Over 100 Scientists, Doctors, & Leading Authorities Call For Increased Vitamin D Use To Combat COVID-19
Scientific evidence indicates vitamin D reduces infections & deaths

To all governments, public health officials, doctors, and healthcare workers,
[Residents of the USA: Text “VitaminDforAll” to 50409 to send this to your state’s governor.]

Research shows low vitamin D levels almost certainly promote COVID-19 infections, hospitalizations, and deaths. Given its safety, we call for immediate widespread increased vitamin D intakes.

Vitamin D modulates thousands of genes and many aspects of immune function, both innate and adaptive. The scientific evidence\(^1\) shows that:

- Higher vitamin D blood levels are associated with lower rates of SARS-CoV-2 infection.
- Higher D levels are associated with lower risk of a severe case (hospitalization, ICU, or death).
- Intervention studies (including RCTs) indicate that vitamin D can be a very effective treatment.
- Many papers reveal several biological mechanisms by which vitamin D influences COVID-19.
- Causal inference modelling, Hill’s criteria, the intervention studies & the biological mechanisms indicate that vitamin D’s influence on COVID-19 is very likely causal, not just correlation.

Vitamin D is well known to be essential, but most people do not get enough. Two common definitions of inadequacy are deficiency < 20ng/ml (50nmol/L), the target of most governmental organizations, and insufficiency < 30ng/ml (75nmol/L), the target of several medical societies & experts.\(^2\) Too many people have levels below these targets. Rates of vitamin D deficiency <20ng/ml exceed 33% of the population in most of the world, and most estimates of insufficiency <30ng/ml are well over 50% (but much higher in many countries).\(^3\) Rates are even higher in winter, and several groups have notably worse deficiency: the overweight, those with dark skin (especially far from the equator), and care home residents. These same groups face increased COVID-19 risk.

It has been shown that 3875 IU (97mcg) daily is required for 97.5% of people to reach 20ng/ml, and 6200 IU (155mcg) for 30ng/ml,\(^4\) intakes far above all national guidelines. Unfortunately, the report that set the US RDA included an admitted statistical error in which required intake was calculated to be ~10x too low.\(^4\) Numerous calls in the academic literature to raise official recommended intakes had not yet resulted in increases by the time SARS-CoV-2 arrived. Now, many papers indicate that vitamin D affects COVID-19 more strongly than most other health conditions, with increased risk at levels < 30ng/ml (75nmol/L) and severely greater risk < 20ng/ml (50nmol/L).\(^1\)

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\(^1\) The evidence was comprehensively reviewed (188 papers) through mid-June [Benskin ‘20] & more recent publications are increasingly compelling [Merzon et al ‘20; Kaufman et al ‘20; Castillo et al ‘20]. (See also [Jungreis & Kellis ‘20] for deeper analysis of Castillo et al’s RCT results.)

\(^2\) E.g.: 20ng/ml: National Academy of Medicine (US, Canada), European Food Safety Authority, Germany, Austria, Switzerland, Nordic Countries, Australia, New Zealand, & consensus of 11 international organizations. 30ng/ml: Endocrine Society, American Geriatrics Soc., & consensus of scientific experts. See also [Bouillon ‘17].

\(^3\) [Palacios & Gonzalez ‘14; Cashman et al ‘16; van Schoor & Lips ‘17] Applies to China, India, Europe, US, etc.

\(^4\) [Heaney et al ‘15; Veugelers & Ekwaru ‘14]
Evidence to date suggests the possibility that the COVID-19 pandemic sustains itself in large part through infection of those with low vitamin D, and that deaths are concentrated largely in those with deficiency. The mere possibility that this is so should compel urgent gathering of more vitamin D data. Even without more data, the preponderance of evidence indicates that increased vitamin D would help reduce infections, hospitalizations, ICU admissions, & deaths.

Decades of safety data show that vitamin D has very low risk: Toxicity would be extremely rare with the recommendations here. The risk of insufficient levels far outweighs any risk from levels that seem to provide most of the protection against COVID-19, and this is notably different from drugs. Vitamin D is much safer than steroids, such as dexamethasone, the most widely accepted treatment to have also demonstrated a large COVID-19 benefit. Vitamin D’s safety is more like that of face masks. There is no need to wait for further clinical trials to increase use of something so safe, especially when remedying high rates of deficiency/insufficiency should already be a priority.

