4 years. Equally important, Local Law 13 of 2019 charges the EEPC with conducting a citywide analysis of racial and ethnic classification underutilization. Underutilization occurs when the number of employees in a job group who belong to a specific racial/ethnic or gender group is less than the number reasonably expected when compared to the availability of qualified persons in the relevant labor pool. Among other things, Local Law 13 requires the EEPC to submit an annual report identifying the racial and ethnic groups underutilized in the City's workforce, provide recommendations for strengthening agency affirmative employment plan oversight and enforcement, provide funding recommendations, and provide recommendations for citywide corrective actions, including legislative, regulatory and budgetary changes for the purpose of remediating chronic or systemic underutilization of minorities and women in the City's workforce, and to increase diversity in the recruitment, selection and promotion of City employees. It must be noted that an analysis of women was not included in the original legislation and our office submitted a letter to the previous Speaker requesting their inclusion. We intend to reiterate that request shortly.

As mentioned earlier, the EEPC recently completed and submitted its second report on underutilization of women and minorities in City government, in accordance with Local Law 13. We found (1) The job group availability estimates in the CEEDS availability reports are aged and not consistently aligned with other availability estimates, such as the U.S. Census data and the Civil Service list date. Availability estimates should be periodically reviewed to ensure they are current and accurate; (2) Underutilization applies to job groups regardless of the number of entities that use the title, the size of the entity, or the number of employees in the title at a particular entity; (3) Occupational segregation is present and varies by demographics in many titles; and (4) In many instances, White male applicants passed Civil Service exams at higher rates than other applicants on Civil Service exams. In some instances, they were also selected for hire in percentages that substantially exceeded their availability estimates, even though considerable numbers of applicants with other demographics also passed the exam.

Occupational segregation is defined as the concentration of racial groups, gender groups, or other demographic groups in certain occupations and/or job groups. With respect to occupational segregation, we found that in general, White workers tend to be more populous in those titles and job groups that are paid more than other titles and job groups that are predominately comprised of Black, Hispanic, and Asian individuals. The EEPC recommended in its report that the City offer training and other opportunities for advancement for those workers in these job groups in order to offer opportunities for growth and advancement in their careers as well as access to jobs that are more highly compensated.

Consistent with our charter mandate, we recently formed and convened an employment advisory committee. The purpose of the Committee is to collaborate with other agencies to prioritize research topics, cooperate with other agencies to avoid the duplication of research efforts, leverage the collective expertise of the Committee to help inform the EEPC in its work, assist, if needed, in any Committee or citywide research initiatives and provide assistance to the EEPC with data collection efforts, if needed. Invited to participate were representatives from DCAS, NYC's Office of Labor Relations, the CUNY Community Colleges, the NYC Law Department, the NYC Commission on Human Rights, the Mayor's Office and City Council's Committees on Women & Gender Equity and Civil & Human Rights. We held our first meeting on September 14, 2022, which was largely administrative but during the course of the meeting, we touched on the fact that DCAS has plans to study pay equity at the City agencies. This was important to know because the EEPC was also planning to conduct a compensation study as part of our analysis of underutilization for next year's Local Law 13 report. However, to avoid duplicating efforts and wasting the EEPC's extremely limited resources, we may defer to DCAS if it turns out that the scope of DCAS' project would overlap with the EEPC's planned research topics.

I would be remiss if I did not note that the Chair of the EEPC, Aldrin Rafael Bonilla, who was not available to testify today, feels very strongly that City government needs to recognize that despite efforts to the contrary, "we tend to hire workers with the same demographics as the workers that are already in the workforce. In other words, new hires regardless of the City agency they are in, whether it is the Fire Department, the Sanitation Department or the Department of Correction, etc. reflect the incumbent agency workforce. Thus, there is no significant change in the demographics of the City's workforce despite all efforts to the contrary." He would have wanted me to note that "we should use this opportunity to recognize the inherent limitations of the civil service system in the selection of diverse candidates and perhaps think about re-imagining how selections can be made from civil service lists in order to be able to truly cast a wider recruitment net to achieve different outcomes." And lastly, he wanted me to point out that "there are no numerical minorities in New York City. Instead, we have pluralities but if we look at a specific group like Latinos, which comprise approximately 28% of the City's population, we should expect to see a greater representation of Latinos in the City's workforce, which is not the case."

The remainder of my remarks will be on the particulars of this proposed legislation. First, this legislation will amend Section 815 of the City Charter, which section concerns the powers and duties of agency heads concerning personnel management. It amends paragraph (19) to specify that each agency must include in its plan to provide equal employment opportunity **an analysis of the agency's compensation data and measures**

to address pay disparity and occupational segregation, among other things. (Emphasis added). Thus, if the agencies are addressing these important issues on an annual basis, it is unclear how the EEPC's comparable worth analysis, as included in this legislation, can add to the conversation.

Secondly, the comparable worth analysis would require the EEPC to physically go to every agency to determine the nature of the work required by each role in the agency, the demands of the role, and the skills a worker utilizes in the role. It is unclear why the agency, who would be in the best position to make these assessments, would not be asked to do so as part of their assessment of pay disparity and occupational segregation. According to recent statements prepared by the Office of the State Deputy Comptroller for the City of New York, the City's workforce comprises 129 distinct agencies (including the Department of Education and the offices of elected officials) and 59 Community Boards. While the majority of these agencies employ a small fraction of the City's full-time employees, the 38 largest agencies (with 250 or more full-time positions) employ nearly all of the City's full-time workforce. The City's full-time staff numbers approximately 284,000 – 300,000 employees. The City's career and salary plan for its full-time employees contains more than 1,600 civil service titles, although many refer to the same type of occupation, differentiated by factors such as assignment or level of experience. Compensation for represented employees is handled by the Office of Labor Relations for 95% of City employees. Given the numbers of agencies, titles and employees, the kind of analysis contemplated by this legislation would be a huge endeavor for even expert consultants to undertake. For the EEPC, it would be nearly impossible given the EEPC's team of 3 City Research Scientists, who must also fulfill our comprehensive Local Law 13 reporting responsibilities. Moreover, even if the EEPC had the resources and expertise to undertake such an analysis, it is unclear what value this analysis will bring, particularly since the agency heads will be required to address compensation and occupational segregation in their workforces through their annual plans. Since DCAS already has plans to conduct a pay equity study then perhaps the City's resources should not be used to create a comparable worth analysis but instead explore other, less resource-heavy alternatives that could provide greater value. For example, focusing on those job groups where occupational segregation is found and conducting surveys to gauge employee interest in preparing for other, career growth opportunities that are better paying; conducting a pilot program to address occupational segregation on a more-focused scale; and re-evaluating determinations of underutilization when a job group contains a majority of minority employees. As an example of a difference that may be within the City's control, if an agency is deemed to have underutilization of Black women in its clerical job group and Black women make up the majority of the clerical job group, aren't we just perpetuating occupational segregation of Black women

in the clerical job group? Perhaps we should look at our current practices to see if such unintended consequences can be easily rectified. Again, I applaud the work of the Council for their interest and willingness to address and rectify these difficult issues. The EEPC is pleased to be part of the solution and would be delighted to be part of the planning process and consulted on the proposed legislation, solutions, and remedies, but the EEPC is absolutely unable to perform either the comparable worth analysis that is being proposed or any other additional analyses with our current staffing levels and resources. In fact, the EEPC, with its current staff of 12, split between the Audit Unit, the Research Unit, and the Administrative team, is unable to take on any additional work, unless additional resources, staffing, and expertise is provided, or our mandated requirements are amended.

Thank you for the opportunity to present our position on the proposed legislation.

This concludes my remarks.

PUBLIC ADVOCATE FOR THE CITY OF NEW YORK

Jumaane D. Williams

**TESTIMONY OF PUBLIC ADVOCATE JUMAANE D. WILLIAMS
TO THE NEW YORK CITY COUNCIL COMMITTEE ON CIVIL SERVICE AND LABOR AND
COMMITTEE ON CIVIL AND HUMAN RIGHTS
SEPTEMBER 22, 2022**

Good afternoon,

My name is Jumaane D. Williams and I am the Public Advocate for the City of New York. I would like to thank Chair De La Rosa, Chair Williams, members of the Committee on Civil Service and Labor, and members of the Committee on Civil and Human Rights for holding this hearing.

Just two weeks ago, the City Council held a hearing on maintaining the municipal workforce. I submitted written testimony outlining my belief that the way forward for our city is to implement a hybrid work model, flexible to city workers' needs. While I focused on the value of hybrid work, I also acknowledged additional factors contributing to municipal workforce attrition that have existed long before the COVID-19 pandemic. What I wish to focus on today is two of these factors: the issue of pay, in particular wage gaps, and disparities in city workforce opportunities, both of which are intertwined.

September 21st was Black Women's Equal Pay Day. This day exists because Black women continue to be undervalued and underpaid for their work. As for our city, pay inequity still persists, be it by race, gender, or other demographics, and our Black and Brown women bear the brunt of these pay disparities. In fact, Local Law 18 of 2019[1] (which I co-sponsored during my time as a Council Member) codified the requirement for the Mayor's Office of Data Analytics to report city agency pay data. Recently in 2021, the City Council released a report analyzing the findings of this reported pay data.[2] Overall, the report found pay disparities across a range of demographics to be no more than 1.9% (the highest being Black female employees and Hispanic or Latino female employees who are expected to make 1.9% and 1.5% less, respectively, than white male employees for the same job titles). Although these differences are seemingly small, the impacts of missing dollars no matter how big or small can be deeply felt by those who are not equitably compensated.

These dollars could mean all the difference in socioeconomic mobility: the ability to pay off loans, become a homeowner, afford childcare and healthcare, and reduce poverty, amongst a slew of possibilities. It is also important to note pay disparities will follow the employees for the entirety of their lives, not just during the course of their employment. Municipal pensions are based on two factors: the length of employment with a minimum of ten years coupled with the employee's highest annual salary earned over three years. Therefore, the pay disparity in employment results in a pay disparity during retirement. This is an unsettling truth. We are doing our city workers, especially the Black and Brown women who make up a significant percentage of agencies like HRA, DCAS, and ACS, a major disservice

[1] https://legistar.council.nyc.gov/LegislationDetail.aspx?ID=3371662&GUID=5FCAFC03-035E-45D9-BE1A-4EBE7D6DF43C&Options=ID%7CText%7C&
[2] https://council.nyc.gov/data/pay-equity/

if we do not take steps to mitigate pay disparities. Additionally, this lack of competitive pay will see our city workers leaving the workforce and the impacts will be felt not only by the workers and city agencies, but the New Yorkers they serve everyday.

Furthermore, if we look at non-adjusted pay data overall, the median salary for male employees is $21,600 higher than the median salary for female employees; the median salary for white employees is $27,800 higher than the median salary for a Black employee and $22,200 higher than the median salary for a Hispanic or Latino employee.[3] Granted, this is a comparison of pay across a range of roles and salaries, but when you dive deeper into the data, there is a pattern that may contribute to these stark pay gaps: as the percentage of nonwhite employees for a specific job title increases, "there is a marked and nearly linear decline in wages."[4]

I believe this is an issue that needs greater attention. The Council's report found that positions with less than 10% nonwhite employees had a median salary of $125,500, compared to positions with more than 90% nonwhite employees which had a median salary of $47,400. Overall, we see that higher ranking and higher paying positions are by and large held by white men whereas women and people of more color tend to hold lower paying positions. The report mentions that "the civil service titles with the lowest median salaries have a larger proportion of female and non-white employees." Occupational segregation[5] is a reality in our city workforce that we must reckon with and address head on. We must reassess the workforce opportunities that are made available to New Yorkers, the eligibility requirements for each role such as education and experience, where the greatest outreach is being done for recruiting talent, and the possible avenues to take to diversify and ensure that pay gaps are not further exacerbated by this siloing of certain demographics in specific job roles.

The City of New York is the largest employer in the city, and it is crucial to the continued success of our city that the people who keep the lights on and the gears running day-in and day-out are compensated equitably. Additionally, the talent we recruit must be sought from all over the five boroughs and even beyond, and at its core the City must provide the necessary outreach and opportunity–in particular to Black and Brown communities–to pursue a range of careers and positions. The City owes to its workers that they are seen, heard, and recognized for their worth and contributions to the city we all call home.

Thank you.

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[3] https://council.nyc.gov/press/2021/08/02/2098/

[4] *Pay Equity in NYC: Analysis of pay differences in the New York City municipal workforce*, Page 26.

[5] "Occupational segregation occurs when one demographic group is overrepresented or underrepresented among different kinds of work or different types of jobs." https://equitablegrowth.org/fact-sheet-occupational-segregation-in-the-united-states/#:~:text=Occupational%20segregation%20occurs%20when%20one,or%20different%20types%20of%20jobs.

Testimony of
Dalvanie Powell, President
NYC United Probation Officers Association

Civil Service and Labor and Civil and Human Rights Committee
Virtual hearing on Intros 515, 527, and 541
September 22, 2022

Good afternoon Committee Chairs Williams and De La Rosa, committee members, and all City Council members.

My name is Dalvanie Powell. I am President of the United Probation Officers Association, which represents close to 700 Probation Officers – the majority of whom are women of color – working for the City of New York in all five boroughs.

In its simplest form, Probation is an alternative to incarceration. We serve this City faithfully as law enforcement officers.

We carry guns … perform search and seizures … execute warrants … make arrests … remove guns and drugs from

homes … and make field visits in some of the City's most dangerous neighborhoods … all **SUBSTANTIALLY SIMILAR** work to Police Officers.

We deal with the same individuals who are going through the criminal justice system as Correction Officers, making sure those on probation obey the rules … work toward rehabilitation … and are held accountable for their actions… all **SUBSTANTIALLY SIMILAR** work to Correction Officers.

There are, however, some **SUBSTANTIAL DIFFERENCES**.

Probation Officers **MUST** have either a **graduate degree …** or a bachelor's degree **AND** two years of experience in

counseling or casework – something Correction and Police officers do **NOT** need.

We **ALSO** prepare reports for the courts … conduct risk assessments … and during the pandemic, we were **ORDERED** by the Mayor's office to monitor inmates under Correction's jurisdiction who were released to an electronic monitoring program to minimize the spread of COVID.

Our caseload has increased tremendously with the implementation of Raise The Age, which now puts more New Yorkers under the age of 18 on probation rather than in prison. Yet, the number of Probation Officers has decreased tremendously because we are paid **SIGNIFICANTLY LESS**

for our work than white men doing substantially similar work in different agencies.

If you don’t already see the problem, let me explain.

UPOA represents women – and women of color – struggling to make ends meet because of an outdated and unfair pay structure that ultimately acts like a paper cup with holes in the bottom. No matter how many new employees Probation puts **INTO** the cup, a disproportionate number drain out the bottom because they cannot make ends meet on salaries significantly below par.

It is **NOT** the difference in our work that is the significant problem, but the difference in our compensation and how we are treated.

This is not a new story. In fact, this is why we are here today.

Local Law 18 was the first step in bringing pay equity to New York City. Intros 515, 527, and 541 are the next steps needed to stop the stark pay inequity and gender discrimination that unfortunately exists in this City – and definitely in Probation.

The data is clear. The highest-paying jobs are **STILL** reserved for white males. The problem is that Probation is mostly Black females.

In fact, we recently discovered that approximately 1/3 of our members are paid **LESS** than the legally allowable minimum salary under our contract.

As a City Council, and the first female-dominant City Council, you have the power to change this. UPOA looks forward to working with you to eliminate the segregated workforce of this City and replace it with equal employment opportunities for all.

Thank you for allowing me to address you today.

TESTIMONY of Dr. GREGORY MANTSIOS
FOUNDING DEAN, CUNY SCHOOL OF LABOR AND URBAN STUDIES

I have the privilege of serving as the Founding Dean of the CUNY School of Labor and Urban Studies, the 25th and newest school within the City University system – and one that is specifically dedicated to public service and social justice. Many members of City Council know about SLU, because the Council was so instrumental in establishing the School. What you may not know is that SLU's original incarnation, the LEAP program at Queens College (which I also founded), was established in 1984 in partnership with DC 37 and CWA 1180, and that we have been serving NYC civil service employees ever since.

So I come here before you with 38 years of experience not only with these two unions, but with the city workers that they represent. The worker/students we have been serving are predominantly adult women and people of color.

So what have I, as an educator, heard from these worker/students? For one, I've heard that working for the City is a great job. You work eight hours a day serving the public good and in return you have a decent wage, decent benefits, steady income, and a level of economic security you might not otherwise have.

And yet, there is a level of frustration and a sense of injustice that sometimes boils over into rage. And that rage is not unlike the rage that we see at other workplaces – most recently witnessed amongst workers at the Amazon warehouse on Staten Island, or at Starbucks stores across the nation.

And it's not simply about money. It's also about opportunity, respect, and fairness.

So when CWA Local 1180 conducts a study that spotlights pay inequities as well as racial and gender segregation in the City's workforce, and the City Council conducts a similar study and comes to similar conclusions, it both validates and quantifies what City workers have been feeling and expressing for decades: that the system isn't fair.

It is in that context that I come before you to urge passage of all three legislative proposals under consideration by the Council.

Speaker Adams' bill addresses issues of occupational segregation and pay disparity, and calls on agencies to analyze and report on compensation, recruitment, retention, and promotion.

Councilmember De LaRosa's bill addresses recruitment and advancement by requiring agencies to report on exam metrics.

Councilmember Louis's bill 541 addresses pay disparities by calling on the Department of Administrative Service to expand the employment data it collects.

Reports aren't the solution to injustice, but we know from history that reports matter.

These bills identify a very serious problem of inequity in the civil service system and provide a framework to finding a solution.

Moreover, each of these proposed bills points to the issue of education and training, and calls on City agencies to report on the opportunities they provide for employees to advance their careers.

And so I go back to the worker/students that we serve as the CUNY School of Labor and Urban Studies. What do they want? They want better career paths and enhanced opportunities to better themselves and their families.

So in addition to urging the passage of these pieces of legislation, I want to suggest several steps that agencies can adopt in the reporting process, that would increase opportunities for City workers and address the issues of pay inequity and occupational segregation.

