EMPLOYEE RELIGIOUS EXEMPTION (ATTESTATION FORM)
MANHATTAN COLLEGE'S REQUIRED PROOF OF COVID-19 VACCINATION

I, _____, am a Manhattan College employee. I understand that Manhattan College requires that all employees must demonstrate proof of full COVID-19 vaccination, which includes a full series of vaccines and a booster shot by **June 15, 2022**. I hereby request an exemption from Manhattan College's proof of full COVID 19 vaccination requirement based upon the following reason:

Sincerely Held Religious Belief Contrary to the Practice of Vaccination

I understand that any employee seeking a religious exemption to the proof of full COVID-19 vaccination must provide Manhattan College with a completed and signed religious exemption request form (see attached form) providing statements. The employee is also required to discuss with and obtain a signature of a healthcare provider (see below) who has informed them of the risks of COVID-19.

I understand that while Manhattan College will take reasonable measures to mitigate the spread of COVID-19 among its employees and students, the College cannot protect any individual employee from all risks associated with contracting the virus. I have received information regarding the benefits and risks of immunizations. I understand that choosing to forego vaccination puts me at risk for getting the disease with the associated risk of long-term medical problems or death. In order to minimize risk of viral spread, I understand that I may be required to undergo regular screening tests for COVID-19.

I agree to follow any College COVID-19 prevention program that may be in effect during the semester, including: testing, mask wearing, quarantine, and completing the Daily Symptom Tracker when on campus. I further understand that if testing is a requirement, the College will not be responsible for any testing costs.

With a full understanding of this information, I request to be exempted from Manhattan College's COVID-19 vaccination requirement, and I accept the potential consequences associated with this decision.

DATE: _____ Employee Signature: _____

Healthcare Provider: Please complete the information below and acknowledge that you have discussed with and informed the employee of the risks of COVID-19:

Healthcare Provider Name (print): _____

State and Medical License #: _____

Office Address: _____

Contact Number: _____

Signature: _____ Date: _____