Therefore, we call on all governments, doctors, and healthcare workers worldwide to immediately recommend and implement efforts appropriate to their adult populations to increase vitamin D, at least until the end of the pandemic. Specifically to:

1. Recommend amounts from all sources sufficient to **achieve 25(OH)D serum levels over 30ng/ml (75nmol/L)**, a widely endorsed minimum with evidence of reduced COVID-19 risk.
2. Recommend to adults **vitamin D intake of 4000 IU (100mcg) daily** (or at least 2000 IU) in the absence of testing. 4000 IU is widely regarded as safe.\(^5\)
3. Recommend that adults at increased risk of deficiency due to excess weight, dark skin, or living in care homes may need higher intakes (eg, 2x). Testing can help to avoid levels too low or high.
4. Recommend that adults not already receiving the above amounts get 10,000 IU (250mcg) daily for 2-3 weeks (or until achieving 30ng/ml if testing), followed by the daily amount above. This practice is widely regarded as safe. The body can synthesize more than this from sunlight under the right conditions (e.g., a summer day at the beach). Also, the NAM (US) and EFSA (Europe) both label this a “No Observed Adverse Effect Level” even as a daily maintenance intake.
5. **Measure 25(OH)D levels of all hospitalized COVID-19 patients** & treat w/ calcifediol or D3, to at least remedy insufficiency <30ng/ml (75nmol/L), possibly with a protocol along the lines of Castillo et al ‘20 or Rastogi et al ‘20, until evidence supports a better protocol.

Many factors are known to predispose individuals to higher risk from exposure to SARS-CoV-2, such as age, being male, comorbidities, etc., but **inadequate vitamin D is by far the most easily and quickly modifiable risk factor with abundant evidence to support a large effect**. Vitamin D is inexpensive and has negligible risk compared to the considerable risk of COVID-19.

Please Act Immediately

\(^5\) The following include 4000 IU within their tolerable intakes in official guidelines: NAM (US, Canada), SACN (UK), EFSA (Europe), Endocrine Society (international), Nordic countries, The Netherlands, Australia & New Zealand, UAE, and the American Geriatrics Soc. (USA, elderly). No major agency specifies a lower tolerable intake limit. The US NAM said 4000 IU “is likely to pose no risk of adverse health effects to almost all individuals.” See also [Giustina et al ‘20].
The signatories below endorse this letter. Affiliations do not imply endorsement of the letter by the institutions themselves.

This letter takes no position on other public health measures besides vitamin D. Personal views of individual signatories on any other matter do not represent the group as a whole.

All signatories declare no conflicts of interest except as noted. 

To emphasize: The organizing signatories have no conflicts of interest in this area (financial or otherwise), nor have they done research in this area prior to 2020.

<table>
<thead>
<tr>
<th>Signatories (197)</th>
<th>recommended intake</th>
<th>personal daily intake</th>
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<tbody>
<tr>
<td><strong>Dr. Karl Pfleger</strong>, PhD AI &amp; Computer Science, Stanford. Former Google Data Scientist. Biotechnology Investor, AgingBiotech.info, San Francisco, CA, USA. (organizing signatory)</td>
<td>4000 IU</td>
<td>7000 IU</td>
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<tr>
<td><strong>Dr. Bruce W Hollis</strong>, PhD. Professor of Pediatrics, Medical University of South Carolina, USA.</td>
<td>4000 IU</td>
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<tr>
<td><strong>Dr. Barbara J Boucher</strong>, MD, FRCP (London). Honorary Professor (Medicine), Bizard Institute, Bart's &amp; The London School of Medicine and Dentistry, Queen Mary University of London, UK. (significantly contributing signatory)</td>
<td>4000 IU</td>
<td>2000 IU</td>
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<tr>
<td><strong>Dr. Ashley Grossman</strong>, MD FRCP FMedSci. Emeritus Professor of Endocrinology, University of Oxford, UK. Professor of Neuroendocrinology, Barts and the London School of Medicine. 2020 Endocrine Society Laureate Award.</td>
<td>2000 IU</td>
<td>2200 IU</td>
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<tr>
<td><strong>Dr. Gerry Schwalfenberg</strong>, MD, CCFP, FCFP. Assistant Clinical Professor in Family Medicine, University of Alberta, Canada.</td>
<td>4000 IU</td>
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<tr>
<td><strong>Dr. Giovanna Muscogiuri</strong>, MD PhD. Associate Editor, European Journal of Clinical Nutrition. Department of Clinical Medicine and Surgery, Section of Endocrinology, University “Federico II” of Naples, Naples, Italy..</td>
<td>4000 IU</td>
<td>1000 IU</td>
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<tr>
<td><strong>Dr. Michael F. Holick</strong>, PhD MD. Professor Medicine, Physiology and Biophysics and Molecular Medicine, Director Vitamin D, Skin and Bone Research Laboratory, Boston University Medical Center, USA. (6000 IU) Disclosure: Consultant Biogena and speaker’s Bureau Abbott Inc.</td>
<td>4000 IU</td>
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<tr>
<td><strong>Dr. John Umhau</strong>, MD, MPH. CDR, USPHS (ret). President, Academy of Medicine of Washington, DC, USA. Ex-NIH: co-author of the first peer-reviewed report linking vitamin D deficiency with acute respiratory infection. (significantly contributing signatory)</td>
<td>4000 IU</td>
<td>5000 IU</td>
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<tr>
<td><strong>Dr. Pawel Pludowski</strong>, MD, dr hab. Associate Professor, Biochemistry, Radioimmunology and Experimental Medicine, Children’s Memorial Health Institute, Warsaw, Poland. Chair, European Vitamin D Association (EVIDAS) [non-profit].</td>
<td>4000 IU</td>
<td>2000 IU</td>
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<tr>
<td><strong>Dr. Cedric F. Garland</strong>, DrPH. Professor Emeritus, Department of Family Medicine and Public Health, University of California, San Diego, USA.</td>
<td>4000 IU</td>
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</tbody>
</table>
Dr. Jose M. Benlloch, PhD. Professor, Director of the Institute for Instrumentation on Molecular Imaging, CSIC-UPV, Valencia, Spain. 2000 IU 3000 IU