1) Provide more clearly articulated pipelines and pathways for career advancement – especially for those occupations and occupational levels that remain stubbornly segregated.
2) Provide City workers (or targeted categories of workers) with free tuition – even paid leave – to complete training and educational programs that would prepare them for opportunities for promotion.
3) Upon completion of training and educational programs, entitle employees to:
    a) An immediate pay increase (similar to the 30+ increase provided to teachers by the UFT and DOE).
    b) The opportunity to take a promotional rather than a competitive exam, thus recognizing the knowledge, experience, training, and loyalty of the City's current workforce.
    c) Provide employees who complete a certificate or degree with additional points on civil service exams (similar to the points awarded on exams to veterans).
    d) Any combination of the above.

We at SLU are happy to collaborate with municipal agencies and unions on these or any proposals that will break down barriers for City workers, and lead to a more fair and equitable civil service system for our great City.

Community Voices Heard Testimony on
Pay Equity in the Municipal Workforce

Over 300,000 people are employed by the City of New York, the largest municipal workforce in the nation. A 2021 report by the New York City Council found significant pay disparities existed for Black, Latina, and Asian women in the municipal workforce. Community Voices Heard (CVH) supports City Council Introductions 0541-2022, 0527-2022, and 0515-2022 as necessary tools to increase pay equity in New York City's workforce for women of color.

Community Voices Heard is a member-led, multi-racial organization principally composed of women of color and low-income families in New York State. CVH tackles tough issues and builds power to secure racial, social and economic justice for all New Yorkers. Through grassroots organizing, leadership development, policy changes, and creating new models of direct democracy CVH is creating a truly equitable New York State. We are the largest Black-led organizing institution in New York State.

New York City's municipal workforce is 59% women and 62% non-white. Women and people of color are the backbone of the City, providing essential services. It is incumbent upon New York City to be a leader in addressing pay disparities in its workforce and be an example to the private sector and other cities.

Introduction 0541-2022 will ensure that the City Council has the detailed data needed to hold New York City agencies accountable for race and gender disparities.

Civil service jobs have long been a pathway to the middle class, yet there are significant racial and gender disparities in those who are able to make it through the long process of civil service examination, appointment, and training. Introduction 0527-2022 requires agencies to report data to the City Council on completion of each step of the process. Information is important, but the City Council must be committed to taking action and allocating resources to close race and gender gaps where they exist, and to holding agencies accountable.

Introduction 0515-2022 requires agencies to create comprehensive plans to address equity, along with reporting important equity data. It also addresses the issues created by the high degree of segregation in the jobs that men and women perform by requiring an analysis of jobs that are qualitatively different, but comparable work for different pay. Too often, women are

penalized in pay and advancement because familial care-taking responsibility disproportionately fall on women.

We cannot continue to short-change women of color in pay, advancement, opportunity. The women of color in our municipal workforce are key to our thriving City.

Juanita Lewis
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(914) 519-8588

Submitted: September 25, 2022

Testimony for the City Council Hearing on Pay Equity in Municipal Workforce before the Civil Service and Labor and Civil and Human Rights Committees 9/22/22

Good afternoon. Thank you to Chair De La Rosa, Chair Williams, and members of the Civil Service and Labor and Civil and Human Rights committees for inviting us here today. My name is Henry Garrido, Executive Director of District Council 37.

DC 37 represents over 100,000 full- and part-time employees who are directly employed by Mayoral agencies, the Department of Education, NYC Housing Authority and NYC Health and Hospitals. We also represent another 50,000 members in non-mayoral agencies, culturals, libraries and non-profits, and we continue to grow.

I would like to thank Speaker Adams for her acknowledgement yesterday of Black Women's Pay Equity Day, and hope that when we return next year that gap will have closed.

DC 37 is in support of strengthening the existing laws regarding diversity, opportunity and equal pay in the city workforce. There is plenty of data available, and I will not go into great detail about every area but will highlight our concerns.

In 2019, Local Law 13 was passed, which requires the EEPC to analyze and submit a report annually to the Mayor's Office and New York City Council on citywide racial and ethnic classification underutilization and recommendations. Prior to that law, the EEPC produced a report called the EEO-4, thus requiring the reporting by salary and the number of full time employees in seven occupational groups. Our DC 37 members fall into six of those seven, with many concentrated in the Professional, Technical and Administrative Support categories, and then Service, Maintenance and Skilled Craft. A significant pay discrepancy can be found within city workers of color and women, and their counterparts.

Union Equity Fund

Being proactive on shortening the pay discrepancy within our city workers is extremely important for DC 37. That is why in the 2017 -2021 round of bargaining, we negotiated a city-wide promotional program that encourages and helps workers of color get promoted to supervisorial titles. Additionally, the bargaining committee also agreed to set aside funds into a union equity fund, and to identify titles where recruitment and retention is a critical issue. The equity fund, which was equally matched by the city, allowed us to address some of the pay inequities within the identified titles. But this isn't enough. Inequities persist in many titles nevertheless. The Equity Fund could not address all of the recruitment and retention issues that exist. The point here is all of our union members should not repeatedly have to set aside a portion of an overall raise to fund increases for other union members in specific titles because their salaries have not kept up with the increasing costs of living in New York.

Improvements must be made to our current reporting mechanisms. In future reports, we would like to see more civilian titles analyzed. As I mentioned earlier, there are a number of reports available and the data is available on OpenData. EEPC has issued the second report pursuant to Local Law 13 and analyzed a number of titles, but only the Social Worker and Case worker titles in this year's report are specifically represented by DC 37.

The City must increase consequences for noncompliance. Currently, agencies who fail to pursue diversification may be subject to another audit in less than four years. We believe the consequences should be greater. There is no real incentive or motivation for the agencies to

take diversity seriously.

One glaring example is the Parks Department, which according to the public records is late on reporting. Parks Department employees who are white males make up one-third of all the professionals in the $70K + salary band. There is also a significant gap in pay between male and female employees. Additionally, the department counts public events as "diversity events" and the employee climate survey shows continued employee complaints of racial and sexual harassment.

Recommendations:

There are a number of ways the City can address problems with pay equity and diversity in the municipal workforce.

- DCAS needs additional support and staff to develop, administer and establish civil service open competitive and promotional exams. During the last several years there has been a decline in the number of promotional exams. It is finally picking up this year. Promotional exams allow incumbent employees within an agency who are in a title directly below the promotional title to use their knowledge of the work to demonstrate their ability to move to the next title and to have an inside advantage over a person on an open competitive list from the outside or from another agency. This allows continuity of service and upward mobility.
- The Equal Employment Opportunity Commission needs support to properly audit and monitor agency reporting. This agency has a very small staff of less than 20 people to monitor agencies with 300,000 employees.
- We agree with EEPC that analysis must be done on an entity/agency-specific level in order to find out where the highest needs really are and go after the biggest opportunities for improvement. City employees often feel that their agency is their family and want to grow within their agency. Aggressive training should be offered to those occupational groups where concentrations of women and minorities are currently clustered at the lower end of the pay scale, including school food service, school guards, caseworkers and clerical titles. Our DC 37 Education Fund is ready to collaborate with the City to provide training, but the training must lead to a better job or workers will not engage in it.
- The City must increase accountability for noncompliant agencies. This should include fines, required action plans and oversight of hiring practices. These are recommendations we believe will help the City with recruitment and retention, which will contribute to making the City workforce more efficient and representative of the New Yorkers it serves.

Thank you for your time and attention to this very important topic. I am available for questions.

September 22, 2022

Testimony of Kathleen, President
EMS Superior Officers Association - FDNY
RE: Pay Equity in the Municipal Workforce and in support of Intros 515, 527, and 541
Committees on Civil and Human Rights, Civil Service and Labor, New York City Council

Dear Chairs Williams and De La Rosa, and Committee members,

My name is Kathleen Knuth and I am the President of the EMS Superior Officers Association of the FDNY, representing the Deputy Chiefs and Division Chiefs in the Bureau of EMS. Thank you for allowing me to speak today on pay equity in the municipal workforce and in support of intros 515, 527 and 541.

I would also like to thank this body and especially the Speaker for consistently showing up to support pay equity in the municipal workforce and in specific the FDNY.

The issue of pay equity could not be more relevant than at the FDNY, a Department whose first responders are an integrated team providing cohesive emergency services, but which engages in a policy that separates and treats different the two sides of this integrated team of first responders.

There is an outdated mentality that EMS first responders perform less important, different and less dangerous work than the first responders

within the Department's Bureau of Fire Operations . Without diminishing the heroic work our colleagues do in Fire Operations , for which they should be commended, our Bureau of EMS member s work is equally heroic and should be valued equally. We have to ask ourselves why isn't it? It does not go unnoticed the extreme difference in demographics between the two bureaus .

This creates a vicious cycle causing several unintended consequences. Obviously being underpaid is demoralizing to our members and causes them the additional stress of trying to make ends meet in one of the most expensive cities in the world. A long-term impact of underpayment is the increased turnover of personnel, which is not only costly to the City but puts the public at risk. It also discourages qualified applicants from applying, putting more stress on the job.

In addition to segregating the workforce, the Department represses our minimum salaries and does not give our EMS members the chance to flourish in their career. By way of example, the salaries being proposed for our members who are Deputy Chiefs and Division Chiefs is not only far less than their Fire Operations colleagues, but even less than their own subordinates.

Unfortunately, the FDNY is an excellent example of what the City must not do to its municipal workforce. By creating false differences that undervalue EMS, and make them seem different and less than, the City justifies a two tiered system that perpetuates pay inequity to the great detriment of the Department as a whole. Fixing this helps all of us.

As the saying goes, "A rising tide lifts all boats." By ensuring fair pay for EMS first responders and the greater municipal workforce, we ensure better treatment for all New Yorkers.

Thank you again for your time and commitment to this important issue.

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September 22, 2022
Testimony on behalf of Local 1559

Good afternoon, my name is Celeste Carballo and I am on the Executive Board of Local 1559. I am an Exhibition Preparator at the American Museum of Natural History, and have worked there in various capacities for 10 years. The workers in the Culturals, while DC37 members, are frequently not included in conversations about New York City's municipal workforce. We share many similarities with the city's workforce and I ask that the City Council Members keep us in mind when considering these three bills being discussed here today; Int 0541-2022, Int 0527-2022 and Int 0515-2022.

When I became a full time Preparator in 2018, I had attained my childhood dream job, which was to be an artist who works on the models and dioramas at the Museum of Natural History. My starting salary in 2018 was in the $33k range, which is considered *very low income* in NYC. I lived with my parents for years to be able to keep the job that I had wanted for so long. During my job interview, I will never forget that the supervisor himself expressed concern over the low salary and had to make sure that I was still interested.

I grew up in Hell's Kitchen, the daughter of Argentine immigrants. My father has been a member of 32BJ SEIU for most of my life, so I have long understood the importance and benefits of being in a union.

I have a BFA and an MFA, and over $100k in student debt, with interest that keeps adding up. I am always living paycheck to paycheck. Were it not for the support of my husband and family, I would not realistically be able to sustain myself on the Preparator's salary, which for me currently is below $54,000. This is still considered very low income in NYC. The archaic city pay orders are in great need of re-evaluation and need to be adjusted to reflect the true cost of living in this city. I am hoping that the passage of these three bills examining pay equity and diversification in the municipal workforce will help provide the data and the political will needed to amend these pay orders. I've witnessed multiple talented union members resign in the past few years because they could not make ends meet. One member of our scientific staff was working at Trader Joe's to supplement her income because she could not afford her rent. She ultimately resigned. An Exhibition Preparator had a side job teaching at FIT in order to supplement her income. She too, eventually resigned. Several other full time coworkers do freelance work and have side gigs to make ends meet. This is a problem that existed long before Covid. And now with inflation, our meager paychecks are worth

even less. The cost of living has gone up exponentially but our pay has not proportionally increased over the years, leading to this current crisis in the city workforce.

My landlord refused to renew my lease last month and openly admitted that they intended to relist my apartment for $1200 more than what I currently pay. I will note that they are asking for far more than the apartment ever rented for pre-Covid. If the city cannot create rent caps for the majority of us living in non-regulated apartments, how are we supposed to live with such a lack of stability? I know that I am not the only person who has experienced this sort of upheaval in recent months, as this is the worst rental market for tenants in my lifetime. Our small paychecks do not support the cost of rising rents and day to day expenses, whether its groceries, fuel, or other basic necessities. This makes it not only impossible to save money, but impossible to plan for the future.

We also need to address the fact that these abysmally low salaries are a barrier for entry for anyone who does not have a financial cushion, whether that's a trust fund or family support. Low pay, in fact, prevents people from minority/disadvantaged communities from entering the workforce in the Culturals. Similar to the Civil Service jobs, our union members at the Museum have jobs that require certain levels of education, training and experience. Why do we treat these jobs as if they require no skills? For too long, city employers have banked on the fact that there are plenty of people who will line up to work for them, and that alone justified the low wages because there is intrinsic value in just being able to do work that is rewarding or prestigious. Well as they say, *"You can't eat prestige!"*

Decades of this practice has resulted in low morale, which in turn affects the quality of work and the number of people willing to do this kind of work. With low morale comes diminished participation in government and democracy, as people lose faith that the unions, politicians and other institutions have their best interest at heart. This is a downward spiral that we need to put an end to! Some people complain that individuals should not go out and get expensive college degrees if they can't pay off their student loans. But our jobs at the cultural institutions are part of what makes New York City the incredible place that it is. These institutions generate millions of dollars in revenue for the city each year, yet we can't pay their union employees a decent salary?

Lastly, because our salaries are so low, institutions like the AMNH now have a chronic staffing and retention problem, which places more burden on the existing staff. And with members juggling side jobs to make rent, how can we expect people to take on even more responsibility at their main jobs? People are leaving to take jobs in the private

sector, where the pay is better. Increased diversification of the workforce is a noble goal- and I urge you to pass these three bills- but we are not going to get there without significant increases to the salaries paid to the municipal workforce, including the culturals.The city needs to recognize that its workers make the city run; we are the heart and soul that may operate behind the scenes, but without us, the city cannot function. We did not accept these jobs because we set out to make a ton of money. We have these jobs because we care about what we do and we seek the stability and protections that unions offer. Like many of my colleagues, I love my job and truly value the unique and close-knit community at the Museum. But to be clear, we are not asking for a luxury, we are asking for respect in the form of living wages!

September 22, 2022

Testimony of Christell Cadet, Member Local 2507 and FDNY Paramedic
Committees on Civil and Human Rights, Civil Service and Labor, New York City Council
RE: Pay Equity in the Municipal Workforce and in Support of Intros 515, 527 and 541

Good Afternoon Speaker, Chairs and Committee Members and thank you for the opportunity to provide this testimony.

My name is Christell Cadet and I have been a paramedic for almost 10 years in the FDNY.

I love my job and I put my heart and soul into it. However, it is a stressful job that is only made worse by being underpaid and undervalued.

When you talk about diversity in the Department it is not enough to talk about the demographic makeup of the Department. It is important to talk about how those of us who are diverse are treated.

Fundamental to understanding the diversity in the FDNY is understanding the reality that the Department engages in a segregated workforce in which women and people of color are placed on the EMS side of the Department while the Fire side continues to be overwhelmingly white and male. Little has changed in the decade I have been here.

Even though we show up at the same emergencies, and handle the same level of risk, Firefighters are paid almost twice as much as EMTs and other EMS First Responders.

And yes, the work is just as challenging. I am spit on, attacked by patients, exposed to infectious pathogens and other life-threatening diseases. I am required to respond to life and death situations on a daily basis. I have to go into unsafe buildings, homes where there is domestic violence, and yes, as a paramedic I have had to go into burning buildings.

In fact, I have gone into a burning building to save the life of a firefighter who was injured and needed medical assistance. So please, don't say that our work is not as hazardous or challenging. I am attaching here an affidavit submitted as part of EMS members' EEOC complaint regarding discriminatory pay practices which explains in more detail how are jobs are just ask risky as our colleagues on the fires ide.

EMS First Responders are also not given the same respect, or benefits as Firefighters.

In March of 2020 I contracted Covid-19 while on the job. I have included in this submission some press coverage of both the importance of pay equity and the difficulties I face as one of many EMS first responders who experienced Covid on the frontlines before there was a vaccine or any other protections we now have.

Contracting Covid in the line of duty changed my life completely. I was majorly affected; I was on a ventilator and life support for 30 days. I had to learn how to walk again and try to regain a new form of normalcy in my life. After giving over 10 years of my life to the department, I am now unable to continue my work as a Paramedic on an ambulance. I continue to suffer the side effects of Covid. This all comes from being directly in the frontline, like my fellow firefighters as a first responder.

One of the biggest differences is that even though the law says we are uniformed service, we are treated like civilians. This has devastating impacts none more clear than when we are injured on the job. Instead of being given full disability with a job with a reasonable accommodations and other benefits of uniform service, the result of my injury on the job is that I am being pushed out of the Department and will ultimately be terminated because I do not have sufficient sick leave or reasonable accommodations. In other words I will be terminated for having been injured in the line of duty, whereas a firefighter injured in the line of duty would get benefits that covered them and their family, including long-term disability. Instead, I have to apply for these benefits through NYCERS as if I were a civilian and as of yet after more than two years have not been granted these benefits, as they are rarely if ever given to civilians.

These indignities of being segregated and treated as different and less than have real life devastating consequences. Even small issues like the fact that EMS first responders who are most impacted by Covid had to take their own time to get vaccinated when firefighters are literally paid to wait to see doctors, as the enclosed documents show, have an impact.

We deserve the same respect, dignity, rights and pay as any other first responder that risk their lives daily. The practice of pay inequity is catastrophic for those of us who work on the frontlines for this City.

UNITED STATES
EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

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FDNY LOCAL 2507, UNIFORMED EMTs, PARAMEDICS & FIRE INSPECTORS, DC-37, AFSCME, AFL-CIO, Individually and on behalf of its current and former members, JANE and JOHN DOE #1-4000, and similarly-situated individuals, FDNY LOCAL 3621, EMS OFFICERS UNTION, DC-37, AFSCME, AFL-CIO, Individually and on behalf of its current and former members, JANE and JOHN DOE #4001-4750 and similarly-situated individuals, and NYC EMS SUPERIOR OFFICERS ASSOCIATION, Individually and on behalf of its current and former members, JANE and JOHN DOE #4751-4800,

Claimants,

-against-

City of New York and New York City Fire Department,

Respondents.

