

ANNEX 1:

Therapeutic use exemption application form

Identification of Anti-Doping Organization

(Logo or Name of the ADO)

Application form

**THERAPEUTIC USE EXEMPTIONS
TUE**

Please complete all sections in capital letters or typing

1. Athlete Information

Surname: _____		Given Names: _____.	
Female <input type="checkbox"/>	Male <input type="checkbox"/>	Date of Birth (d/m/y) _____	
Address: _____			
City: _____		Country: _____	Postcode: _____
Tel.: _____ (with international code)		E-mail: _____	
Sport: _____		Discipline/Position: _____	
International or National Sport Organization: _____			
Please mark the appropriate box:			
<input type="checkbox"/> I am part of an International Federation Registered Testing Pool			
<input type="checkbox"/> I am part of a National Anti-Doping Organization Testing Pool			
<input type="checkbox"/> I am participating in an International Federation event for which a TUE granted pursuant to the International Federation's rules is required ¹ - Name of the competition: _____			
<input type="checkbox"/> None of the above			
If athlete with disability, indicate disability: _____			

¹ Refer to your International Federation for the list of designated events

2. Medical information

Diagnosis with sufficient medical information (see note 1):

If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication

3. Medication details

Prohibited substance(s): <u>Generic name</u>	Dose	Route	Frequency
1.			
2.			
3.			

Intended duration of treatment: (Please tick appropriate box)	once only <input type="checkbox"/>	emergency <input type="checkbox"/>
	or duration (week/month): _____	

Have you submitted any previous TUE application:	yes <input type="checkbox"/>	no <input type="checkbox"/>
For which substance?		
To whom? _____ When? _____		
Decision:	Approved <input type="checkbox"/>	Not approved <input type="checkbox"/>

4. Medical practitioner's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.

Name: _____

Medical specialty: _____

Address: _____

Tel.: _____

Fax: _____

E-mail: _____

Signature of Medical Practitioner: _____ Date: _____

5. Athlete's declaration

I, _____, certify that the information under 1. is accurate and that I am requesting approval to use a Substance or Method from the WADA Prohibited List. I authorize the release of personal medical information to the Anti-Doping Organization (ADO) as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorized staff that may have a right to this information under the provisions of the Code.

I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my information; (2) exercise my right of access and correction or (3) revoke the right of these organizations to obtain my health information, I must notify my medical practitioner and my ADO in writing of that fact. I understand and agree that it may be necessary for TUE-related information submitted prior to revoking my consent to be retained for the sole purpose of establishing a possible anti-doping rule violation, where this is required by the Code.

I understand that if I believe that my personal information is not used in conformity with this consent and the International Standard for the Protection of Privacy and Personal Information I can file a complaint to WADA or CAS.

Athlete's signature: _____ **Date:** _____

Parent's/Guardian's signature: _____ **Date:** _____

(if the athlete is a minor or has a disability preventing him/her to sign this form, a parent or guardian shall sign together with or on behalf of the athlete)