Dr. Samantha Kimball, PhD, MLT. Professor, St. Mary's University, Calgary, Alberta, Canada. Research Director, GrassrootsHealth Nutrient Research Institute [non-profit]. (significantly contributing signatory) 4000 IU 6000 IU

Dr. William B. Grant, PhD Physics, U. of California, Berkeley. Director at Sunlight, Nutrition, and Health Research Center [non-profit], San Francisco, CA, USA. Disclosure: Receives funding from Bio-Tech Pharmacal, Inc. 4000 IU 5300 IU

Dr. Carol L. Wagner, MD. Professor, Medical University of South Carolina, USA. 4000 IU 5000 IU

Dr. Paul Marik, MD, FCCP, FCCM. Chief of Pulmonary and Critical Care Medicine and Professor of Medicine, Eastern Virginia Medical School, Norfolk, VA, USA. 2000 IU 2000 IU

Dr. Morry Silberstein, MD. Associate Professor, Curtin University, Australia. 4000 IU

Dr. Vatsal Thakkar, MD. Founder, Reimbursify, NY, USA. Former faculty, NYU and Vanderbilt. Op-Ed writer on Vitamin D and COVID-19. (significantly contributing signatory) 4000 IU 10,000 IU

Dr. Peter H Cobbold, PhD. Emeritus Professor, Cell Biology, University of Liverpool, UK. 4000 IU 4000 IU

Dr. Afrozul Haq, PhD. Professor Dept of Food Technology, Jamia Hamdard University, New Delhi, India. 4000 IU 2000 IU

Dr. Barry H. Thompson, MD, FAAP, FACMG. Clinical Associate Professor (Pediatrics), Uniformed Services University of the Health Sciences, Bethesda, MD, USA. 4000 IU 5000 IU

Dr. Reinhold Vieth, PhD, FCACB. Professor, Departments of Nutritional Sciences and Laboratory Medicine & Pathobiology, University of Toronto, Canada. Director (retired), Bone and Mineral Group Laboratory, Mt Sinai Hospital. Disclosure: Receives patent royalties from Ddrops (an infant vitamin D supplement). 4000 IU 4000 IU

Dr. Linda Benskin, PhD, RN, SRN(Ghana), CWCN, CWS, DAPWCA. Independent Researcher for Tropical Developing Countries and Ferris Mfg. Corp, Texas, USA. (significantly contributing signatory) 4000 IU 4000 IU

Jim O’Neill, CEO, SENS Research Foundation. Former principal associate deputy secretary of Health and Human Services, USA. 4000 IU 6000 IU

Dr. Eric Feigl-Ding, PhD. Epidemiologist & Health Economist. Senior Fellow, Federation of American Scientists. USA. 4000 IU 5000 IU

Rt Hon David Davis MP, Member of Parliament (Conservative Party). BSc, Joint Hons Molecular Science / Computer Science, Warwick University, UK. 4000 IU 6000 IU

Dr. Rupa Huq MP, Member of Parliament (Labour Party). PhD, Cultural Studies, University of East London, UK. 4000 IU

Dr. Susan J Whiting, PhD. Professor Emerita, University of Saskatchewan, Canada. 4000 IU 4000 IU

Dr. Richard Mazess. PhD. Emeritus Professor, University of Wisconsin, Madison, USA. 4000 IU 5000 IU

Dr. Helga Rhein, MD (retired). Sighthill Health Centre, Edinburgh, UK. (significantly contributing signatory) 4000 IU 3500 IU
Dr. Andrea Doeschl-Wilson, PhD. Professor of Infectious disease genetics and modelling, The Roslin Institute, University of Edinburgh, UK. 2000 IU


Dr. Luigi Gennari, MD PhD. Full Professor, Internal Medicine, Department of Medicine, Surgery and Neurosciences, University of Siena, Siena, Italy. 4000 IU 3500 IU

Dr. Ased Ali, MBChB, PhD, FRCS. Consultant Urological Surgeon, Mid Yorkshire Hospitals NHS Trust, UK. 4000 IU 8000 IU