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AFFIDAVIT OF CHRISTELL CADET

EEOC Charges:
520-2020-01722
520-2020-01723
520-2020-01724
520-2020-01725
520-2020-01726
520-2020-01727

STATE OF NEW YORK)
) ss:
COUNTY OF ~~NEW YORK~~ Queens)

I, **CHRISTELL CADET**, being duly sworn, depose and say under the penalties of perjury:

1. I am a paramedic in the New York City Fire Department ("FDNY") working out of Station 54 in Queens, New York.
2. I submit this affidavit to provide information regarding my job duties and responsibilities as a paramedic in the FDNY.
3. I graduated from Francis Lewis High School in 2003. In 2010 I completed an Associate's Degree from Queensborough College. I also completed one year of nursing school.

4. When I was 17 years old my father suffered a heart attack in our home in Flushing, Queens. I watched with awe and gratitude as EMTs arrived in minutes and saved my father's life. I knew then I wanted to go into the field of emergency medicine. Later, when I was in nursing school I had the opportunity to go on a ride-along with a classmate who happened to be a Paramedic. I was struck again by the intensity and importance of the work and realized that this was the career I wanted to pursue.

5. Before someone can apply to be a paramedic in the FDNY you are required to first be an EMT. In order to be an FDNY EMT you must attend and successfully complete intensive training at the FDNY Academy which is an advanced state of the art Academy with two large campuses, one at Fort Totten and one on Randall's Island. The length and intensity of this training is equivalent to 1 to 2 college semesters. Only after you successfully complete this training and take the examination to become an EMT can you then qualify to become a paramedic. In order to be a paramedic in the FDNY a candidate must complete an additional 9-12 months of intensive training at the FDNY Academy. This training is equivalent to a 2-year college program. Both courses are demanding, detailed, hands on, and imperative to providing life saving measures to residents in our communities. During each course, we are trained in the science and the skills we need to practice life saving patient care. We must also remain up to date on emergency medicine and demonstrate our ongoing abilities and skills to perform this advanced life saving work and are required by law to re-certify as paramedics with New York State and New York City every 3 years. This requires going back to the FDNY Academy for additional training on developments in equipment, techniques and information regarding emergency medicine. In addition to the educational qualifications, we are also required to demonstrate our ability to endure

rigorous physical exertion. By way of example we must demonstrate our ability to lift and carry a minimum of 125lbs, not including our patient care equipment which can be almost as heavy.

6. I began working for the FDNY in 2012 as an EMT. In March of 2013 I entered the FDNY Paramedic Academy and graduated in November of 2013. I completed and passed my paramedic certification exams with New York State and New York City in November of 2013 and was promoted on November 29, 2013 to the position of paramedic in the FDNY
7. My primary job duty as a paramedic in the FDNY is to rescue and save lives by responding to emergencies throughout the New York City area. I believe that this is also the primary job of a firefighter. I base this belief on my experience working side by side with FDNY firefighters for almost a decade.
8. There is often a misconception that Firefighters' job duties are to respond to fires and EMS first responders' job duties are to respond to medical emergencies. But that is not true. We are not dispatched from the FDNY based on whether there is a fire or a medical emergency. Rather we are an integrated Department that responds to all emergencies and dispatches units from both EMS and Fire based on the severity and the type of emergency. Firefighters regularly respond to non-fire emergencies. EMS personnel regularly respond to fire emergencies. Many Firefighters are Certified First Responders ("CFR") which means they are able to provide medical care to victims in need. EMS personnel are trained to enter burning buildings, to extinguish fires, and are required to enter burning buildings when needed to rescue victims in burning buildings. At the FDNY Academy, we are trained on what is called May Day which is how to enter burning buildings to treat Firefighters for smoke inhalation. Often times emergencies include several types of life threatening issues

happening together at the same time. We work as an interdependent web of first responders to provide what I believe is some of the best emergency care in the country.

9. The emergencies I and other EMS personnel respond to include car accidents, fires, active shooters, collapsing of structures such as buildings and bridges, terrorist threats, natural disasters, exposure to hazardous materials, and acts of violence, to name a few.

10. I respond to, and appear at, the same emergencies as my FDNY colleagues who are firefighters, including entering burning buildings. In fact, I have even provided medical care to a firefighter inside a burning building where a pillar from the ceiling had fallen on him, knocking him unconscious. I entered the same burning building he had, even after this pillar fell, and without the same protective gear given to firefighters, I performed life saving care. I administered first aid and helped transport this firefighter to safety, ultimately saving his life.

11. EMS FDNY personnel respond to the same fire emergencies that FDNY firefighters respond to, as well as many other emergencies. We are also trained and required to crawl crouch and stand for prolonged periods of time like firefighters, at the same Academy that trains them. When responding to fires along with my FDNY firefighter colleagues, I too must enter the building. Attached here as **Exhibit 4** please see the Forward Triage Order that directs EMS to enter buildings when responding to fires. I am also carrying with me heavy bags of medical equipment and gear. I also must not only enter the same hazardous environments but also lift and transport patients from those dangerous and hazardous environments to an ambulance for transport, all the while administering advanced life saving care in the most urgent and quickest way possible. In doing so I am also potentially exposed to contagious diseases and other hazards. I am often having to run up flights of

stairs to reach patients in critical conditions at high rates of speed, as every second counts, bending over to lift gurneys, carrying heavy bags filled with medical equipment with me. Victims are often in extremely hazardous situations, thus they are in danger such that they need emergency help. I in no way mean to diminish the heroic work that firefighters do. Their work is challenging and hazardous. But not any more than my work.

12. In my work as a paramedic I have a high degree of accountability and responsibility. I am responsible for the medical care of my patient until I transport them to the hospital. This is literally life and death. My job obligations include not only administering advance life support medical care but also other responsibilities. By way of example, pursuant to FDNY policy and procedure it is EMS First Responders only who are authorized to pronounce victims dead and determine time of death for the Department. We are also responsible for determining if a victim needs to be evaluated for psychiatric care.
13. This job is beautiful and fulfilling, yet it is also very stressful, tiring and draining.
14. Prior to my contracting Covid-19 I worked 12 to 16 hour shifts, handling back to back patients in dangerous and life-threatening situations repeatedly throughout these shifts. The scenes I encounter with patients can linger and affect me for days. It is my job to try to separate work from home life, but I often had to work extra shifts just to make ends meet. My normal weekly schedule is 37.5 hours, but I would have to work on average 60 to 70 hours per week just to cover my living expenses. I have missed a lot of life's moments because of this. For example, I have a disabled parent at home and can't always care for him as I would like or as he needs because I have to work over-time shifts. Even my former marriage was strained due to my lack of presence at home, ultimately ending in 2015.

15. I contracted Covid-19 while working at station 47 where other EMTs and Paramedics were returning from calls.

16. On March 18, 2020 I was admitted into the hospital into critical care. On March 19, 2020 I tested positive for Covid-19. I developed a high fever, shortness of breath and coughing. By March 23, 2020 I was unable breathe on my own and by the evening of March 23, 2020 I was sedated and intubated. I did not regain consciousness again until April 24, 2020 over a month later. Throughout this time my family did not know if I was going to live or die. When I woke up I was unable to move at all as all my muscles had atrophied. I was discharged on April 30, 2020 with a torn MCL on my right knee with complications, and a partial tear on my left knee. I also now have chronic pulmonary and neuropathy issues as a result of Covid-19. I am easily winded and often cannot do basic activities without losing my breath. I go to occupational therapy twice a week for my hands and shoulders which I have yet to get full recovery of and have limited range of motion. I go to physical therapy twice a week to relearn how to walk, heal the torn MCLs and build up pulmonary endurance. I need a walker and cane to ambulate. This process was made more difficult by the fact that my family could not be with me during my illness because of the highly contagious nature of Covid-19. I estimate it will be years of therapy to recover, and that I may never fully recover from these injuries. But as a Paramedic in the FNDY I am only given 18 months of leave from work for line of duty injuries ("LODI") and so my future is uncertain. I don't know what I will do if I am not fully recovered, as I most likely will not be, and able to return to work in a little over a year when my LODI runs out. This also has a devastating impact on me financially in the immediate because LODI pays only my base salary, i.e. the 37.5 hours, not the 60 to 70 hours that I needed to work with overtime

to make ends meet. This means I am making roughly a quarter of the amount I had been making before my line of duty injury. This has caused me substantially more stress financially while I try to recover from this injury. Also if I do have to retire do to contracting Covid-19 on the job, it is unlikely that I would be given the ¾ pension that my colleagues on the fire side receive when they retire from an injury in the line of duty.

Dated: July 31, 2020
New York, New York

Christell Cadet

Sworn to before me this 31
day of July, 2020

Notary Public

BRIAN A JASINSKI
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 02JA6402579
Qualified in New York County
Commission Expires January 06, 2024

The New York Times https://www.nytimes.com/2019/09/21/opinion/sunday/emt-paramedics-salary.html

Emergency Medical Workers Deserve Pay Equity

Paramedics and E.M.T.s are just as professional as firefighters and should be compensated accordingly.

Sept. 21, 2019

By The Editorial Board
The editorial board represents the opinions of the board, its editor and the publisher. It is separate from the newsroom and the Op-Ed section.

Christell Cadet says she had been on the job as a paramedic for the New York Fire Department for just weeks in 2012 when the ambulance she and her partner were in came under gunfire during a call in Harlem, forcing them to peel away.

Paramedics and emergency medical technicians in New York learn to be prepared for anything: rushing into burning buildings to give aid to firefighters; braving active shooters to reach the wounded; enduring assaults by patients — particularly those addicted to opioids, who are sometimes confused or event violent after being revived with the anti-overdose drug naloxone.

“I love what I do,” Ms. Cadet says. “But it’s stressful.”

Christell Cadet has been a paramedic for the New York Fire Department since 2012. Damon Winter/The New York Times

This is the job of the roughly 4,100 E.M.T.s and paramedics of the F.D.N.Y. The job is getting tougher in New York, where medical calls, not fires, now make up most of the Fire Department's responsibilities. In 2018, more than 80 percent of the 1.7 million incidents to which the department responded were medical, according to department officials. The same year, the more than 11,000 firefighters and officers of the F.D.N.Y. responded to 40,784 fires, including 1,983 so-called serious fires, like apartment fires or fires that spread to several buildings.

Firefighters across the country also perform the duties of paramedics and E.M.T.s. But in New York, paramedics and E.M.T.s are a separate work force within the F.D.N.Y. Though they are all skilled workers employed by the same city agency, the difference in pay and benefits is striking.

The base salary for an E.M.T. is $50,604 after five years on the job. That base rises to $65,226 for paramedics, who receive more training and perform advanced lifesaving procedures like intubation. Though the pay is comparable to private ambulance services, it is significantly less than what the city's firefighters earn. After five years on the job, a firefighter's base pay is $85,292.

The benefits are also different. Firefighters have unlimited sick pay, for example, while paramedics and E.M.T.s — who regularly come into contact with sick patients — have 12 days of paid sick leave every year.

Ms. Cadet is one of roughly 4,100 E.M.T.s and paramedics of the F.D.N.Y. Damon Winter/The New York Times

Responding to a call in Queens about a child with seizures. Damon Winter/The New York Times

The unions that represent E.M.T.s and paramedics have fought to close the gap, pointing to the growing workload and arguing that they face some of the same dangers as firefighters.

On Sept. 4, Local 2507 and Local 3621 of District Council 37, along with the E.M.S. Superior Officers Association, filed a complaint with the United States Equal Employment Opportunity Commission, charging that the disparity was also a matter of racial and gender discrimination. Their evidence: Nearly 78 percent of the department's firefighters and officers are white, and nearly 99 percent of them are male. The F.D.N.Y.'s emergency medical services are far more diverse: About 41 percent are white, 28 percent Hispanic, 21 percent black and 5 percent Asian. More than one in four Emergency Medical Services workers are female.

Labor and civil rights attorneys say a discrimination case would most likely depend on the ability of the E.M.S. unions to show that their jobs are sufficiently similar to that of firefighters to justify similar pay. The case could be strengthened by the department's history of discriminatory hiring practices. In 2014, the city agreed to give $98 million in back pay and benefits to minority firefighter applicants to settle a class-action suit that argued the F.D.N.Y.'s hiring practices discriminated against racial minorities. In the late 1970s and early 1980s, New York was forced to allow women to become firefighters after Brenda Berkman, an applicant who had been rejected, successfully sued the city.

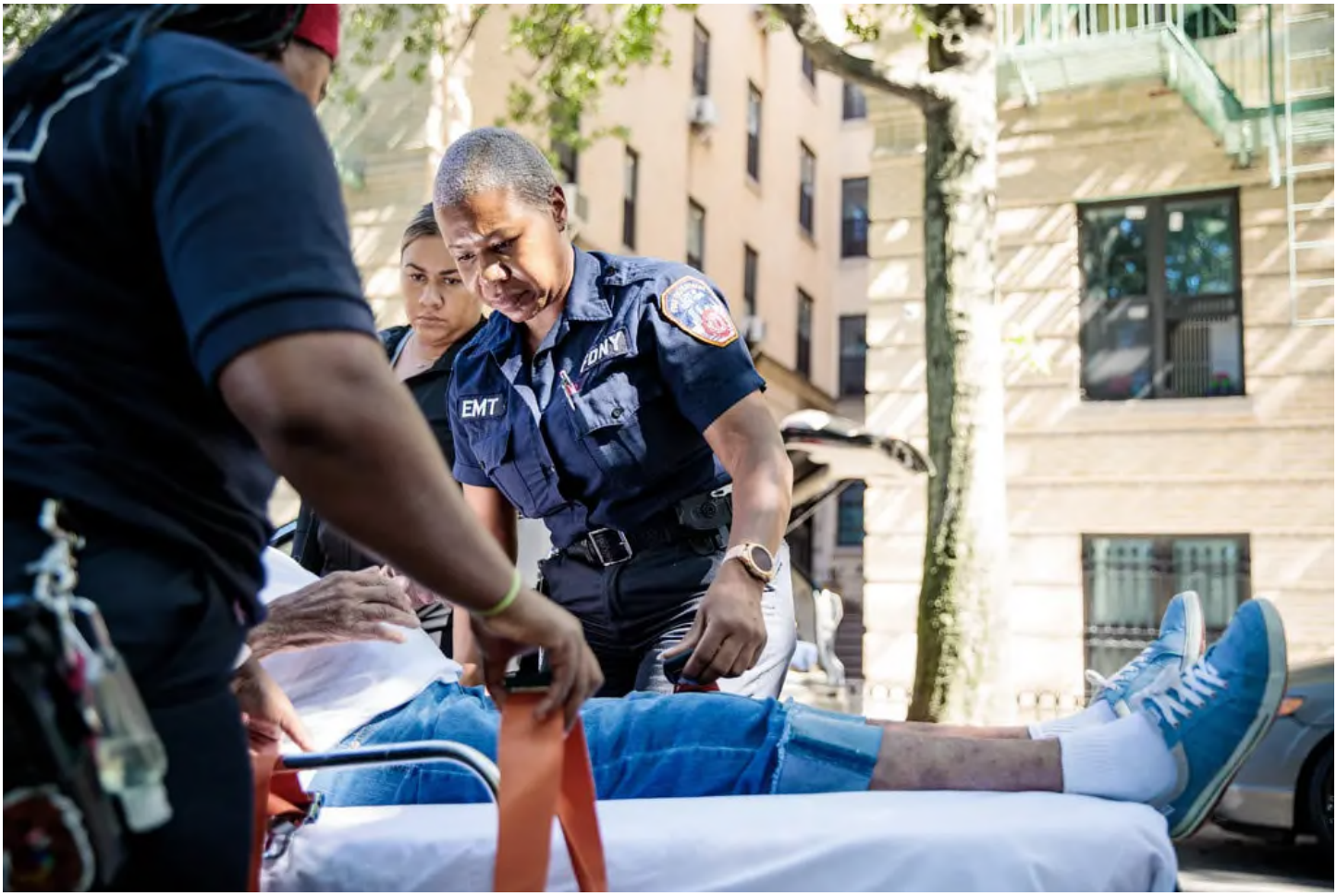
Mayor Bill de Blasio, whose administration has been in contract negotiations with the unions representing E.M.T.s and paramedics for more than a year now, has dismissed the idea that the disparities are discriminatory, saying the work is simply different than that of firefighters. City officials said giving similar or equal pay to paramedics and E.M.T.s could cost the city some $450 million annually. Cutting down on overtime pay at the Fire Department — which amounted to more than $340 million in fiscal year 2019, which ended in June — may help.

Firefighters do have different jobs. There are far fewer structural fires in New York than there once were, but that doesn't make the job of fighting them any less hazardous. Firefighters are more likely to die on the job than paramedics and E.M.T.s. Since 2009, nine firefighters have died in the line of duty in New York City, compared with one member of the E.M.S. The figures don't include firefighters and E.M.S. workers who have died of illnesses related to toxic air in the Sept. 11 attacks.

Yet as the department's role in emergencies changes, and it becomes a significant provider of medical care, the salary and benefits of its E.M.S. workers must also evolve.

As Ms. Cadet's experience shows, in addition to a rising workload, paramedics and E.M.T.s regularly encounter hazards similar to those faced by the police and firefighters. A 2013 University of Maryland study, using data from the Department of Labor, found that the injury rate of E.M.T.s and paramedics is three times higher than the national average for the general population. In March, James Booth, the E.M.S. chief at the time, said during testimony before a City Council committee that assaults on paramedics and E.M.T.s by the public had increased by nearly 50 percent between 2015 and 2018, from 79 to 117.

Such conditions, along with the disparity in pay and benefits, have prompted hundreds of E.M.T.s and paramedics to become firefighters in recent years. They get preferential treatment in hiring, and since 2013, 1,533 of them have become firefighters, according to city officials. The move is considered a promotion, and has helped improve racial diversity in the city's firefighting force. But it has also left the ambulance service with fewer and less-experienced emergency medical personnel.



