`

Request for COVID-19 Immunization Exemption Form

[ ] Employee or [ ] Student

Name: _____

TNUMBER:_____ School/ Department:_____

College Email:_____Phone: _____

New York Medical College and the Touro College of Dental Medicine (NYMC and TCDM) policy requires all students and employees to be Vaccinated for COVID-19. An exemption may be granted upon receipt of a completed form (below) not more than 6 months old; for medical exemptions the form must be signed and certified by a licensed healthcare provider, not related to the submitter, and whose specialty is appropriate to the associated condition.

NYMC and TCDM will carefully review all requests, though approval is not guaranteed. After your request has been reviewed and processed, you will be notified, in writing, if an exemption has been granted or denied. If the approved exemption contains an expiration, you will be expected to complete the requirement at that time.

In order to submit a request, please:

- **Read the CDC COVID-19 Vaccine Information at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html**
- **Complete the following page of this form;**
- **For medical exemptions: Have your health care provider complete the page "Request for COVID-19 Vaccination: Medical Exemption".**
- **For religious exemption:**
- **Attach all supplemental materials; and**
- **Submit the completed exemption request form with all required documentation to:**

health_services@nymc.edu Note: incomplete submissions will not be reviewed. Be sure all forms and documentation are submittedat one time.

`

Initial next to each of the statements below:

	I request exemption from the COVID-19 vaccination requirements due to my current medical condition or for religious reasons. I understand and assume the risks of non-vaccination. I accept full responsibility for my health, thus removing liability from New York Medical College and Touro College of DentalMedicine (the "College") for any COVID-19 related injury.
	I understand that in the event of an outbreak or threatened outbreak, I may be at increased risk of acquiring SARS-CoV-2 infection and will take measures to ensure I do not expose the NYMC community to SARS-CoV-2 infection.
	Should I contract COVID-19, I will immediately report it to Health_Services@nymc.edu and comply with all isolation procedures specified by the College.
	I acknowledge that I have read the **CDC COVID-19 Vaccine Information at** • **Read the CDC COVID-19 Vaccine Information at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html** And am aware of the vaccine options
	I understand and agree to comply with and abide by all College policies and procedures.
	I certify that the information I have provided in connection with this request is accurate and complete. I understand this exception may be revoked and I may be subject to College disciplinary action if any of the information I provided in support of this exemption is false.
	I give permission to the College to contact my health care provider if further information on my medical condition(s) is needed for review of this exemption request.

Printed Name: _____

Signature:_____

Date: _____

TNUMBER:_____College Email: _____

Phone number: _____

☐ By checking this box and typing my name above, I am electronically signing this form.

`

Request for COVID-19 Vaccination: Medical Exemption

Patient Name: (First Name, Last Name)_____

Date: _____

TNUMBER :_____ NYMC email: _____

Phone number: _____

Attention Health Care Provider:

New York Medical College/Touro College of Dental Medicine policy requires that all students and employees are to receive a COVID-19 vaccination in accordance with policy, which is receipt of primary vaccination.

Please certify below the medical reason that your patient should not be vaccinated for COVID-19 by completing this form and attaching available supporting documentation.

Option 1 - Allergy: A documented history of a severe allergic reaction to any component of a COVID-19 vaccine or to asubstance that is cross-reactive with a component.

- Moderna - List the component(s): _____
- Pfizer - List the component(s): _____
- NovaVax – List the component(s): _____

Option 2 – Physical Condition/Medical Circumstance

__ The physical condition of the patient or medical circumstances relating to the individual are such that immunization is not considered safe. Please state, with sufficient detail for independent medical review, the specific nature and probable duration of the medical condition. (attached additional pages if necessary)

Certification

I certify that_____(patient name) has the above contraindication and support the request for a medical exemption from the COVID-19 vaccine requirement at New York Medical College.

Duration of this medical exemption: _____

Provider Information

Medical Provider Name: _____

Medical Provider Specialty: _____

Signature:_____

Provider License Number and state: _____

Date:_____

Phone number: _____ Email: _____

Name and Address of Provider Company_____

`

Request for COVID-19 Vaccination: Religious Exemption

Name: (First Name, Last Name)_____

Date: _____

TNUMBER :_____ NYMC email: _____

Phone number: _____

Note that objections to vaccination may not be based solely on grounds of personal philosophy, preference or inconvenience.

On a separate sheet of paper, please provide the following:

1. **Please identify your religion, the sincerely held religious belief, practice or observance that is the basis for your request for religious accommodation and how long you have held this.**

2. **Please explain how your sincerely held religious belief, practice, or observance conflicts with the College's COVID-19 vaccine mandate.**

3. **Please describe how your sincerely held religious belief, practice, or observance has affected your receipt of other vaccines, including the measles, mumps, rubella vaccine.**

I verify that the information I am submitting in support of my request for an exemption is complete and accurate to the best of my knowledge, and I understand that any intentional misrepresentation contained in this request may result in disciplinary action. I also understand that my request for an exemption may not be granted if it is not reasonable, if it poses a direct threat to the health and/or safety of others in the workplace, school environment, and/or to me, or if it creates an undue hardship on the College.

Applicant Signature Date

Return this request form, answers to the questions, the completed "Affidavit of Religious Objection to COVID-19 Vaccination", and any other supporting information you would like to submit, all as a PDF document to health_services@nymc.edu

AFFIDAVIT OF RELIGIOUS OBJECTION TO COVID-19 VACCINATION

The undersigned employee personally appeared before the undersigned notary public and swore or affirmed as follows:

1. I, the undersigned, certify that I am over eighteen years of age and competent to make this affidavit.

2. I understand that New York Medical College and the Touro College of Dental Medicine (the "College") requires individuals to have received at least primary COVID-19 immunization.

3. I sincerely affirm that vaccination is contrary to my religious beliefs, and that my objections to this vaccination are **not** based solely on grounds of personal philosophy, preference or inconvenience.

4. I understand and accept that, notwithstanding my religious objections, I may be excluded from on-campus facilities during an epidemic, pandemic or threatened epidemic or pandemic of any disease preventable by a vaccination required by the College, and that I may still be required to later receive the vaccination if required by New York State.

I certify that the foregoing is true and correct.

This_____day of_____, 2022.

_____
Applicant Signature

Touro ID# _____

State of

County of

Subscribed and Sworn to before me this_____day of_____20__

by; _____ _____
Name of Student/Employee Notary Signature