Dr. Pavel Kocovsky, PhD DSc FRSE FRSC. Professor Charles University, Prague, and Czech Academy of Sciences, Czech Republic. 4000 IU 6000 IU

Dr. Ace Lipson, MD. Endocrinologist. Clinical Professor, George Washington University, Washington, DC, USA. 4000 IU 2000 IU

Dr. Attila R Garami, MD, PhD Multidisciplinary Medical Sciences. Senior Biomarker Consultant, Switzerland. 4000 IU 2500 IU

Dr. David S Grimes, MD (retired), FRCP, University of Manchester, UK. 4000 IU 4000 IU

Dr. Larry Callahan, PhD. Chemist, FDA, Maryland, USA. 2000 IU 3000 IU

Dr. Jeanne M Marconi, MD, Pediatrics. Vice President of PM Pediatrics, New York, USA. 4000 IU 5000 IU

Dr. Spiros Karras, MD. Endocrinologist, Department of Endocrinology and Metabolism-Diabetes Center, 1st Department of Internal Medicine, AHEPA University Hospital, Thessaloniki, Greece. 2000 IU 2000 IU

Dr. Joanna Byers, MBChB, University of Birmingham, UK. 4000 IU 5000 IU

Dr. Jaimin Bhatt, MBChB, MMed(Surgery) FRCS(Urol) FEBU. Consultant Urological Surgeon, Queen Elizabeth University Hospital, NHS Greater Glasgow and Clyde, UK. (2000 IU) 4000 IU 2000 IU

Dr. Christiane Northrup, MD. Obstetrician/Gynecologist, USA. 4000 IU 7500 IU

Dr. Jörg Spitz, Dr med. Academy of Human Medicine, Schlangenbad, Germany. 4000 IU 10,000 IU

Dr. Naghmeh Mirhosseini, MD, PhD, MPH. Research Associate, School of Public Health, University of Saskatchewan, Canada. 4000 IU 5000 IU

Dr. Iacopo Chiodini, MD. Associate Professor of Endocrinology, Dept. of Medical Biotechnology and Translational Medicine, University of Milan, Milan, Italy. Head, Unit for Bone Metabolism Diseases and Diabetes, Istituto Auxologico Italiano, IRCCS, Milan, Italy. 4000 IU 3500 IU

Dr. David C Anderson, MD MSc FRCPE FRCPath. Retired Physician and Endocrinologist, Former Professor of Endocrinology, Manchester University, UK and Professor of Medicine, The Chinese University of Hong Kong. 4000 IU 4000 IU