Shakeria Tate, right, loading a patient onto an ambulance during her shift in the Bronx. Damon Winter/The New York Times

In large part because of this shortage, E.M.S. workers regularly work lots of overtime — 1.2 million hours of overtime in 2018, up from 893,000 in 2008, despite the addition of 1,000 workers over the past decade, according to city data. Mayor de Blasio's administration seemed to acknowledge this fact when it said in an annual performance report last week that it planned to increase the sizes of its incoming E.M.T. and paramedic classes. The announcement came alongside the news that dispatch and travel time of ambulances to life-threatening medical emergencies in the city had increased by nearly 30 seconds. "Despite the department's aggressive efforts to hire additional E.M.T.s and paramedics," city officials wrote, the number of ambulances in service every day fell to 460 in fiscal year 2019, compared with 472 the previous year.

Many E.M.S. workers say they rely on overtime to make ends meet anyway, because of the low pay and the high cost of living in New York. Shakeria Tate, an E.M.T., said she works a double shift about twice a week. Ms. Tate has two children, and when she works her grandmother watches her 9-year-old daughter, Ms. Tate's youngest. "I have to make sure I can pay the bills," she says.

But Ms. Tate said that though she enjoys the job, the work can be grinding. "I've been in active shootings. I've been hit by patients," she said. "The public really doesn't know what we do. We're not just taxi drivers. We're here to help you live."

New York's emergency medical workers should be paid salaries and benefits far closer, if not equal to, the city's firefighters. That's what's owed the tiny force of people providing New Yorkers with critical medical care in their hour of need.

The number of ambulances in service every day fell in 2019. Damon Winter/The New York Times

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A version of this article appears in print on , Section SR, Page 8 of the New York edition with the headline: E.M.T.s Deserve Pay Equity

CORONAVIRUS

NYC paramedic hospitalized with coronavirus sedated, breathing with ventilator as condition worsens, family says

By Noah Goldberg
New York Daily News • Mar 24, 2020 at 6:21 pm

Expand

Christell Cadet, an FDNY paramedic with coronavirus. (Courtesy of Sherry Singleton)

Listen to this article

FDNY EMS paramedic Christell Cadet — who shared her coronavirus struggle with the world last week from her hospital bed — is now unable to breathe comfortably on her own and has been hooked up to a ventilator, her distraught family told the Daily News Tuesday.

Cadet, 34, is sedated and has a breathing tube down her throat, but hasn't given up the fight, her family and friends said.

On Friday, Cadet was well enough to speak to CNN from her Long Island hospital, where she was admitted last week.

But over the weekend, her condition took a dramatic turn for the worse, said her family and friends, who are unable to visit her due to the highly-contagious nature of the virus.

“She has definitely gotten worse,” said friend and fellow FDNY EMS paramedic Sherry Singleton, who last spoke with Cadet via text on Saturday. Cadet’s condition then showed signs of small signs of deterioration, Singleton said. Her friend was short of breath and getting oxygen round the clock.

By Monday, Cadet was unreachable by either phone or text — and her concerned family soon learned why.

Cadet was transferred to the ICU and sedated, her mother, Jessy Cadet, 61, told The News. The family learned the news early Tuesday.

“Since this morning it’s really, really difficult for me. I can’t think or focus. I try to remind myself I have to remain strong even though she can’t hear me right now,” the anxious mother said.

Cadet was hospitalized a week ago after she collapsed outside her Queens home upon returning from an EMS tour. Her family found her on her hands and knees and struggling to breathe. She later tested positive for coronavirus.

On Friday, speaking to CNN from her hospital bed, Cadet said she'd been working light duty — meaning not doing ambulance tours — with EMS for the past several weeks. She was not handling patients directly and only interacting with other FDNY staff.

"It's terrifying and we're just hoping she makes it through to the other side," her friend Singleton said.

People practice social distancing while enjoying the nice weather at Central Park's Sheep Meadow on Saturday, May 2, 2020, in New York. New York City police dispatched 1,000 officers this weekend to enforce social distancing as warmer weather tempted New Yorkers to come out of quarantine. (Ronald Blum/AP)

Her family is trying to understand why an otherwise healthy 34-year-old woman has been hit so hard by the respiratory virus, which is considered most dangerous for the elderly.

“It’s a big question mark for me … 34 years old, for that virus to get on her so aggressively, it’s heartbreaking. I don’t even know how to express that or describe it,” said Jessy Cadet.

FDNY spokesman Jim Long said the department hopes “for a quick return to health for all FDNY members affected by COVID-19.”

As of Monday, 45 FDNY members, including firefighters, EMS and civilians, had tested positive for coronavirus.

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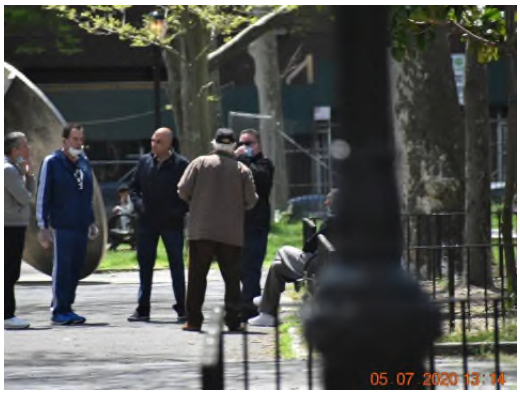

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IRISH CAUCUS

January 12, 2021

Hon. Bill de Blasio, Mayor
City of New York
City Hall
New York, NY 10007

Dear Mayor de Blasio,

Last year was a challenging year for our city, especially for the men and women in Emergency Medical Services (EMS) and Emergency Medical Technicians (EMT). We have had over 1800 of these brave heroes who have contracted COVID-19 and five who have passed. Since the onset of this deadly pandemic, our first responders have put themselves in harm's way to save others, and we must make every effort to provide them with essential services.

It has come to my attention that EMS/EMT workers are not being vaccinated during their work hours and have to schedule vaccinations during their time off. Their grueling schedules and the trauma they face at their jobs daily necessitate much-needed rest for these heroes. Forcing EMS/EMT workers to schedule vaccinations when not on duty could be a deterrent to vaccination, and this issue must be addressed. The City and the Fire Department of New York (FDNY) ought to make every effort to vaccinate these workers during work hours.

I have also learned that if EMS/EMT workers have severe reactions to a vaccine or suffer a medical problem resulting from contracting COVID-19, or in the process of their duties, they do not qualify for medical insurance workers compensation. Considering the pay parity issues which have plagued this city for years and with no resolution in sight, it is disheartening to learn that our brave first responders have to use their sick days for this purpose. Other first responders can acquire workers' compensation and do not have to use their sick days, and this should also be offered to EMS/EMT workers.

This is a critical issue that needs immediate resolution. I look forward to hearing from you about how City Hall can better assist these individuals, who have put so much on the line for 8.6 million New Yorkers.

Sincerely,

Robert F. Holden
Council Member, District 30

Cc: Daniel A. Nigro, Commissioner of the New York City Fire Department (FDNY)
Oren Barzilay, President of the Uniformed EMTs, Paramedics & Fire Inspectors, FDNY, Local 2507 (DC37)
Vincent Variale, President of the Unfirmed EMS Officers Union, FDNY, Local 3621

The City of New York

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Director, Employee Benefits Program

ATTACHMENT S

Gerard Fitzgerald, President
Uniformed Firefighters Association
204 East 23rd Street
New York, NY 10010

Re: 2010-2017 UFA Agreement

Dear Mr. Fitzgerald:

This will confirm our mutual understanding that a member who reports being injured or becoming ill while on duty shall receive overtime while waiting for a doctor after his or her scheduled tour of duty ends if ordered by the medical officer to stay.

Very truly yours,

RENEE CAMPION

AGREED AND ACCEPTED ON BEHALF OF THE UFA:

By: GERARD FITZGERALD

September 22, 2022

Testimony of Oren Barzilay, President
Local 2507
Uniformed EMTs, Paramedics and Fire Inspectors
Committees on Civil and Human Rights, and Civil Service and Labor
RE: Pay Equity in the Municipal Workforce and in Support of Intro 515, 527, and 541

Hello, my name is Oren Barzilay. I am the President of Local 2507 representing over 4,000 Uniform EMTs Paramedics and Fire Inspectors serving in the FDNY.

I want to thank the Committee Chairs as well as the Speaker for your tireless efforts with this important issue.

I have to be honest, it is very disappointing that DCAS and OLR are so unwilling to be part of the solution to this very serious problem that has had such a devastating impact on our members and the greater municipal workforce that serves this City every day.

This is not the first hearing we have had on this matter. In fact, the disparity of pay in our Department is so staggering that in 2020 this body passed a resolution calling on the City to remedy the pay inequity within the FDNY. Yet here we area again with the same excuses and no action. Equal employment opportunity is not a goal in the future, it is a right every municipal worker has TODAY. Pay equity is not too expensive, what is expensive is the crippling effect of discrimination and

suppressed wages. And its not just pay it's respect. FDNY withholding benefits to EMS while pretending there are civilian even though the law says otherwise is not just unlawful, it is inhumane. Let me try to put a human face on why this matters so much.

Christell Cadet, a paramedic and member of our union, was not able to be here today but submitted testimony detailing her experiences as an EMS First Responder when she was injured in the line of duty by contracting Covid on the job in the early part of the pandemic before there were vaccines or medicines to protect her. Paramedic Cadet was in a coma for a month intubated and fighting for her life. By the grace of god she pulled through, when many did not.

Was she held up as a hero by the FDNY? Was she given the resources and benefits that any first responder in the FDNY should be given when they risk their lives to save others? No.

EMS first responders are not allowed unlimited sick leave, so she had to use up her vacation time and then when she had no more vacation time she had to fight the bureaucracy of workers compensation which pays a fraction of what she was making. Because as an EMS first responder she is not recognized as uniform by the City even though the law says she is, she is not entitled to disability benefits. Instead she has had to go through a grueling process hiring an attorney to fight NYCERS for disability which most likely she will not get, all while trying to heal from a life threatening illness. The Department has not given her a reasonable accommodation like a desk job as they would of course give a firefighter in this situation. The prognosis for Paramedic Cadet is that once her worker's compensation runs out she will be forced out of the Department and lose her career. This is unacceptable. She risked her life for this City at its most vulnerable time in history. THIS is what pay inequity looks like.

I will give you another example. EMS first responders handle fire calls along with firefighters. They work side by side firefighters even

going onto the fire floor. At any fire scene you can spot EMS first responders because they are the FDNY members wearing the beige jackets.

Imagine, god forbid, as they are working together a gas line explodes or the fire traps them, and their lives are tragically lost;

The firefighters family gets a lifetime of death coverage where they receive the firefighters' annual income for life and the spouse and children get lifetime health insurance (children until 26 years old) along with many programs to cover their college, etc. Let's say conservatively that the firefighters salary was $100,000 for 20 years plus health benefits. That's $2 Million plus benefits.

The spouse of the first responder who happens to be in a beige uniform (EMS) gets the value of three years of salary (which again is significantly less than their firefighter counterpart) and nothing more. No lifetime health insurance, no health insurance for children, no lifetime salary. Let's say their salary is $50,000 a year for 3 years. That's $150,000 and no benefits.

When are we going to start valuing the lives of these women and people of color who fight every day to save the lives of others only to be treated with such indignity and disregard? THIS is what pay inequity looks like.

Thank you for your time.

##

September 22, 2022

Testimony of Anthony Almojera, Vice President
Uniformed EMS Officers Union, Local 3621,
FDNY AFSCME AFL-CIO
Committees on Civil and Human Rights, and
Civil Service and Labor
RE: Pay Equity in the Municipal Workforce and in Support of Intro 515, 527, and 541

Thank you Chairs Williams and De La Rosa, and distinguished committee members.

My name is Anthony Almojera and I am the Vice President of Local 3621 representing EMS Lieutenants and Captains serving in the FDNY.

I want to follow up on the testimony of my colleague Mr. Barzilay to first thank these committees and the Speaker and express our support of intros 515, 527 and 541. The transparency these bills will bring is much needed.

Anyone who has worked for the City or has basic familiarity with its workforce understands that the problem with pay inequity is Citywide. We hear time and again that the titles are just too different, the disparity pay is reasonable and the demographics are a coincidence, or at least not the City's fault.

In the FDNY you have firefighters who are predominately white and male and EMS first responders who are mostly of color with significantly more women. You can guess which side is paid pennies to the dollar, the argument being the fire side's work is substantially more challenging, justifying the pay difference. But when you actually look closer, the facts show something very different.

Since 1996, due to a decline in structural fires and a change in the emergency needs of the City, the New York City Fire Department merged with EMS and became an integrated department of first responders providing lifesaving emergency services to protect the public. Both EMS and fire personnel are dispatched to the same emergencies, are trained at the same facilities to perform life-saving skills, and put in the same hazardous environments in the field.

Some of the emergency services which EMS and fire are both trained for and respond to together include:

- Active shooters
- Basic Life Saving and Trauma Events
- Bomb threats
- Building fires
- Car Accidents
- Cardiac Arrests
- Chemical leaks
- Electrical fires
- Exposure to contaminates
- Haztec
- Hurricane response
- Respiratory distress calls
- Terrorist attacks

In addition to this field work, the work performed within FDNY operations, such as dispatch, training and general operations are fully integrated. As such, there is no difference in the work performed in these units whether EMS or fire personnel perform them.

Yet the Department continues to perpetrate the myth that these titles are so different that it justifies paying the EMS first responders half what the firefighters responding to these same emergencies are paid. And to be clear the training and expertise of EMS first responders is highly intense and substantially more than a firefighter. By way of example firefighters are only trained in minimal basic life saving less than that of an EMT, while Paramedics are trained in advance life saving. What that means is that a firefighter with 5 years experience is paid $96,000 a year to provide less basic life saving services in the same emergencies than an EMT with 5 years experience who is paid $59,000 to provide more advanced life saving services at that same emergency. There is no non-discriminatory explanation for that.

While the environment and demands of FDNY First Responders are similar, what is different is the racial and gender make up.

To: COMMITTEE ON CIVIL AND HUMAN RIGHTS
Meeting of September 22, 2022

Written Testimony of Taras M. Czebiniak
Submitted Online

RE: A Demand To End Human Rights Violations in New York City, Perpetuated by Mayor Eric Adams and the City Council, with Covid-19 Private and Public Worker Injection Mandates

The purpose of this written testimony with supporting exhibits is to make it easy for future historians of New York City to confirm that you, the City Council, together with Mayor Eric Adams commit and perpetuate human rights violations here with your full personal knowledge and consent. There remains a legal mandate in New York City that all City workers, and all private workers, have received a Covid injection in order to earn a living (the "**Mandate**"). (*See* EXHIBIT 1: Emergency Executive Order No. 317, December 15, 2021.) The Mandate is inconsistent, hypocritical, dangerous, it goes against the global consensus against mRNA injection mandates, and it violates the Nuremberg Code established after examination of the Nazi atrocities of World War II.

You can no longer claim ignorance of, or deny your full complicity with, Human Rights Violations in New York City in 2022.

The City Council has the power to stop the human rights violations, but up until today, the Council has refused to stand against the Mayor, and the Council therefore stands against human rights.

1. The Mandate violates the fundamental human right of every New Yorker to choose his or her medical interventions, a right enunciated in the Nuremberg Code of August 1947. EXHIBIT 2 provides the relevant text of the Nuremberg Code. The threat of being fired from one's job, losing one's pension or retirement benefits, and any and all other methods of coercion and duress to force the Covid injection violate the Nuremberg Code -- period. The Nuremberg Code is clear, it is written in plain English, and it is accessible and understandable by every human citizen on each. One need not be an 'expert' of any kind to understand and demand the rights confirmed by the Nuremberg Code.

2. Private employers continue to block non-injected workers from working, and they threaten existing workers with an ultimatum to take the injection and return to the office, or else be fired. The Mayor has stated that he is not personally enforcing the private employer mandate. But New Yorkers remain unable to work or are forced into taking the injection, because the Mayor has merely deputized private employers who conduct the enforcement on his behalf. My personal friend was given an ultimatum to either permit Mayor Adams to violate her bodily autonomy and take a Covid injection, or else be fired. (*See* NEW YORK CITY COUNCIL, Testimony of Taras M. Czebiniak, online video of the proceedings of the September 9, 2022 meeting of the Committee on Civil Service and Labor, time index: 3 hours 44 minutes.) Large private employers will not violate standing law, regardless of a politician's promise not to enforce, therefore the Mandate remains pernicious to private workers and violates them. As another example, Goldman Sachs has dropped all of its Covid injection mandates – except in New York City and Lima, Peru. (*See* BLOOMBERG, August 30, 2022, *Goldman Lifts Most Vaccination Rules for Staff in Office*.) This is because only those cities still require Covid injection from employees where Goldman Sachs maintains offices. (Regarding the worker mandates in Lima, Peru, *see* ACTUALIDAD CIVIL, March 28, 2022, *A partir del 1 de abril, trabajadores deberán tener las tres dosis de la vacuna contra el covid-19*.)

3. The Mandate forces a medically dangerous intervention, that both government and pharmaceutical companies have provably lied about, for nearly 2 years. A recent study published in VACCINE confirms that the Covid mRNA injections, those most prevalent in the United States, carry a 1 in 800 rate of serious adverse events, defined by the Code of Federal Regulations (21 C.F.R. section 312.32(a)) as death, life-threatening illness, hospitalization or prolongation of hospitalization, permanent disability, congenital anomaly, or birth defect. Neither the federal or city government, nor the pharmaceutical companies themselves, have disclosed these numbers. Consent to any medical procedure is not informed, as required by medical ethics, when material information is withheld, obfuscated, censored, and outright lied about by those in power. (EXHIBIT 3: VACCINE 40:40, 22 September 2022, pages 5798-5805, *Serious adverse events of special interest following mRNA COVID-19 vaccination in randomized trials in adults*.) Further, the authors of the VACCINE study confirm that both the federal FDA and Pfizer-BioNTech have the underlying data, but they refuse to release it to unbiased third parties to determine safety and efficacy. Finally, the German Health Ministry has confirmed that 1 in 5,000 Germans have experienced "serious side effects" from Covid injections.

4. Most other countries have long since ended their Covid injection mandates. Denmark has gone even further: Denmark no longer recommends Covid injections to anyone under 50 years without other health risks. The Danish Health Authority now recognizes that the Covid injections no longer have a benefit for individuals under 50. Not only are the injections not mandated, but they are not even recommended. (*See* EXHIBIT 4: Danish Health Authority, updated September 13, 2022, *Vaccination against covid-19*.) Mayor Adams is not a physician nor a public health official, and yet he claims to magically know more about Covid than virtually every other country on earth that has eliminated mandates and even recommendations to continue injecting.

5. The Mandate exempts celebrities and athletes and treats them differently from everyday New Yorkers. This policy which has absolutely no scientific or medical basis. The Mandate must end for all. On March 4, 2022, Mayor Adams exempted performing artists and their staff, as well as professional athletes and their staff, from the private sector Covid injection mandate. (EXHIBIT 5: Emergency Executive Order 62.) There is no study demonstrating any scientific or medical reason for exempting rich, elite artists and athletes from the mandate. The entire mandate itself constitutes a human rights violation, and the Mayor must immediately rescind the Mandate for all New Yorkers -- not just his rich buddies that he wants to rub elbows and have himself photographed with.

CONCLUSIONS

It is a **crime against humanity** to coerce under duress harmful medical interventions to individuals without their free, voluntary, and informed consent to the intervention.

Mayor Adams has directly and indirectly **violated the bodies of tens of thousands of New Yorkers** by maintaining his Covid injection requirement to earn a living in New York City, which is a human right.

The New York **City Council is complicit in crimes against humanity** through its inaction to rein in this dictatorial Mayor and return and restore proper representation to the citizens of New York City.

Historians will look upon the 2022 New York City Council and the Mayor with absolute horror. You are fully aware of your perpetuation of crimes against humanity, yet, you have done nothing to stop this. Today is the day for the Council to draft and pass legislation to END the Mayor's Covid injection mandate.

Best regards,
Taras M. Czebiniak
TarasMC@gmail.com

EXHIBIT 1

Emergency Executive Order No. 317, December 15, 2021

See attached.

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

EMERGENCY EXECUTIVE ORDER NO. 317
December 15, 2021

WHEREAS, the COVID-19 pandemic has severely impacted New York City and its economy, and is addressed effectively only by joint action of the City, State, and Federal governments; and

WHEREAS, the state of emergency to address the threat and impacts of COVID-19 in the City of New York first declared in Emergency Executive Order No. 98, and extended most recently by Emergency Executive Order No. 296, remains in effect; and

WHEREAS, on October 29, 2021, U.S. Food and Drug Administration authorized the emergency use of the Pfizer-BioNTech COVID-19 Vaccine for the prevention of COVID-19 to include children 5 through 11 years of age; and

WHEREAS, on November 26, 2021, New York State Governor Kathy Hochul issued Executive Order No. 11 to address new emerging threats across the State posed by COVID-19, finding that New York is experiencing COVID-19 transmission at rates the State has not seen since April 2020 and that the rate of new COVID-19 hospital admissions has been increasing over the past month to over 300 new admissions a day; and

WHEREAS, the recent appearance in the City of the highly transmissible Omicron variant of COVID-19 suggests an increased risk of reinfection; and

WHEREAS, 70% of City residents are fully vaccinated and mandating vaccinations at the types of establishments that residents frequent will incentivize vaccinations, increasing the City's vaccination rates and saving lives; and

WHEREAS, additional reasons for requiring the measures continued in this Order are set forth in Emergency Executive Order No. 316;

NOW, THEREFORE, pursuant to the powers vested in me by the laws of the State of New York and the City of New York, including but not limited to the New York Executive Law, the New York City Charter and the Administrative Code of the City of New York, and the common law authority to protect the public in the event of an emergency:

Section 1. I hereby direct that Emergency Executive Order No. 316, dated December 13, 2021, shall be superseded in its entirety by the provisions of section 2 of this Order.

§ 2. a. The program set forth in this section shall be known as the "Key to NYC" program.

b. I hereby order that, except as provided in subdivision c of this section, a covered entity shall not permit a patron, full- or part-time employee, intern, volunteer, or contractor to enter a covered premises without displaying proof of vaccination and identification bearing the same identifying information as the proof of vaccination. However, for a child under the age of 18 only proof of vaccination, and not additional idenfication, is required to be displayed.

c. I hereby order that the following individuals are exempted from this section, and therefore may enter a covered premises without displaying proof of vaccination, provided that such individuals wear a face mask at all times except when they are consuming food or beverages:

(1) Individuals entering for a quick and limited purpose (for example, using the restroom, placing or picking up an order or service, changing clothes in a locker room, or performing necessary repairs);

(2) A nonresident performing artist not regularly employed by the covered entity, or a nonresident individual accompanying such a performing artist, while the performing artist or individual is in a covered premises for the purposes of such artist's performance, except that a performing artist is not required to wear a face mask while performing;

(3) A nonresident professional or college athlete/sports team that is not based in New York City (i.e., not a New York City "home team"), or a nonresident individual accompanying such professional or college athlete/sports team, who enters a covered premises as part of their regular employment for purposes of the professional or college athlete/sports team competition, except that such athlete is not required to wear a face mask while playing in a competition;

(4) An individual 5 years of age or older who enters a covered premises to participate in a school or after-school program offered by any pre-kindergarten through grade twelve public or non-public school, the Department of Youth & Community Development (DYCD), or another City agency, except that Department of Education (DOE) and charter school students participating in high risk extracurricular activities must comply with the vaccination requirements for high risk extracurricular activities as described in the relevent Order of the Commissioner of Health and Mental Hygiene Order issued on December 10, 2021;

(5) An individual who enters for the purposes of voting or, pursuant to law, assisting or accompanying a voter or observing the election; and

(6) An individual who was younger than five years of age on December 13, 2021, until 45 days after such individual's fifth birthday.

d. I hereby direct each covered entity to develop and keep a written record describing the covered entity's protocol for implementing and enforcing the requirements of this section. Such written record shall be available for inspection upon a request of a City official as allowed by law.

e. I hereby direct each covered entity to:

(1) Maintain a copy of workers' proof of vaccination or, if applicable, a record of reasonable accommodation(s) as described in paragraph (2)(iv) of this subdivision; or

(2) Maintain a record of such proof of vaccination, provided that such record shall include:

(i) the worker's name; and

(ii) whether the person is fully vaccinated; and

(iii) for a worker who submits proof of the first dose of a two-dose vaccine, the date by which proof of the second dose must be provided, which must be no later than 45 days after the proof of first dose was submitted; and

(iv) for a worker who does not submit proof of COVID-19 vaccination because of a reasonable accommodation, the record must indicate that such accommodation was provided, and the covered entity must separately maintain records stating the basis for such accommodation and any supporting documentation provided by such worker; or

(3) Check the proof of vaccination before allowing a worker to enter the workplace and maintain a record of the verification.

For a non-employee worker, such as a contractor, a covered entity may request that the worker's employer confirm the proof of vaccination in lieu of maintaining the above records. A covered entity shall maintain a record of such request and confirmation.

Records created or maintained pursuant to this section shall be treated as confidential.

A covered entity shall, upon request by a City agency, make available for inspection records required to be maintained by this section, consistent with applicable law.

f. I hereby direct each covered entity to post a sign in a conspicuous place that is viewable by prospective patrons prior to entering the establishment. The sign must alert patrons to the vaccination requirement in this section and inform them that employees and patrons are required to be vaccinated. The Department for Health and Mental Hygiene ("DOHMH") shall determine the text of such sign and provide a template on its website that a covered entity may use. A covered entity may use the sign available online at

nyc.gov/keytoNYC, or use its own sign, provided its sign must be no smaller than 8.5 inches by 11 inches, with text provided by DOHMH in at least 14-point font.

g. For the purposes of this Order:

(1) "Contractor" means the owner or employee of any business that a covered entity has hired to perform work within a covered premise.

(2) "Covered entity" means any entity that operates one or more covered premises, except that it shall not include pre-kindergarten through grade twelve (12) public and non-public schools and programs, houses of worship, childcare programs, senior centers, community centers, or as otherwise indicated by this Order.

(3) "Covered premises" means any of the following locations, except as provided in subparagraph (iv) of this paragraph:

(i) **Indoor Entertainment and Recreational Settings, and Certain Event and Meeting Spaces** including indoor portions of the following locations, regardless of the activity at such locations: movie theaters, music or concert venues, adult entertainment, casinos, botanical gardens, commercial event and party venues, museums, aquariums, zoos, professional sports arenas and indoor stadiums, convention centers and exhibition halls, hotel meeting and event spaces, performing arts theaters, bowling alleys, arcades, indoor play areas, pool and billiard halls, and other recreational game centers;

(ii) **Indoor Food Services**, including indoor portions of food service establishments offering food and drink, including all indoor dining areas of food service establishments that receive letter grades as described in section 81.51 of the Health Code; businesses operating indoor seating areas of food courts; catering food service establishments that provide food indoors on its premises; and any indoor portions of an establishment that is regulated by the New York State Department of Agriculture and Markets offering food for on-premises indoor consumption. The requirements of this Order shall not apply to any establishment offering food or drink exclusively for off-premises or outdoor consumption, or to a food service establishment providing only charitable food services, such as soup kitchens; and

(iii) **Indoor Gyms and Fitness Settings**, including indoor portions of standalone and hotel gyms and fitness centers, gyms and fitness centers in higher education institutions, yoga/Pilates/barre/dance studios, boxing/kickboxing gyms, fitness boot camps, indoor pools, CrossFit or other plyometric boxes, and other facilities used for conducting group fitness classes.

(iv) "Covered premises" do not include houses of worship or locations in a residential or office building the use of which is limited to residents, owners, or tenants of that building.

(4) "Identification" means an official document bearing the name of the individual and a photo or date of birth. Examples of acceptable identification include but are not limited to: driver's license, non-driver government ID card, IDNYC, passport, and school ID card.

(5) "Indoor portion" means any part of a covered premises with a roof or overhang that is enclosed by at least three walls, except that the following will not be considered an indoor portion: (1) a structure on the sidewalk or roadway if it is entirely open on the side facing the sidewalk; and (2) an outdoor dining structure for individual parties, such as a plastic dome, if it has adequate ventilation to allow for air circulation.

(6) "Nonresident" means any individual who is not a resident of New York City.

(7) "Patron" means any individual 5 years of age or older who patronizes, enters, attends an event, or purchases goods or services within a covered premise.

(8) "Proof of vaccination" means proof of receipt of a full regimen of a COVID-19 vaccine authorized for emergency use or licensed for use by the U.S. Food and Drug Administration or authorized for emergency use by the World Health Organization, not including any additional recommended booster doses, except that for children who are 5 years of age or older as of December 13, 2021, but younger than 12 years of age, "proof of vaccination" means proof of receipt of at least one dose of such a vaccine until January 28, 2022, after which time it shall mean proof of receipt of a full regimen of such vaccine. Such proof may be established by:

(i) A CDC COVID-19 Vaccination Record Card or an official immunization record from the jurisdiction, state, or country where the vaccine was administered or a digital or physical photo of such a card or record, reflecting the person's name, vaccine brand, and date administered; or

(ii) A New York City COVID Safe App (available to download on Apple and Android smartphone devices);

(iii) A New York State Excelsior Pass;

(iv) CLEAR's digital vaccine card; or

(v) any other method specified by the Commissioner of Health and Mental Hygiene as sufficient to demonstrate proof of vaccination.

(9) "Worker" means an individual who works in-person in New York City at a workplace in New York City. Worker includes a full- or part-time staff member, employer, employee, intern, volunteer or contractor of a covered entity, as well as a self-employed individual or a sole practitioner.

Worker does not include an individual who works from their own home and whose employment does not involve interacting in-person with co-workers or members of the public. Worker also does not include an individual who enters the workplace for a quick and limited purpose.

(10) "Workplace" means any location, including a vehicle, where work is performed in the presence of another worker or member of the public.

h. I hereby direct that each instance that a covered entity fails to check an individual's vaccination status shall constitute a separate violation of this section.

i. I hereby direct the City's Commission on Human Rights to publish guidance to assist covered entities in complying with this section in an equitable manner consistent with applicable provisions of the New York City Human Rights Law.

j. I hereby direct, in accordance with section 25 of the Executive Law, that staff from any agency designated by the Commissioner of Health and Mental Hygiene shall enforce the directives set forth in this section.

k. (1) I hereby direct that any person or entity who is determined to have violated the requirements of the Key to NYC program shall be subject to a fine, penalty and forfeiture of not less than $1,000. If the person or entity is determined to have committed a subsequent violation of this section within twelve months of the initial violation for which a penalty was assessed, such person or entity shall be subject to a fine, penalty and forfeiture of not less than $2,000. For every violation thereafter, such person or entity shall be subject to a fine, penalty and forfeiture of not less than $5,000 if the person or entity committed the violation within twelve months of the violation for which the second penalty was assessed. This section may be enforced pursuant to sections 3.05, 3.07, or 3.11 of the Health Code and sections 558 and 562 of the Charter.

(2) I hereby suspend: (i) Appendix 7-A of Chapter 7 of Title 24 of the Rules of the City of New York to the extent it would limit a violation of this section to be punished with a standard penalty of $1,000 or a default penalty of $2,000; and (ii) section 7-08 of such Chapter 7 and section 3.11 of the Health Code, to the extent such provisions would limit the default penalty amount that may be imposed for a violation of this section to $2,000.

(3) Notwithstanding the foregoing, this subdivision shall not apply until December 27, 2021 with respect to proof of receipt of a second dose of a two-dose vaccine.

l. Covered entities shall comply with further guidelines issued by DOHMH to further the intent of this section and increase the number of vaccinated individuals in the City.

m. I hereby order that section 20-1271 of the Administrative Code of the City of New York is modified by adding the following provision to the definition of "just cause:" Notwithstanding any provision of this chapter, a fast food employer shall be deemed to

have just cause when a fast food employee has failed to provide proof of vaccination required by an emergency executive order issued in response to the COVID-19 pandemic and shall not be required to follow progressive discipline procedures prior to terminating the employee, provided that the employee shall have 30 days from the date when the employer notified the employee of the requirement to submit such proof and the employee shall be placed on leave following such notification until such proof is provided. This provision shall not excuse the employer from the responsibility to provide a reasonable accommodation where required by law.

§ 3. This Emergency Executive Order shall take effect immediately.

Bill de Blasio,
MAYOR

EXHIBIT 2

Nuremberg Code, August 1947

1. The voluntary consent of the human subject is absolutely essential.

This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

Source: https://www.ushmm.org/information/exhibitions/online-exhibitions/special-focus/doctors-trial/nuremberg-code

EXHIBIT 3

Scientific Journal VACCINE, volume 40, issue 40, September 22, 2022

Serious Adverse Events of Special Interest Following mRNA Covid-19 Vaccination in Randomized Trials in Adults

See attached.

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Serious adverse events of special interest following mRNA COVID-19 vaccination in randomized trials in adults

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Serious adverse events
Adverse events of special interest
Brighton Collaboration
Coalition for Epidemic Preparedness Innovations
Safety Platform for Emergency vACcines

ABSTRACT

Introduction: In 2020, prior to COVID-19 vaccine rollout, the Brighton Collaboration created a priority list, endorsed by the World Health Organization, of potential adverse events relevant to COVID-19 vaccines. We adapted the Brighton Collaboration list to evaluate serious adverse events of special interest observed in mRNA COVID-19 vaccine trials.

Methods: Secondary analysis of serious adverse events reported in the placebo-controlled, phase III randomized clinical trials of Pfizer and Moderna mRNA COVID-19 vaccines in adults (NCT04368728 and NCT04470427), focusing analysis on Brighton Collaboration adverse events of special interest.

Results: Pfizer and Moderna mRNA COVID-19 vaccines were associated with an excess risk of serious adverse events of special interest of 10.1 and 15.1 per 10,000 vaccinated over placebo baselines of 17.6 and 42.2 (95 % CI −0.4 to 20.6 and −3.6 to 33.8), respectively. Combined, the mRNA vaccines were associated with an excess risk of serious adverse events of special interest of 12.5 per 10,000 vaccinated (95 % CI 2.1 to 22.9); risk ratio 1.43 (95 % CI 1.07 to 1.92). The Pfizer trial exhibited a 36 % higher risk of serious adverse events in the vaccine group; risk difference 18.0 per 10,000 vaccinated (95 % CI 1.2 to 34.9); risk ratio 1.36 (95 % CI 1.02 to 1.83). The Moderna trial exhibited a 6 % higher risk of serious adverse events in the vaccine group: risk difference 7.1 per 10,000 (95 % CI –23.2 to 37.4); risk ratio 1.06 (95 % CI 0.84 to 1.33). Combined, there was a 16 % higher risk of serious adverse events in mRNA vaccine recipients: risk difference 13.2 (95 % CI −3.2 to 29.6); risk ratio 1.16 (95 % CI 0.97 to 1.39).

Discussion: The excess risk of serious adverse events found in our study points to the need for formal harm-benefit analyses, particularly those that are stratified according to risk of serious COVID-19 outcomes. These analyses will require public release of participant level datasets.

1. Introduction

In March 2020, the Brighton Collaboration and the Coalition for Epidemic Preparedness Innovations partnership, Safety Platform for Emergency vACcines (SPEAC), created and subsequently updated a "priority list of potential adverse events of special interest relevant to COVID-19 vaccine trials." [1] The list comprises adverse events of special interest (AESIs) based on the specific vaccine platform, adverse events associated with prior vaccines in general, theoretical associations based on animal models, and COVID-19 specific immunopathogenesis. [1] The Brighton Collaboration is a global authority on the topic of vaccine safety and in May 2020, the World Health Organization's Global Advisory Committee on Vaccine Safety endorsed and recommended the reporting of AESIs based on this priority list. To our knowledge, however, the list has not been applied to serious adverse events in randomized trial data.