Dr. Colin Bannon, MBChB. GP (retired), Devon, UK. 4000 IU 5000 IU

Dr. Patricia S. Latham, MD EdD. Professor of Pathology & Medicine, George Washington University School of Medicine and Health Sciences, Washington, DC, USA. 2000 IU 2000 IU
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<thead>
<tr>
<th>Name</th>
<th>Institution and Position</th>
<th>Vitamin D Dose</th>
<th>Calcium Dose</th>
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<tbody>
<tr>
<td>Dr. Teresa Fuller</td>
<td>MD PhD. Pediatrician, Owings Mills, MD, USA.</td>
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<tr>
<td>Dr. Omar Wasow</td>
<td>PhD, Harvard. Assistant Professor, Politics, Princeton University, NJ, USA.</td>
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<tr>
<td>Dr. Fabio Vescini</td>
<td>MD PhD. Endocrinology and Metabolism Unit, University-Hospital S. Maria della Misericordia, Italy.</td>
<td>2000 IU</td>
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<tr>
<td>Dr. Emily Grossman</td>
<td>PhD Molecular Biology, University of Manchester, UK. Science Author, Broadcaster and Educator.</td>
<td>4000 IU</td>
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<tr>
<td>Dr. David Carman</td>
<td>MBChB, University of Cape Town, South Africa.</td>
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<tr>
<td>Dr. Kalliopi Kotsa</td>
<td>MD PhD. Professor, Endocrinology-Diabetes, Dept of Medicine, Aristotle University, Thessaloniki, Greece.</td>
<td>4000 IU</td>
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<tr>
<td>Dr. Eva Kocovska</td>
<td>PhD, Queen Mary University of London. Gillberg Neuropsychiatry Centre, University of Gothenburg, Sweden. Medical College, Prague, Czech Republic.</td>
<td>2000 IU</td>
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<tr>
<td>Dr. Benjamin Jacobs</td>
<td>MBBS MD MRCP(UK) FRCPCH. Royal National Orthopaedic Hospital, UK.</td>
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<tr>
<td>Dr. Joan Lappe</td>
<td>PhD RN FAAN. Professor, Creighton University, Omaha, Nebraska, USA.</td>
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<tr>
<td>Dr. Ronald A. Primas</td>
<td>MD FACP FACPM DABIHM CTH. New York, NY, USA.</td>
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<tr>
<td>Dr. Cristina Eller Vainicher</td>
<td>MD. Unit of Endocrinology, Fondazione Ca’Granda IRCCS OSpedale Maggiore Policlinico Milan, Italy. Head of the outpatients clinic for osteoporosis.</td>
<td>4000 IU</td>
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<tr>
<td>Dr. Matthias Gauger</td>
<td>MD. General Practitioner, Switzerland.</td>
<td>2000 IU</td>
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<td>Dr. David Warwick</td>
<td>DDS. Dentist, Alberta, Canada. Published Researcher.</td>
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<tr>
<td>Dr. Sunil J. Wimalawansa</td>
<td>MD PhD MBA FRCP FRCPPath FACE FACP DSc. Professor of Medicine, Endocrinology &amp; Nutrition, Cardiometabolic &amp; Endocrine Institute, New Jersey, USA.</td>
<td>4000 IU</td>
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<td>Perry S. Holman</td>
<td>Executive Director, Vitamin D Society [non-profit], Canada.</td>
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<tr>
<td>Sharon McDonnell</td>
<td>MPH. Biostatistician, GrassrootsHealth Nutrient Research Institute [non-profit], Encinitas, CA, USA.</td>
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<td>Mike Fisher</td>
<td>Founder, VitaminDassociation.org [non-profit]. Director of Research, Systems Biology Laboratory, UK.</td>
<td>4000 IU</td>
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<tr>
<td>Dr. Lina Zgaga</td>
<td>MD, PhD. Associate Professor of Epidemiology, Trinity College Dublin, University of Dublin, Ireland.</td>
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<tr>
<td>Dr. Irwin Jungreis</td>
<td>PhD, Harvard University. Research Scientist, Massachusetts Institute of Technology, Cambridge, MA, USA.</td>
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<tr>
<td>Dr. Jane Coad</td>
<td>PhD. Professor of Nutrition, Massey University, New Zealand.</td>
<td>4000 IU</td>
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<tr>
<td>Dr. Cedric Annweiler</td>
<td>MD PhD. Professor of Geriatric Medicine, School of Medicine, Health Faculty, University of Angers and Department of Medicine, Clinique de l’Anjou, Angers, France. Disclosure: occasional consultant for Mylan Laboratories Inc.</td>
<td>2000 IU</td>
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</table>
Dr. Salvatore Minisola, MD. Full Professor of Internal Medicine, "Sapienza" Rome University, Italy.

Dr. Mats B. Humble, MD PhD. Psychiatrist (retired), Senior lecturer, Department of Medical Sciences, Örebro University, Sweden.

Dr. Andrea Fabbri, MD PhD. Professor of Endocrinology, Head Endocrinology Division, Ospedale CTO A. Alesini, University of Rome Tor Vergata, Rome, Italy.

Dr. Steve Jones, PhD FRSE. Emeritus Professor of Human Genetics, Dept of Genetics, Evolution and Environment, University College London, UK.

Dr. Hermann Brenner, MD MPH. Professor of Epidemiology, Head of Clinical Epidemiology and Aging Research, German Cancer Research Center, Heidelberg, Germany.

Dr. Helder F. B. Martins, MD PhD (hon). Specialist & Emeritus Professor of Public Health. Former Minister of Health, Mozambique. Former WHO. Member, Mozambican Government COVID-19 advisory committee.

Dr. G. Siegfried Wedel, MD. Internist-Nephrologist (retired), Vierhöfen, Germany.

Dr. Robin Weiss, PhD FRCP FMedSci FRS. Emeritus Professor of Viral Oncology, Division of Infection & Immunity, University College London, UK.

Dr. Giancarlo Isaia, MD. Full Professor, University of Turin. President of the Academy of Medicine of Turin, Italy.

Dr. Susanne Bejerot, MD. Professor, Örebro University, Sweden.

Dr. Antonio D’Avolio, PhD. Professor of Pharmacology, University of Turin, Italy.

Dr. Gustavo Duque, MD PhD FRACP FGSA. Chair of Medicine & Director of the Australian Institute for Musculoskeletal Science (AIMSS). The University of Melbourne and Western Health, Melbourne, Australia.

Dr. Giovanni Passeri, MD PhD. Associate Professor, Internal Medicine, Dep. of Medicine and Surgery, University of Parma, Parma, Italy.

Dr. Pankaj Kapahi, PhD. Professor, Buck Institute for Research on Aging, Novato, California, USA.

Dr. Giuseppe Poli, MD PhD. Emeritus Professor of General Pathology, University of Turin, Italy.

Dr. Patrick McCullough, MD. Chief of Medical Services, Summit Behavioral Healthcare, Cincinnati, Ohio USA.

Dr. Prashanth Kulkarni, MD DM FSCAI FACC. Consultant Cardiologist, Hyderabad, India.