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0264-410X/

We sought to investigate the association between FDA-authorized mRNA COVID-19 vaccines and serious adverse events identified by the Brighton Collaboration, using data from the phase III randomized, placebo-controlled clinical trials on which authorization was based. We consider these trial data against findings from post-authorization observational safety data. Our study was not designed to evaluate the overall harm-benefit of vaccination programs so far. To put our safety results in context, we conducted a simple comparison of harms with benefits to illustrate the need for formal harm-benefit analyses of the vaccines that are stratified according to risk of serious COVID-19 outcomes. Our analysis is restricted to the randomized trial data, and does not consider data on post-authorization vaccination program impact. It does however show the need for public release of participant level trial datasets.

2. Methods

Pfizer and Moderna each submitted the results of one phase III randomized trial in support of the FDA's emergency use authorization of their vaccines in adults. Two reviewers (PD and RK) searched journal publications and trial data on the FDA's and Health Canada's websites to locate serious adverse event results tables for these trials. The Pfizer and Moderna trials are expected to follow participants for two years. Within weeks of the emergency authorization, however, the sponsors began a process of unblinding all participants who elected to be unblinded. In addition, those who received placebo were offered the vaccine. These self-selection processes may have introduced nonrandom differences between vaccinated and unvaccinated participants, thus rendering the post-authorization data less reliable. Therefore, to preserve randomization, we used the interim datasets that were the basis for emergency authorization in December 2020, approximately 4 months after trials commenced.

The definition of a serious adverse event (SAE) was provided in each trial's study protocol and included in the supplemental material of the trial's publication. [2–4] Pfizer and Moderna used nearly identical definitions, consistent with regulatory expectations. An SAE was defined as an adverse event that results in any of the following conditions: death; life-threatening at the time of the event; inpatient hospitalization or prolongation of existing hospitalization; persistent or significant disability/incapacity; a congenital anomaly/birth defect; medically important event, based on medical judgment.

In addition to journal publications, we searched the websites of the FDA (for advisory committee meeting materials) and Health Canada (for sections of the dossier submitted by sponsors to the regulator). [5] For the FDA website, we considered presentations by both the FDA and the sponsors. [6] Within each of these sources, we searched for SAE results tables that presented information by specific SAE type; we chose the most recent SAE table corresponding to the FDA's requirement for a safety median follow-up time of at least 2 months after dose 2.

For each trial, we prepared blinded SAE tables (containing SAE types without results data). Using these blinded SAE tables, two clinician reviewers (JF and JE) independently judged whether each SAE type was an AESI. SAE types that matched an AESI term verbatim, or were an alternative diagnostic name for an AESI term, were included as an AESI. For all other SAE types, the reviewers independently judged whether that SAE type was likely to have been caused by a vaccine-induced AESI, based on a judgment considering the disease course, causative mechanism, and likelihood of the AESI to cause the SAE type. Disagreements were resolved through consensus; if consensus could not be reached, a third clinician reviewer (PW) was used to create a majority opinion. For each included SAE, we recorded the corresponding Brighton Collaboration AESI category and organ system. When multiple AESIs could potentially cause the same SAE, the reviewers selected the AESI that they judged to be the most likely cause based on classical clinical presentation of the AESI.

We used an AESI list derived from the work of Brighton Collaboration's Safety Platform for Emergency vACcines (SPEAC) Project. This project created an AESI list which categorizes AESIs into three categories: those included because they are seen with COVID-19, those with a proven or theoretical association with vaccines in general, and those with proven or theoretical associations with specific vaccine platforms. The first version was produced in March 2020 based on experience from China. Following the second update (May 2020), the WHO Global Advisory Committee on Vaccine Safety (GACVS) adopted the list, and Brighton commenced a systematic review process "to ensure an ongoing understanding of the full spectrum of COVID-19 disease and modification of the AESI list accordingly." [7] This resulted in three additional AESIs being added to the list in December 2020. The subsequent (and most recent fourth) update did not result in any additional AESIs being added to the list. [1].

We matched SAEs recorded in the trial against an expanded list of AESIs created by combining Brighton's SPEAC COVID-19 AESI list with a list of 29 clinical diagnoses Brighton identified as "known to have been reported but not in sufficient numbers to merit inclusion on the AESI list." [7] Sensitivity analysis was used to determine whether use of the original versus expanded list altered our results.

Risk ratios and risk differences between vaccine and placebo groups were calculated for the incidence of AESIs and SAEs. We excluded SAEs that were known efficacy outcomes (i.e. COVID-19), consistent with the approach Pfizer (but not Moderna) used in recording SAE data. The Pfizer study trial protocol states that COVID-19 illnesses and their sequelae consistent with the clinical endpoint definition were not to be reported as adverse events, "even though the event may meet the definition of an SAE." [8] For unspecified reasons, Moderna included efficacy outcomes in their SAE tables, effectively reporting an all-cause SAE result. Because we did not have access to individual participant data, to account for the occasional multiple SAEs within single participants, we reduced the effective sample size by multiplying standard errors in the combined SAE analyses by the square root of the ratio of the number of SAEs to the number of patients with an SAE. This adjustment increased standard errors by 10 % (Pfizer) and 18 % (Moderna), thus expanding the interval estimates. We estimated combined risk ratios and risk differences for the two mRNA vaccines by averaging over the risks using logistic regression models which included indicators for trial and treatment group.

We used a simple harm-benefit framework to place our results in context, comparing risks of excess serious AESIs against reductions in COVID-19 hospitalization.

3. Results

Serious adverse event tables were located for each of the vaccine trials submitted for EUA in adults (age 16 + for Pfizer, 18 + for Moderna) in the United States: Pfizer-BioNTech COVID-19 vaccine BNT162b2 (NCT04368728) [2,9,10] and Moderna COVID-19 vaccine mRNA-1273 (NCT04470427). [3,11,12] (Table 1).

3.1. Reporting windows and serious adverse events

Moderna reported SAEs from dose 1 whereas Pfizer limited reporting from dose 1 to 1 month after dose 2. Both studies

Table 1
Data sources for phase III trials.

Trial	Data cutoff date	Journal articles	FDA sources	Health Canada sources
Pfizer trial in ages 16 and above (NCT04368728)	14 Nov 2020 (supported Dec 2020 EUA)	Aggregate data only	**Table 23 in sponsor briefing document**	**Table 55 in sponsor document C4591001 Final Analysis Interim Report Body**
Moderna trial in ages 18 and above (NCT04470427)	25 Nov 2020 (supported Dec 2020 EUA)	Table S11 in publication	Table 27 in sponsor briefing document	**Table 14.3.1.13.3 in sponsor document mRNA-1273-P301 Unblinded Safety Tables Batch 1 (DS2)**

Note: bolded font indicates dataset chosen for analysis; EUA = Emergency Use Authorization.

reported all data at the time of data cutoff (14 Nov 2020 for Pfizer, 25 Nov 2020 for Moderna). 17 SAEs that were efficacy endpoints were removed from the Moderna trial (16 "COVID-19" SAEs and 1 "COVID-19 pneumonia" SAE). One such efficacy endpoint meeting the definition of a SAE was removed from the Pfizer trial ("SARS-CoV-2 test positive" SAE).

The Pfizer trial exhibited a 36 % higher risk of serious adverse events in vaccinated participants in comparison to placebo recipients: 67.5 per 10,000 versus 49.5 per 10,000; risk difference 18.0 per 10,000 vaccinated participants (95 % compatibility[1] interval 1.2 to 34.9); risk ratio 1.36 (95 % CI 1.02 to 1.83). The Moderna trial exhibited a 6 % higher risk of SAEs in vaccinated individuals compared to those receiving placebo: 136 per 10,000 versus 129 per 10,000; risk difference 7.1 per 10,000 (95 % CI −23.2 to 37.4); risk ratio 1.06 (95 % CI 0.84 to 1.33). Combined, there was a 16 % higher risk of SAEs in mRNA vaccine recipients than placebo recipients: 98 per 10,000 versus 85 per 10,000; risk difference 13.2 (95 % CI −3.2 to 29.6); risk ratio 1.16 (95 % CI 0.97 to 1.39). **(**Table 2**)**.

3.2. Serious adverse events of special interest

Regarding whether each SAE type was included on the SPEAC derived AESI list, agreement between the two independent clinician reviewers was 86 % (281/325); 40 of the 44 disagreements were resolved through consensus, and only four disagreements necessitated a third clinician reviewer. **Supplemental** Table 1 includes a full list of included and excluded SAEs across both trials.

In the Pfizer trial, 52 serious AESI (27.7 per 10,000) were reported in the vaccine group and 33 (17.6 per 10,000) in the placebo group. This difference corresponds to a 57 % higher risk of serious AESI (RR 1.57 95 % CI 0.98 to 2.54) and a risk difference of 10.1 serious AESI per 10,000 vaccinated participants (95 % CI −0.4 to 20.6). In the Moderna trial, 87 serious AESI (57.3 per 10,000) were reported in the vaccine group and 64 (42.2 per 10,000) in the placebo group. This difference corresponds to a 36 % higher risk of serious AESI (RR 1.36 95 % CI 0.93 to 1.99) and a risk difference of 15.1 serious AESI per 10,000 vaccinated participants (95 % CI −3.6 to 33.8). Combining the trials, there was a 43 % higher risk of serious AESI (RR 1.43; 95 % CI 1.07 to 1.92) and a risk difference of 12.5 serious AESI per 10,000 vaccinated participants (95 % CI 2.1 to 22.9). **(**Table 2**)**.

Of the 236 serious AESIs occurring across the Pfizer and Moderna trials, 97 % (230/236) were adverse event types included as AESIs because they are seen with COVID-19. In both Pfizer and Moderna trials, the largest excess risk occurred amongst the Brighton category of coagulation disorders. Cardiac disorders have been of central concern for mRNA vaccines; in the Pfizer trial more cardiovascular AESIs occurred in the vaccine group than in the placebo group, but in the Moderna trial the groups differed by only 1 case. **(**Tables 3 and 4**)**.

[1] A compatibility interval is identical to a confidence interval, but relabeled to emphasize that it is not a Bayesian posterior interval (as is improperly suggested by the "confidence" label).[13,14].

3.3. Sensitivity analysis

As a sensitivity analysis, we restricted the serious AESI analysis to those AESIs listed in SPEAC's COVID-19 AESI list (i.e. separating out Brighton's list of 29 clinical diagnoses "known to have been reported but not in sufficient numbers to merit inclusion on the AESI list.") This reduced the total number of AESIs across the two trials by 48 (35 vaccine group, 13 placebo group). There was still a higher risk of serious AESI when limited to the SPEAC COVID-19 AESI list, but the magnitude of the excess (in both relative and absolute terms) was smaller than when using the larger AESI list. **(Supplemental** Table 2**)**.

3.4. Harm-benefit considerations

In the Moderna trial, the excess risk of serious AESIs (15.1 per 10,000 participants) was higher than the risk reduction for COVID-19 hospitalization relative to the placebo group (6.4 per 10,000 participants). [3] In the Pfizer trial, the excess risk of serious AESIs (10.1 per 10,000) was higher than the risk reduction for COVID-19 hospitalization relative to the placebo group (2.3 per 10,000 participants).

4. Comparison with FDA reviews

In their review of SAEs supporting the authorization of the Pfizer and Moderna vaccines, the FDA concluded that SAEs were, for Pfizer, "balanced between treatment groups," [15] and for Moderna, were "without meaningful imbalances between study arms." [16] In contrast to the FDA analysis, we found an excess risk of SAEs in the Pfizer trial. Our analysis of Moderna was compatible with FDA's analysis, finding no meaningful SAE imbalance between groups.

The difference in findings for the Pfizer trial, between our SAE analysis and the FDA's, may in part be explained by the fact that the FDA analyzed the total number of participants experiencing any SAE, whereas our analysis was based on the total number of SAE events. Given that approximately twice as many individuals in the vaccine group than in the placebo group experienced multiple SAEs (there were 24 more events than participants in the vaccine group, compared to 13 in the placebo group), FDA's analysis of only the incidence of participants experiencing any SAE would not reflect the observed excess of multiple SAEs in the vaccine group.

A more important factor, however, may be that FDA's review of non-fatal SAEs used a different analysis population with different follow-up windows. The FDA reported 126 of 21,621 (0.6 %) of vaccinated participants experienced at least one SAE at data cutoff compared to 111 of 21,631 (0.5 %) of placebo participants. In contrast, our analysis found 127 SAEs among 18,801 vaccine recipients versus 93 SAEs among 18,785 placebo recipients. [15] While summary results for the population we analyzed was provided in a table, FDA did not report an analysis of them. The substantially larger denominators in FDA's analysis (5,666 more participants) reflect the fact that their analysis included all individuals receiving at least one dose (minus 196 HIV-positive participants), irrespec-

Table 2
Serious adverse events.

Trial	Total events (events per 10,000 participants)[a] Vaccine	Placebo	Risk difference per 10,000 participants (95 % CI)[e]	Risk ratio (95 % CI)[e]
Serious adverse events				
Pfizer[b]	127 (67.5)	93 (49.5)	18.0 (1.2 to 34.9)	1.36 (1.02 to 1.83)
Moderna[c,d]	206 (135.7)	195 (128.6)	7.1 (−23.2 to 37.4)	1.06 (0.84 to 1.33)
Combined[f]	333 (98.0)	288 (84.8)	13.2 (-3.2 to 29.6)	1.16 (0.97 to 1.39)
Serious adverse events of special interest				
Pfizer	52 (27.7)	33 (17.6)	10.1 (-0.4 to 20.6)	1.57 (0.98 to 2.54)
Moderna	87 (57.3)	64 (42.2)	15.1 (-3.6 to 33.8)	1.36 (0.93 to 1.99)
Combined[f]	139 (40.9)	97 (28.6)	12.5 (2.1 to 22.9)	1.43 (1.07 to 1.92)

[a] Denominators for Pfizer were 18,801 in the vaccine group and 18,785 in the placebo group, and for Moderna were 15,185 in the vaccine group and 15,166 in the placebo group.
[b] Pfizer excluded efficacy outcomes from its SAE table (COVID-19 illnesses and their sequelae meeting the definition of an SAE). However, at least one SAE appears to have been inadvertently included, which we removed from our calculations (“SARS-CoV-2 test positive”: 0 vaccine group; 1 placebo group).
[c] Moderna included efficacy outcomes in its SAE table (COVID-19 illnesses and their sequelae meeting the definition of an SAE). We removed efficacy SAEs outcomes that could be identified: “COVID-19” and “COVID-19 pneumonia.” Lacking access to participant level data, SAEs that were sequelae of serious COVID-19 could not be identified and therefore remain included in this analysis.
[d] “All SAEs” for Moderna was calculated using the “Number of serious AEs” row in Moderna’s submission to FDA.[11].
[e] Standard errors used to estimate 95% CIs were inflated by the factor $\sqrt{}$[#SAE]/[#patients with SAE] to account for multiple SAE within patients.
[f] The combined risk differences and risk ratios were computed from the fitted logistic regression models and so may not exactly equal comparisons computed from the first two columns.

Table 3
Serious AESIs, Pfizer trial.

Brighton category	Vaccine	Placebo	Vaccine events per 10,000	Placebo events per 10,000	Difference in events per 10,000	Risk ratio
Association with immunization in general						
Anaphylaxis	1	1	0.5	0.5	0.0	1.00
Association with specific vaccine platform(s)						
Encephalitis/encephalomyelitis	0	2	0.0	1.1	−1.1	0.00
Seen with COVID-19						
Acute kidney injury	2	0	1.1	0.0	1.1	N/A
Acute liver injury	0	1	0.0	0.5	−0.5	0.00
Acute respiratory distress syndrome	2	1	1.1	0.5	0.5	2.00
Coagulation disorder	16	10	8.5	5.3	3.2	1.60
Myocarditis/pericarditis	2	1	1.1	0.5	0.5	2.00
Other forms of acute cardiac injury	16	12	8.5	6.4	2.1	1.33
Subtotal	39	28	20.7	14.9	5.8	1.39
Brighton list of 29 clinical diagnoses seen with COVID-19						
Abscess	4	1	2.1	0.5	1.6	4.00
Cholecystitis	4	2	2.1	1.1	1.1	2.00
Colitis/Enteritis	1	1	0.5	0.5	0.0	1.00
Diarrhea	1	0	0.5	0.0	0.5	N/A
Hyperglycemia	1	1	0.5	0.5	0.0	1.00
Pancreatitis	1	0	0.5	0.0	0.5	N/A
Psychosis	1	0	0.5	0.0	0.5	N/A
Subtotal	13	5	6.9	2.7	4.3	2.60
Total	**52**	**33**	**27.7**	**17.6**	**10.1**	**1.57**

tive of the duration of post-injection follow-up time. In contrast, our analysis was based on the study population with median follow-up $\geq$ 2 months after dose 2 (minus 120 HIV-positive participants), of which 98.1 % had received both doses. [2,17] The FDA’s analysis of SAEs thus included thousands of additional participants with very little follow-up, of which the large majority had only received 1 dose.

4.1. Comparison with post-authorization studies

Although the randomized trials offer high level evidence for evaluating causal effects, the sparsity of their data necessitates that harm-benefit analyses also consider observational studies. Since their emergency authorization in December 2020, hundreds of millions of doses of Pfizer and Moderna COVID-19 vaccines have been administered and post-authorization observational data offer a complementary opportunity to study AESIs. Post-authorization observational safety studies include cohort studies (which make use of medical claims or electronic health records) and disproportionality analyses (which use spontaneous adverse event reporting systems). In July 2021, the FDA reported detecting four potential adverse events of interest: pulmonary embolism, acute myocardial infarction, immune thrombocytopenia, and disseminated intravascular coagulation following Pfizer’s vaccine based on medical claims data in older Americans. [18] Three of these four serious adverse event types would be categorized as coagulation disorders, which is the Brighton AESI category that exhibited the largest excess risk in the vaccine group in both the Pfizer and Moderna trials. FDA stated it would further investigate the findings but at the time of our writing has not issued an update. Similarly, spontaneous-reporting systems have registered serious adverse reactions including anaphylaxis (all COVID-19 vaccines), thrombocytopenia syndrome among premenopausal females (Janssen vaccine), and myocarditis and pericarditis among younger males (Pfizer and Moderna vaccines). [19,20].

Using data from three postmarketing safety databases for vaccines (VAERS, EudraVigilance, and VigiBase), disproportionality studies have reported excess risks for many of the same SAE types as in

Table 4
Serious AESIs, Moderna trial.

Brighton category	Vaccine	Placebo	Vaccine events per 10,000	Placebo events per 10,000	Difference in events per 10,000	Risk ratio
Association with specific vaccine platform(s)						
Bell's Palsy	1	0	0.7	0.0	0.7	N/A
Encephalitis/encephalomyelitis	1	0	0.7	0.0	0.7	N/A
Seen with COVID-19						
Acute kidney injury	1	3	0.7	2.0	−1.3	0.33
Acute liver injury	1	0	0.7	0.0	0.7	N/A
Acute respiratory distress syndrome	7	4	4.6	2.6	2.0	1.75
Angioedema	0	2	0.0	1.3	−1.3	0.00
Coagulation disorder	20	13	13.2	8.6	4.6	1.54
Generalized Convulsions	2	0	1.3	0.0	1.3	N/A
Myelitis	0	1	0.0	0.7	−0.7	0.00
Myocarditis/pericarditis	4	5	2.6	3.3	−0.7	0.80
Other forms of acute cardiac injury	26	26	17.1	17.1	0.0	1.00
Other rash	1	1	0.7	0.7	0.0	1.00
Rhabdomyolysis	0	1	0.0	0.7	−0.7	0.00
Single Organ Cutaneous Vasculitis	1	0	0.7	0.0	0.7	N/A
Subtotal	65	56	42.8	36.9	5.9	1.16
Brighton list of 29 clinical diagnoses seen with COVID-19						
Abscess	1	0	0.7	0.0	0.7	N/A
Arthritis	3	1	2.0	0.7	1.3	3.00
Cholecystitis	4	0	2.6	0.0	2.6	N/A
Colitis/Enteritis	6	3	4.0	2.0	2.0	2.00
Diarrhea	2	1	1.3	0.7	0.7	2.00
Hyperglycemia	1	0	0.7	0.0	0.7	N/A
Hyponatremia	1	1	0.7	0.7	0.0	1.00
Pancreatitis	2	0	1.3	0.0	1.3	N/A
Pneumothorax	0	1	0.0	0.7	−0.7	0.00
Psychosis	1	1	0.7	0.7	0.0	1.00
Thyroiditis	1	0	0.7	0.0	0.7	N/A
Subtotal	22	8	14.5	5.3	9.2	2.75
Total	**87**	**64**	**57.3**	**42.2**	**15.1**	**1.36**

the present study. [21–23] For example, a study using VAERS and EudraVigilance comparing the disproportionality of adverse event reports between the influenza vaccine versus the mRNA COVID-19 vaccines reported excess risks for the following Brighton AESIs: cardiovascular events, coagulation events, hemorrhages, gastrointestinal events, and thromboses. [22] While CDC published a protocol[24] in early 2021 for using proportional reporting ratios for signal detection in the VAERS database, results from the study have not yet been reported. [25] Among self-controlled case series, one reported a rate ratio of 1.38 (95 % CI 1.12–1.71) for hemorrhagic stroke following Pfizer vaccine, [26] another reported 0.97 (95 % CI 0.81–1.15), [27] while a cohort study[28] reported 0.84 (95 % CI 0.54–1.27).

5. Discussion

Using a prespecified list of AESI identified by the Brighton Collaboration, higher risk of serious AESI was observed in the mRNA COVID-19 vaccine group relative to placebo in both the Pfizer and Moderna adult phase III trials, with 10.1 (Pfizer) and 15.1 (Moderna) additional events for every 10,000 individuals vaccinated. Combined, there was a risk difference of 12.5 serious AESIs per 10,000 individuals vaccinated (95 % CI 2.1 to 22.9). These results raise concerns that mRNA vaccines are associated with more harm than initially estimated at the time of emergency authorization. In addition, our analysis identified a 36 % higher risk of serious adverse events in vaccinated participants in the Pfizer trial: 18.0 additional SAEs per 10,000 vaccinated (95 % CI 1.2 to 34.9). Consistent with the FDA evaluation, our analysis found no clear difference in SAEs between groups in the Moderna trial.

Results between the Pfizer and Moderna trials were similar for the AESI analysis but exhibited substantial variation in the SAE analysis. Caution is needed in interpreting this variation as it may be substantially explained by differences in SAE recording practices in the trials rather than differences in actual vaccine harm profiles. For reasons that are not documented in the trial protocol, Moderna included efficacy outcomes in its SAE tabulations, while Pfizer excluded them. As a result, Moderna's SAE table did not present a traditional SAE analysis but rather an all-cause SAE analysis. The FDA analysis of the Moderna trial presented an all-cause SAE analysis, which estimates total vaccine effects on SAEs, including effects transmitted via effects on COVID-19. It did not however present a traditional SAE analysis with efficacy endpoints removed, which attempts to estimate only the direct effects on SAEs. While our analysis attempted to perform a traditional SAE analysis by excluding efficacy SAEs (serious COVID-19 and its sequelae), our effort was hindered because we did not have access to patient level data. Easily recognizable efficacy SAEs ("COVID-19", "COVID-19 pneumonia," and "SARS-CoV-2 test positive") could be removed, but many participants who experienced a COVID-19 SAE likely experienced multiple other SAEs (e.g. pneumonia, hypoxia, and thrombotic events) which could not be identified and therefore remain included in our analysis. Of 17 total efficacy SAEs (16 "COVID-19" and 1 "COVID-19 pneumonia") removed from our analysis of the Moderna trial, 16 were in the placebo arm. As a consequence, the background SAE risk (risk in absence of COVID-19) would be overestimated by the Moderna placebo group, resulting in underestimation of the actual risk of SAEs and AESIs attributable to the vaccine in the Moderna comparisons as well as in the combined analysis. Access to patient-level data would allow adjustments for this problem.

Rational policy formation should consider potential harms alongside potential benefits. [29] To illustrate this need in the present context, we conducted a simple harm-benefit comparison using the trial data comparing excess risk of serious AESI against reductions in COVID-19 hospitalization. We found excess risk of serious AESIs to exceed the reduction in COVID-19 hospitalizations in both Pfizer and Moderna trials.

This analysis has the limitations inherent in most harm-benefit comparisons. First, benefits and harms are rarely exact equivalents, and there can be great variability in the degree of severity within both benefit and harm endpoints. For example, intubation and short hospital stay are not equivalent but both are counted in "hospitalization"; similarly, serious diarrhea and serious stroke are not equivalent but both are counted in "SAE." Second, individuals value different endpoints differently. Third, without individual participant data, we could only compare the number of individuals hospitalized for COVID-19 against the number of serious AESI events, not the number of participants experiencing any serious AESI. Some individuals experienced multiple SAEs whereas hospitalized COVID-19 participants were likely only hospitalized once, biasing the analysis towards exhibiting net harm. To gauge the extent of this bias, we considered that there were 20 % (Pfizer) and 34 % (Moderna) more SAEs than participants experiencing any SAE. As a rough sensitivity calculation, if we divide the Pfizer excess serious AESI risk of 10.1 by 1.20 it becomes 8.4 compared to a COVID-19 hospitalization risk reduction of 2.3; if we divide the Moderna excess serious AESI risk of 15.1 by 1.34 it becomes 11.3 compared to a COVID-19 hospitalization risk reduction of 6.4.

Harm-benefit ratios will be different for populations at different risk for serious COVID-19 and observation periods that differ from those studied in the trials. Presumably, larger reductions in COVID-19 hospitalizations would have been recorded if trial follow-up were longer, more SARS-CoV-2 was circulating, or if participants had been at higher risk of serious COVID-19 outcomes, shifting harm-benefit ratios toward benefit. Conversely, harm-benefit ratios would presumably shift towards harm for those with lower risk of serious COVID-19 outcomes--such as those with natural immunity, younger age or no comorbidities. Similarly, waning vaccine effectiveness, decreased viral virulence, and increasing degree of immune escape from vaccines might further shift the harm-benefit ratio toward harm. Large, randomized trials in contemporary populations could robustly answer these questions. Absent definitive trials, however, synthesis of multiple lines of evidence will be essential. [30,48,49].

Adverse events detected in the post-marketing period have led to the withdrawal of several vaccines. An example is intussusception following one brand of rotavirus vaccine: around 1 million children were vaccinated before identification of intussusception, which occurred in around 1 per 10,000 vaccinees. [31] Despite the unprecedented scale of COVID-19 vaccine administration, the AESI types identified in our study may still be challenging to detect with observational methods. Most observational analyses are based on comparing the risks of adverse events "observed" against a background (or "expected") risk, which inevitably display great variation, by database, age group, and sex. [32] If the actual risk ratio for the effect was 1.4 (the risk ratio of the combined AESI analysis), it could be quite difficult to unambiguously replicate it with observational data given concerns about systematic as well as random errors. [33–35].

In addition, disproportionality analyses following COVID-19 vaccination also have limitations, particularly with respect to the type of adverse events seen in our study. The majority of SAEs that contributed to our results are relatively common events, such as ischemic stroke, acute coronary syndrome, and brain hemorrhage. This complicates signal detection because clinical suspicion of an adverse vaccine reaction following an event commonly seen in clinical practice will be lower than for SAEs like myocarditis.[50] For this reason, clinical suspicion leading to the filing of an individual case safety report--may be far less common in the post-authorization setting than in the trials. At the same time, heightened awareness about COVID-19 vaccine SAEs can result in under and overreporting. Public health messages assuring vaccine safety may lower clinical suspicion of potential causal relationships, whereas messages about potential harms can conversely stimulate reports that otherwise may not have been made. These factors can lead to bias both directions, further complicating interpretation. In contrast to these problems, in the randomized trials used in this analysis, all SAEs were to be recorded, irrespective of clinical judgment regarding potential causality.

Although our analysis is secondary, reanalyses of clinical trial data have led to the detection of adverse events well after the market entry of major drugs such as rofecoxib and rosiglitazone. [36,37] Our analysis has an advantage over postmarketing observational studies in that the data are from blinded, placebo-controlled randomized trials vetted by the FDA, which were matched against a list of adverse events created before the availability of the clinical-trial results and designed for use in COVID-19 vaccine trials.

Our study has several important limitations. First, Pfizer's trial did not report SAEs occurring past 1 month after dose 2. This reporting threshold may have led to an undercounting of serious AESIs in the Pfizer trial. Second, for both studies, the limited follow up time prevented an analysis of harm-benefit over a longer period. Third, all SAEs in our analysis met the regulatory definition of a serious adverse event, but many adverse event types which a patient may themselves judge as serious may not meet this regulatory threshold. Fourth, decisions about which SAEs to include or exclude as AESIs requires subjective, clinical judgements in the absence of detailed clinical information about the actual SAEs. We encourage third party replication of our study, with access to complete SAE case narratives, to determine the degree to which these decisions affected our findings. For additional sensitivity analyses, such replication studies could also make use of other AESI lists, such as those prepared by FDA, [38–41] CDC, [24], Pfizer, [42], or a *de novo* AESI list derived from a list of COVID-19 complications understood to be induced via SARS-CoV-2's spike protein. [43,44].

A fifth important limitation is our lack of access to individual participant data, which forced us to use a conservative adjustment to the standard errors. The 95 % CIs[13,14] calculated are therefore only approximate because we do not know which patients had multiple events. Finally, as described above, in the Moderna analysis, the SAEs that were sequelae of serious COVID-19 could not be identified and therefore remain included in our calculations. Because the vaccines prevent SAEs from COVID-19 while adding SAE risks of their own, this inclusion makes it impossible to separately estimate SAEs due to the vaccine from SAEs due to COVID-19 in the available Moderna data, as must be done to extrapolate harm-benefit to other populations. These study limitations all stem from the fact that the raw data from COVID-19 vaccine clinical trials are not publicly available. [45,46].

We emphasize that our investigation is preliminary, to point to the need for more involved analysis. The risks of serious AESIs in the trials represent only group averages. SAEs are unlikely to be distributed equally across the demographic subgroups enrolled in the trial, and the risks may be substantially less in some groups compared to others. Thus, knowing the actual demographics of those who experienced an increase in serious AESI in the vaccine group is necessary for a proper harm-benefit analysis. In addition, clinical studies are needed to see if particular SAEs can be linked to particular vaccine ingredients as opposed to unavoidable consequences of exposure to spike protein, as future vaccines could then be modified accordingly or sensitivities can be tested for in advance. In parallel, a systematic review and meta-analysis using individual participant data should be undertaken to address questions of harm-benefit in various demographic subgroups, particularly in those at low risk of serious complications from COVID-19. Finally, there is a pressing need for comparison of SAEs and harm-benefit for different vaccine types; some initial work has already begun in this direction. [47].

Full transparency of the COVID-19 vaccine clinical trial data is needed to properly evaluate these questions. Unfortunately, as we approach 2 years after release of COVID-19 vaccines, participant level data remain inaccessible. [45,46].

Author contributions

All authors had full access to all of the data in the study (available at https://doi.org/10.5281/zenodo.6564402), and take responsibility for the integrity of the data and the accuracy of the data analysis.

Study concept and design: All authors.
Acquisition of data: Doshi.
Analysis and interpretation: All authors.
Statistical analysis: Jones, Greenland.
Drafting of the manuscript: Fraiman, Doshi.
Critical revision of the manuscript for important intellectual content: All authors.

Data availability

All of the data in the study is available at https://doi.org/10.5281/zenodo.6564402

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Ethical review statement

This research was confirmed to be Not Human Subjects Research (NHSR) by University of Maryland, Baltimore (HP-00102561).

Conflicts of interest

JF, JE, MJ, SG, PW, RK: none to declare. PD has received travel funds from the European Respiratory Society (2012) and Uppsala Monitoring Center (2018); grants from the FDA (through University of Maryland M-CERSI; 2020), Laura and John Arnold Foundation (2017-22), American Association of Colleges of Pharmacy (2015), Patient-Centered Outcomes Research Institute (2014-16), Cochrane Methods Innovations Fund (2016-18), and UK National Institute for Health Research (2011-14); was an unpaid IMEDS steering committee member at the Reagan-Udall Foundation for the FDA (2016-2020) and is an editor at The BMJ. The views expressed here are those of the authors and do not necessarily reflect those of their employers.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.vaccine.2022.08.036.

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EXHIBIT 4

Danish Health Authority, *Vaccination against covid-19*

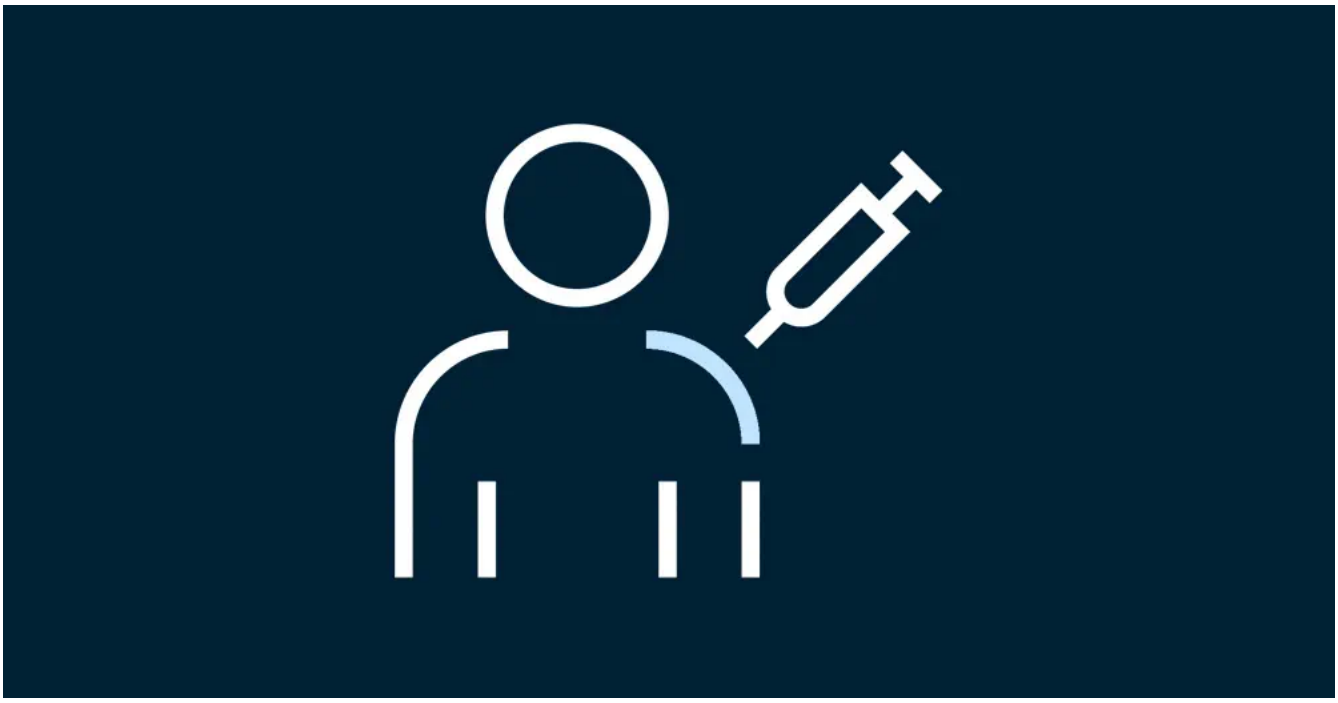
See attached.

DANISH HEALTH AUTHORITY

COVID-19

Vaccination against covid-19

The Danish Health Authority expects that the number of covid-19 infections will increase during autumn and winter. Therefore, we recommend vaccination of people aged 50 years and over as well as selected risk groups. Read more about the autumn vaccination programme here.



With the autumn vaccination programme, we aim to prevent serious illness, hospitalisation and death. The risk of becoming severely ill from covid-19 increases with age. Therefore, people who have reached the age of 50 and particularly vulnerable people will be offered vaccination. We expect that many people will be infected with covid-19 during autumn and winter. It is therefore important that the population remembers the guidance on how to prevent infection, which also applies to a number of other infectious diseases.