Dr. Klaus Badenhoop, MD PhD. Professor, Division of Endocrinology & Diabetes, Department of Internal Medicine, Goethe-University Hospital, Frankfurt am Main, Germany.

Dr. José-María Sánchez-Puelles, PhD. Senior Researcher, CIB Margarita Salas, CSIC, Spain

Dr. Carmelinda Ruggiero, MD PhD. Professor of Geriatric Medicine, School of Medicine, University of Perugia, Italy. Head of the Orthogeriatric Unit, S Maria
Dr. Jose Manuel Quesada Gomez, MD, PHD, Honorary Professor, University of Cordoba. Maimonides Research Institute, Cordoba. Spain.

Dr. Giovanni Minisola, MD. President Emeritus of Italian Society for Rheumatology. Scientific Director of "San Camillo - Forlanini" Foundation, Rome, Italy.

Christine French, MS. Research Analyst at GrassrootsHealth Nutrient Research Institute [non-profit], Encinitas, CA, USA.

Dr. Patrizia Presbitero, MD. Clinical and interventional cardiology, Cardio Center, Humanitas Research Hospital Rozzano, Rozzano, Milan, Italy.


Dr. Rajeev Venugopal, MBBS FRCS FACS DM. Consultant Plastic Surgeon/ Associate Lecturer in Surgery, University of the West Indies at Mona, Jamaica.

Dr. Gianluca Isaia, MD PhD. Geriatrician, Section of Geriatrics, Department of Medical Sciences, University of Turin, A.O.U. Città della Salute e della Scienza di Torino, Molinette, Turin, Italy.

Dr. Piero Stratta, MD. Professor of Nephrology, University Piemonte Orientale, Italy.

Dr. Ben Schöttker, PhD. Scientist, Division of Clinical Epidemiology and Ageing Research, German Cancer Research Center, Heidelberg, Germany.

Dr. Roberto Fantozzi, MD. Full Professor of Pharmacology, University of Turin, Turin, Italy.

Dr. Sheryl L. Bishop, PhD. Professor Emeritus, University of Texas Medical Branch, School of Nursing, Galveston, Texas, USA.

Dr. Wayne Jonas, MD. Professor of Family Medicine, Georgetown University. Former Director NIH Office of Alternative Medicine, USA.

Dr. Ferdinando Silveri, Medical Director of the Rheumatology Clinic of the Marche Polytechnic University, Ancona, Italy.

Dr. Vatsalya Vatsalya, MD. Department of Medicine, University of Louisville. National Institute on Alcohol Abuse and Alcoholism NIH, USA.

Dr. Rachel Nicoll, PhD. Medical researcher, Umeå University, Sweden.

Dr. Raimund von Helden, Dr med. Family medicine. Institute VitaminDelta, Lennestadt, Germany. Disclosure: Institute VitaminDelta sells consumer advice including on vitamin D for modest cost, but with no ties to other commercial interests.

Carole Baggerly, Founder & Director, GrassrootsHealth Nutrient Research Institute [non-profit], Encinitas, CA, USA.

Dr. Edward Gorham, PhD MPH. Adjunct Professor, University of California San Diego, School of Medicine, Dept of Family Medicine and Public Health, USA.

Dr. David Verhaeghen, MD, Anesthesiology, Algology and Pain Medicine, Aalst, Belgium.
Dr. Silvia Migliaccio, MD PhD. Associate Professor at University Foro Italico of Roma, Italy. Secretary of the Italian Society of Food Sciences.

Dr. Vítor Oliveira, MD, Internal Medicine, Brazil.


Dr. Wim Soetaert, PhD. Prof. Microbiology & Biotechnology, Ghent University, Centre for Industrial Biotechnology and Biocatalysis (InBio.be), Belgium.

Dr. Mark S. Braiman, PhD. Professor of Chemistry, Syracuse University, USA.

Dr. Mikko Paunio, MD PhD MHS. Adjunct Professor in General Epidemiology, University of Helsinki. Medical Counselor Ministry of Social Affairs and Health, Finland.

Dr. Manfred Eggersdorfer, PhD. Professor for Healthy Ageing, University Medical Center Groningen, The Netherlands. Member of the Advisory Board of the Johns Hopkins Bloomberg School of Public Health. Disclosure: Head of Nutrition Science and Advocacy, DSM Nutritional Products. Member of the scientific board of PM International.

Dr. Chris Newton, PhD. Research director, Centre for Immuno-Metabolism, Microbiome and Bio-energetic Research (CIMMBER), UK.

Dr. Doreen Brodmann, Dr med. Head of Nephrology, Spitalzentrum Oberwallis, Switzerland.

Dr. Srijit Mishra, PhD, Economics. Professor, Indira Gandhi Institute of Development Research, Mumbai, India.

Dr. Marco Infante, MD. Adjunct Professor of Endocrinology, UniCamillus - Saint Camillus International University of Health Sciences, Rome, Italy.