> See the guidance here: Prevent being infected with covid-19

On this page, you can read who will be offered vaccination, which vaccines we plan to use and when the programme will begin.

Q&A about vaccination

Who will be offered vaccination against covid-19?

People aged 50 years and over will be offered vaccination.

People aged under 50 who are at a higher risk of becoming severely ill from covid-19 will also be offered vaccination against covid-19.

Staff in the healthcare and elderly care sector as well as in selected parts of the social services sector who have close contact with patients or citizens who are at higher risk of becoming severely ill from covid-19 will also be offered booster vaccination against covid-19.

In addition, we recommend that relatives of persons at particularly higher risk accept the offer of vaccination to protect their relatives who are at particularly higher risk.

Why do we need to re-vaccinate?

We have achieved very high population immunity in Denmark. This is due both to the high adherence to the vaccination programme and to many people previously having been infected with covid-19. However, we expect that this immunity will gradually decrease over time. In addition, we know that covid-19 is a seasonal disease and that the number of infections are expected to increase during autumn and winter. We expect that a large part of the population will become infected with covid-19 during the autumn, and we therefore want to vaccinate those having the highest risk so that they are protected from severe illness if they become infected.

When will I be offered vaccination?

Nursing home residents and people aged 85 and over will be offered vaccination from mid-September. For others, the vaccination programme against covid-19 will begin on 1 October 2022.

I have a specific disease or condition – will I be offered vaccination?

People aged under 50 who are at higher risk of becoming severely ill are recommended vaccination against covid-19. This may, for example, be people who have a severely impaired immune system.

> Read more here

Will i get an invitation for vaccination?

If you are offered vaccination based on your age, you will receive an invitation in e-Boks/mit.dk. You will be offered vaccination against covid-19, influenza and pneumococci. For nursing home residents, there will be a special offer of local vaccination without appointment.

If you are in the target group for vaccination based on your illness/condition or your work, you will not receive an invitation. When the programme starts on 1 October, you can instead either:

- Fill in a solemn declaration and booking an appointment for vaccination on www.vacciner.dk. If you are in doubt about whether you are in the target group for vaccination, you can fill in a guiding questionnaire, which is also available on www.vacciner.dk, and then book an appointment if you are in the target group.
- Talk to your doctor, who can set up a vaccination process at www.vacciner.dk for you with the vaccines you are offered. You can then book an appointment yourself. In some cases, your doctor will be able to vaccinate you immediately.

If you are a healthcare professional or elderly care worker or employed in selected parts of the social services sector, your workplace can inform you about whether they offer vaccination of their staff.

Why are people aged under 50 not to be re-vaccinated? +

The purpose of the vaccination programme is to prevent severe illness, hospitalisation and death. Therefore, people at the highest risk of becoming severely ill will be offered booster vaccination. The purpose of vaccination is not to prevent infection with covid-19, and people aged under 50 are therefore currently not being offered booster vaccination.

People aged under 50 are generally not at particularly higher risk of becoming severely ill from covid-19. In addition, younger people aged under 50 are well protected against becoming severely ill from covid-19, as a very large number of them have already been vaccinated and have previously been infected with covid-19, and there is consequently good immunity among this part of the population.

It is important that the population also remembers the guidance on how to prevent the spread of infection, including staying at home in case of illness, frequent aeration or ventilation, social distancing, good coughing etiquette, hand hygiene and cleaning.

Variant-updated vaccines

What does it mean that a vaccine is variant updated? +

The Danish Health Authority will offer variant-updated mRNA vaccines in the autumn vaccination programme. These vaccines have been approved by the European Medicines Agency.

The vaccination, which will be offered during autumn/winter 2022-2023, consists of a variant-updated vaccine. The influenza vaccines are updated every year, and the covid-19 vaccines have likewise also been updated to target the Omicron variant more effectively.

The variant-updated vaccines have been adapted to the variant that is dominant in society.

What side effects do the vaccines have?

All vaccines cause side effects, including the covid-19 vaccines. In general, the side effects are mild and transient, and we consider the vaccines to be very safe and highly documented.

Studies of the variant-updated vaccines have shown that the side effects do not differ from those seen in connection with the vaccines we have previously used in Denmark.

Mild side effects

Most people will experience pain at the injection site. Other common side effects include fatigue, headache, pain in muscles and joints, chills, a slight fever as well as redness and swelling at the injection site. These are generally signs that your body's immune system is reacting as it should to the vaccine. You do not need to call your doctor if you experience these known and transient side effects. If you are among those who do not experience side effects, you should not worry that the vaccine is not working, because it will regardless of whether you experience side effects.

We know from other vaccines that almost all side effects occur within the first six weeks of vaccination. It is very rare for them to occur later than this. Both Danish and European medicines agencies monitor the vaccines closely after they have been approved both in relation to how well they work and how many side effects they cause.

However, there is a difference in how well the immune system of older and younger people responds to vaccines. Elderly people will typically have poorer-responding immune systems, and they will therefore typically experience fewer side effects.

Rare side effects

In rare cases, severe immediate allergic reactions (anaphylaxis) may occur, which may be caused by, for example, allergy to the additives in the vaccine. If you have previously had a severe allergic reaction immediately after being vaccinated or after being injected with a medicinal product, you should contact your doctor before being vaccinated against covid-19. If you have a known allergy to macrogols/PEG/polyethylene glycol, you should not be vaccinated with the mRNA vaccines.

Vaccination of children against covid-19

Children and adolescents rarely become severely ill from the Omicron variant of covid-19.

From 1 July 2022, it was no longer possible for children and adolescents aged under 18 to get the first injection and, from 1 September 2022, it was no longer possible for them to get the second injection.

A very limited number of children at particularly higher risk of becoming severely ill will still be offered vaccination based on an individual assessment by a doctor.

Should I be vaccinated?

Can I tolerate being vaccinated?

Can I tolerate being vaccinated?

Situations in which you should not be vaccinated

You should not be vaccinated against covid-19 if you have:

- A known, ascertained allergy to the vaccine (for example an immediate allergic reaction (anaphylaxis) in connection with the first injection)
- A known allergy to one of the excipients in the vaccine

Situations in which you should postpone vaccination

- You are acutely ill with a fever above 38°. You can be vaccinated if you only have a slight fever or light infections such as a common cold. However, you should always consider whether you might have covid-19 in this connection.
- You have covid-19 or suspect that you have covid-19.
- You have had covid-19 within one month before vaccination.
- You have been tested due to suspicion of covid-19 or because you are a close contact of an infected person.
- You are to undergo surgery within one week before or after vaccination.

Situations in which you should consult a doctor before being vaccinated

- You have been informed that there is a suspicion of allergy to macrogol/PEG/polyethylene glycol.
- You have previously had an immediate allergic reaction (anaphylaxis) after vaccination or after injection of another medicinal product.
- You have previously repeatedly had an immediate allergic reaction (anaphylaxis) after ingestion of other medicinal products (for example laxatives, stomach acid drugs).
- You have mastocytosis (a rare disease of the body's mast cells).

Situations in which you can be vaccinated

Most people tolerate the vaccine well. You can be vaccinated even if:

- You are waiting for the result of a covid-19 test
- You have developed a skin rash after taking other medicinal products (for example penicillin, ibuprofen).
- You cannot tolerate or experience discomfort from strong pills (for example painkillers).
- You have experienced common, known side effects after the first injection of the vaccine.
- You are allergic to foods (for example eggs, shellfish, nuts).
- You are allergic to insecticides, latex or the like.

- You have pollen allergy/hay fever, allergy to animals or asthma eczema.
- You are undergoing fertility treatment.
- You have received another vaccine (for example against influenza or pneumococci) on the same day/recently.
- You are a cancer patient and are undergoing treatment
- You have an impaired/weakened immune system1
- A family member has had an allergic reaction after vaccination.
- You do not want to consume products made from pigs.
- You have previously had treatment with botox.
- You are on ordinary blood-thinning medication.
- You have previously had a blood clot or there is a tendency to blood clots in your family.

[1]People with impaired/weakened immune system may have a poorer effect of the vaccine and should pay special attention to following

> The Danish Health Authority's guidance on how to prevent infection

Need further advice?

Healthcare professionals can contact Statens Serum Institut or the regional pharmacovigilance units/side effect managers.

CanI be vaccinated if I am ill?

If you have a fever of 38 degrees or more or have an acute severe infection such as pneumonia, your vaccination must be postponed.

You can be vaccinated if, for example, you only have a slight fever or a light infection such as a common cold, but you must always consider whether you may have covid-19.

Publications, etc.

Please click on the arrow to view our current publications, etc. on COVID-19 vaccination.

vaccination COVID-19

EXHIBIT 5

Emergency Executive Order 62, March 4, 2022

See attached.

THE CITY OF NEW YORK
OFFICE OF THE MAYOR
NEW YORK, N.Y. 10007

EMERGENCY EXECUTIVE ORDER NO. 62
March 24, 2022

WHEREAS, the COVID-19 pandemic has severely impacted New York City and its economy, and is addressed effectively only by joint action of the City, State, and Federal governments; and

WHEREAS, the state of emergency to address the threat and impacts of COVID-19 in the City of New York first declared in Emergency Executive Order No. 98, issued on March 12, 2020, and extended most recently by Emergency Executive Order No. 46, issued on February 28, 2022, remains in effect; and

WHEREAS, this Order is given because of the propensity of the virus to spread person-to-person, and also because the actions taken to prevent such spread have led to property loss and damage; and

WHEREAS, athletes and performing artists frequently conduct their work at venues both inside and outside of the City, without regard to their residence in the City, and their work benefits the City's economic recovery from the pandemic, often attracting large numbers of visitors to the City; and

WHEREAS, New York City athletic teams have been, and continue to be, at a competitive disadvantage because visiting teams can field unvaccinated players, and this competitive disadvantage has negatively impacted, and continues to negatively impact, New York City teams' success, which is important to the City's economic recovery and the morale of City residents and visitors; and

WHEREAS, additional reasons for requiring the measures continued in this Order are set forth in my prior Emergency Executive Order No. 50, issued on March 4, 2022;

NOW, THEREFORE, pursuant to the powers vested in me by the laws of the State of New York and the City of New York, including but not limited to the New York Executive Law, the New York City Charter and the Administrative Code of the City of New York, and the common law authority to protect the public in the event of an emergency:

Section 1. I hereby direct that section 1 of Emergency Executive Order No. 59, dated March 19, 2022, is extended for five (5) days.

§ 2. I hereby order that section 3 of Emergency Executive Order No. 50, dated March 4, 2022, is amended to read as follows.

§ 3. I hereby direct that:

a. Covered entities that had been covered by the Key to NYC program shall continue to require that a covered worker provide proof of vaccination, unless such worker has received a reasonable accommodation. Covered entities shall continue to keep a written record of their protocol for checking covered workers' proof of vaccination and to maintain records of such workers' proof of vaccination, as described in subdivisions d and e of section 2 of Emergency Executive Order No. 317, dated December 15, 2021.

b. Records created or maintained pursuant to subdivision a of this section shall be treated as confidential.

c. A covered entity shall, upon request by a City agency, make available for inspection the records required to be maintained by this section, consistent with applicable law.

d. For the purposes of this Section:

(1) "Covered entity" means any entity that operates one or more "covered premises," except that "covered entity" does not include pre-kindergarten through grade twelve (12) public and non-public schools and programs, houses of worship, childcare programs, senior centers, community centers.

(2) "Covered premises" means any of the following locations, except as provided in subparagraph (iv) of this paragraph:

> **(i) Indoor Entertainment and Recreational Settings, and Certain Event and Meeting Spaces**, including indoor portions of the following locations, regardless of the activity at such locations: movie theaters, music or concert venues, adult entertainment, casinos, botanical gardens, commercial event and party venues, museums, aquariums, zoos, professional sports arenas and indoor stadiums, convention centers and exhibition halls, hotel meeting and event spaces, performing arts theaters, bowling alleys, arcades, indoor play areas, pool and billiard halls, and other recreational game centers;
>
> **(ii) Indoor Food Services**, including indoor portions of food service establishments offering food and drink, including all indoor dining areas of food service establishments that receive letter grades as described in section 81.51 of the Health Code; businesses operating indoor seating areas of food courts; catering food service establishments that provide food indoors on its premises; and any indoor portions of an establishment that is regulated by the New York State Department of Agriculture and Markets offering food for on-premises indoor consumption; and

(iii) Indoor Gyms and Fitness Settings, including indoor portions of standalone and hotel gyms and fitness centers, gyms and fitness centers in higher education institutions, yoga/Pilates/barre/dance studios, boxing/kickboxing gyms, fitness boot camps, indoor pools, CrossFit or other plyometric boxes, and other facilities used for conducting group fitness classes.

(iv) "Covered premises" does not include houses of worship or locations in a residential or office building the use of which is limited to residents, owners, or tenants of that building.

(3) "Covered worker" means an individual who works in-person in the presence of another worker or a member of the public at a workplace in New York City. "Covered worker" includes a full- or part-time staff member, employer, employee, intern, volunteer, or contractor of a covered entity, as well as a self-employed individual or a sole practitioner.

"Covered worker" does not include:

(i) an individual who works from their own home and whose employment does not involve interacting in-person with co-workers or members of the public;

(ii) an individual who enters the workplace for a quick and limited purpose;

(iii) a performing artist, or an individual accompanying such performing artist, while the performing artist is in a covered premises for the purpose of such artist's performance; or

(iv) a professional athlete, or an individual accompanying such professional athlete or such athlete's sports team, who enters a covered premises as part of their regular employment.

(4) "Proof of vaccination" means proof of receipt of a full regimen of a COVID-19 vaccine authorized for emergency use or licensed for use by the U.S. Food and Drug Administration or authorized for emergency use by the World Health Organization, not including any additional recommended booster doses. Such proof may be established by:

(i) A CDC COVID-19 Vaccination Record Card or an official immunization record from the jurisdiction, state, or country where the vaccine was administered, or a digital or physical photo of such a card or record, reflecting the person's name, vaccine brand, and date administered; or

(ii) A New York City COVID Safe App (available to download on Apple and Android smartphone devices); or

(iii) A New York State Excelsior Pass; or

(iv) CLEAR's digital vaccine card; or

(v) Any other method specified by the Commissioner of Health and Mental Hygiene as sufficient to demonstrate proof of vaccination.

(5) I hereby order that section 20-1271 of the Administrative Code of the City of New York is modified by adding the following provision to the definition of "just cause:" Notwithstanding any provision of this chapter, a fast food employer shall be deemed to have just cause when a fast food employee has failed to provide proof of vaccination required by an emergency executive order issued in response to the COVID-19 pandemic and shall not be required to follow progressive discipline procedures prior to terminating the employee, provided that the employee shall have 30 days from the date when the employer notified the employee of the requirement to submit such proof and the employee shall be placed on leave following such notification until such proof is provided. This provision shall not excuse the employer from the responsibility to provide a reasonable accommodation where required by law.

e. An individual who meets the requirements of subparagraph (iii) or (iv) of section 3(d)(3) of this Order shall be exempt from the Order of the Commissioner of Health dated December 13, 2021, relating to requiring COVID-19 vaccination in the workplace.

§ 3. I hereby direct the Fire and Police Departments, the Department of Buildings, the Sheriff, and other agencies as needed, to enforce the directives set forth in this Order in accordance with their lawful authorities, including Administrative Code sections 15-227(a), 28-105.10.1, and 28-201.1, and section 107.6 of the Fire Code. Violations of the directives set forth in this Order may be issued as if they were violations under Health Code sections 3.07 and 3.11, and enforced by the Department of Health and Mental Hygiene or any other agency.

§ 4. This Emergency Executive Order shall take effect immediately and shall remain in effect for five (5) days unless it is terminated or modified at an earlier date.

Eric Adams
Mayor

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Kadidia Oscar

Address: 1 Centre Street NY, NY

I represent: DCAS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 9/22/22

(PLEASE PRINT)

Name: Jennifer Shaw

Address: EEPC 253 Broadway NYC

I represent: EEPC

Address: —

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Stella Xu

Address: [redacted] Yellowstone Blvd

I represent: DCAS

Address: 1 Centre St

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: Sept. 22, 2022

(PLEASE PRINT)

Name: SILVIA MONTALBAN

Address: _____

I represent: DCAS

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: Barbara Dannenberg

Address: DCAS

I represent: _____

Address: _____

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 9/22/22

(PLEASE PRINT)

Name: Daniel Pollak

Address: 22 Cortlandt St., 14th Floor

I represent: NYC office of Labor Relations

Address: _____

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 0521-2022 0527-2022 0515-2022 Res. No. _____

☑ in favor ☐ in opposition

Date: 09/22/22

(PLEASE PRINT)

Name: M. CELESTE CARBALLO

Address: 347 W. 53RD ST, NY, NY 10019

I represent: LOCAL 1559 (DC 37)

Address:

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 9/22/2022

(PLEASE PRINT)

Name: Kyle Simmons

Address: 125 Barclay Street NY NY 10007

I represent: President, Local 924, DC37

Address: (City Laborers)

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. 515 Res. No. _____

☐ in favor ☐ in opposition

Date: 9/22/22

(PLEASE PRINT)

Name: JEANNE M. VICTOR

Address:

I represent: EQUAL EMPLOYMENT PRACTICES COMM.

Address: 253 BROADWAY, SUITE 602 NY NY. 10007

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☐ in favor ☐ in opposition

Date: 9/22/2022

(PLEASE PRINT)

Name: Celeste Carballo

Address: 125 Barclay Street NY NY 10007

I represent: Exhibit Preparator and Executive Board

Address: Member, Local 1559 (Museum of Natural History)

Please complete this card and return to the Sergeant-at-Arms

THE COUNCIL
THE CITY OF NEW YORK

Appearance Card

I intend to appear and speak on Int. No. _____ Res. No. _____

☑ in favor ☐ in opposition

Date: _____

(PLEASE PRINT)

Name: DeWanie K Powell - President

Address: 2510 Westchester

I represent: United Probation Officers Association

Address: _____

Please complete this card and return to the Sergeant-at-Arms