Dr. Jean-Marc Sabatier, PhD HDR. Director of research at CNRS (French National Centre for Scientific Research), Institut de NeuroPhysiopathologie (INP), Marseille, France.

Dr. Mohsin Sidat, MD PhD. University Eduardo Mondlane, Mondlane, Mozambique.

Dr. Dimitrios T. Papadimitriou, MD PhD. Director, Department of Pediatric-Adolescent Endocrinology & Diabetes, Athens Medical Center, Greece.

Dr. Bodo Schertel, Dr med. Professor, Hochschule Mannheim, Germany.

Dr. Jahit Sacarlal, MD PhD MPH. Professor, Department of Microbiology, Eduardo Mondlane University, Maputo, Mozambique.

Dr. Espen Haug, Phd. Professor, School of Economics and Business, Norwegian University of Life Sciences (NMBU), Norway.

Dr. Martin Hewison, PhD. Professor of Molecular Endocrinology, Institute of Metabolism and Systems Research, University of Birmingham, Birmingham, UK. Disclosure: Received honorarium from Thornton Ross (UK) for online seminar.

Dr. Damien Downing, MBBS MRSB. President, British Society for Ecological Medicine, UK.
Dr. Linda A. Lindsay, MD. Assistant Clinical Professor of Pediatrics, Icahn School of Medicine at Mount Sinai, New York, NY, USA.

Dr. Rose Anne Kenny, MD FRCP FRCPI FRCPEdin FTCD FESC MRIA. Professor, Chair of Medical Gerontology, Trinity College, Dublin, Ireland.

Dr. Mihkel Zilmer, Dr. med. Professor, Medical Biochemistry, Head of Department of Biochemistry, Tartu University, Faculty of Medicine, Estonia.

Dr. Jaan Eha, MD PhD. Professor of Cardiology, Tartu University, Faculty of Medicine, Estonia.

Dr. Anna Moore, MBBS PgDipNutrMed, London, UK.

Dr. Roger D. Seheult, MD. Assistant Professor, Loma Linda University School of Medicine. Associate Professor, UC Riverside School of Medicine. Cofounder, MedCram, USA.

Dr. Jean-Claude Souberbielle, PhD PharmD. Former head of Hormonology Laboratory, Necker Hospital, Paris, France.

Dr. Emmanuelle Faucon, MD, Toulon, France. Former Medical Affairs Director in Immunology and Virology, Bristol Myers Squibb.

Dr. Aida Santaolalla, PhD. Senior Data Scientist, Cancer Epidemiology, King’s College London, UK.

Dr. Elisa Song, MD. Pediatrician, Belmont, CA, USA.

Dr. Mylene Huynh, MD MPH. Colonel (ret), USAF. Adjunct Assistant Professor, Department of Preventive Medicine and Biometrics, Uniformed Services University of the Health Sciences, USA.

Dr. Yosef Weisman, MD. Professor. Retired head of Bone Disease Unit and the Vitamin D Lab, Tel Aviv Sourasky Medical Center, Faculty of Medicine, Tel Aviv University, Israel.

Dr. Andrius Bleizgys, MD PhD. Lector of Clinic of Internal Diseases, Family Medicine and Oncology, Vilnius University Faculty of Medicine, Vilnius, Lithuania.

Dr. Keshav Singhal, FRCS MS(orth) M.Ch(orth). Professor, Consultant Orthopaedic Surgeon. Chair British Association of Physicians of Indian Origin (BAPIO), Wales. Council Member & Trustee, Swansea University. Fellow of Learned Society of Wales, UK.

Dr. Gennadi Glinsky, MD PhD. Professor, Institute of Engineering in Medicine, University of California, San Diego, La Jolla, USA.

Dr. Eero Vasar, MD PhD. Professor of Human Physiology, University of Tartu, Estonia.

Dr. Frank C. Church, PhD. Professor of Pathology and Laboratory Medicine, University North Carolina School of Medicine, Chapel Hill, NC, USA.

Dr. Michael J. A. Robb, MD. Physician, Oto-Neurologist, Robb Oto-Neurology Clinic, Phoenix, Arizona. Past President, Association of American Physicians and Surgeons (AAPS), USA.

Dr. Giles Duffield, PhD. Associate Professor, Department of Biological Sciences & Eck Institute for Global Health, University of Notre Dame, Notre Dame, IN, USA.
Dr. Alessandro Comandone, MD. Director, Dept. of Oncology, San Giovanni Bosco Hospital Turin, Italy.

Dr. Endrit Shahini, MD MSC FPO-IRCCS. Candiolo Cancer Institute, Candiolo (Torino), Italy.

Dr. Phillip C. Gioia, MD MPH FAAP FACPM, Certificate in Clinical Informatics. Medical Director of Cayuga County Health Department, NY, USA.

Dr. Edward Jude, MBBS MD FRCP. Professor of Medicine, University of Manchester, UK.

Dr. Sudeepta Varma, MD DFAPA. Clinical Assistant Professor, Department of Psychiatry, NYU Grossman School of Medicine, NY, USA.

Dr. Olga Louro, MD PhD. Clínical Laboratory, University Clínical Hospital, Santiago de Compostela, Spain.

Dr. Joerg Velker, PhD. Chief Patent Counsel, Idorsia Pharmaceuticals, Switzerland. Former Senior Lab Head, Medicinal Chemistry, Actelion.


Dr. Maria Joana Pinto, Teacher (Docente), Medical Course, Pará State University (UEPA), Marabá Campus, Pará, Brazil.

Dr. Sergio Luis Menéndez Lucero, MD PhD. General Practitioner, Autoimmune Focus. Spain.

Dr. Jean-Michel Wendling, MD, Occupationnal Médecine, ACST, Strasbourg, France.

Dr. Georg Moessmer (Mößmer), Dr med., Hemostaseology, Institute for Clinical Chemistry and Pathobiochemistry, Technical University of Munich, Munich, Germany.

Dr. Haladia Pessotti de Campos Simião, MD. Endocrinologist, Clinical Nutritionist, & General Practitioner, São Paulo, Brazil.

Dr. Franklin Roy Long, MD MPH/PM ABOIM. Family Medicine, Vacaville, CA, USA.

Dr. Stelios Bekiros, PhD. Professor, European University Institute, Department of Economics, Florence, Italy. Affiliate Research Fellow, IPAG Business School. Senior Fellow, Rimini Centre for Economic Analysis (RCEA).

Dr. Farhad Zangeneh, MD. Medical Director & CMO, Endocrine, Diabetes and Osteoporosis Clinic, Washington, DC, USA.

Dr. Adrian F Gombart, PhD. Principal Investigator, Linus Pauling Institute, Professor, Department of Biochemistry and Biophysics, Oregon State University, USA.

Dr. Sari Arponen, MD PhD. Internist and Infectious Diseases Specialist, Associate Professor, Camilo José Cela University, Madrid. University Hospital of Torrejón, Spain.

Dr. Naomi Parrella, MD FAAFP Dipl.ABOM. Assistant Professor. Rush University Medical Center, Chicago, IL, USA.

Dr. Jens Freese, Doctor of Natural Sciences (Dr rer nat, Germany). Dr. Freese Institute for Sport and Nutritional Immunology, Cologne, Germany.
Our goal is to change policy and standard of care to save lives and help mitigate the pandemic, not simply to create the longest possible list of names. At this point, we welcome additional signature requests from those likely to help convince decision makers to implement the calls-to-action enumerated in the letter, such as respected professors, or such as medical doctors with specific credibility in the care of COVID-19, such as those who work with COVID-19 patients in hospitals or who help make standard-of-care decisions for large patient populations. If you are such an authority, please fill out this form. Note: New signatures will not be added immediately.

Signature statistics as of Jan 12, 2021:
197 total signatories
106 professors
118 signatories with medical degrees
105 signatories with PhDs or equivalent or higher degrees
113 signatories with personal intakes of at least 4000 IU per day
26 signatories with personal intakes of at least 10,000 IU per day
32 countries

info@vitaminDforAll.org

Dr. Luciano G Nina, MD. Assistant Professor, Faculdade de Medicina de Jundiaí, Sao Paulo, Brazil.

Dr. Canan Karatay, MD. Professor of Heart and Internal Diseases, former Rector of Istanbul Bilim (Science) University, Istanbul, Turkey.

Dr. David Brownstein, MD. Clinical Professor of Internal Medicine, Wayne State University School of Medicine. Medical Director, Center for Holistic Medicine, West Bloomfield, Michigan, Michigan, USA.

Dr. Vassaras Alexandros-Charalampos, MD, NeuroImmunology. Papageorgiou General Hospital, Greece.

Dr. Sarfraz Zaidi, MD FACP FACE. Endocrinologist, Camarillo, CA. Former Assistant Clinical Professor of Medicine, UCLA, USA.

Dr. Maria Morello, PhD, Clinical Biochemistry and Molecular Biology. Senior Researcher, Department of Experimental Medicine, Tor Vergata University, Rome University Hospital, Rome, Italy.

Dr. Bryan A Stepanenko, MD MPH IFMCP. Active Duty US Army, Member of Task Force Resilience, Army Public Health, Primary Care Physician, USA.

Dr. Yamile Mussa, MD. Pediatrician, Autism Specialist, Bolívar, Venezuela.

Dr. Joseph Parambil, MD. Pulmonologist, Cleveland Clinic, Respiratory Institute, and Assistant Professor of Medicine, Cleveland Clinic, Lerner College of Medicine, Cleveland, OH, USA.

4000 IU

10,000 IU

6000 IU

12,500 IU

4000 IU

10,000 IU

4000 IU

4000 IU

10,000 IU