

Application No.:

Appendix 1

## Therapeutic Use Exemptions Standard Application Form

*I apply for approval from (Anti-Doping Organization) for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods.*

Please complete all sections

### 1. Athlete Information

Surname: ..... Given Names: .....

Female  Male  (tick appropriate box)

Address: .....

City: ..... Country: ..... Postcode: .....

Date of Birth (d/m/y): ..

Tel. Work: ..... Tel. Home: ..... Mobile: .....

E-mail: ..... Fax: .....

Sport: ..... Discipline/Position: .....

National Sporting Organization:

If athlete with disability, indicate disability: .....

### 2. Notifying medical practitioner

Name, qualifications and medical speciality (see note 1): .....

.....

.....

Address: .....

..... E-mail address: .....

Tel. Work: ..... Tel. Home: .....

Mobile: ..... Fax: .....

\*Diagnosis (see note 2): .....

.....

Has the national sporting organisation Chief Medical Officer been notified of this request? Yes:  No:

Name of NSO's Chief Medical Officer (see note 3): .....

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**3. Medication details (see note 4)**

<b>Prohibited Substance(s):</b>	<b>Dose of administration</b>	<b>Route of administration</b>	<b>Frequency of administration</b>
1.			
2.			
3.			

<b>Anticipated duration of this medication plan</b>
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Previous / Current TUE request(s):  yes  no

If yes: Date: .....

Anti-Doping Organization:

Result (*attach previous TUE(s)*):

If appropriate, reasons for not prescribing alternative therapies (see note 5): .....

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**4. Please note additional information and attach sufficient medical information to substantiate the diagnosis and the necessity to use a prohibited substance:**

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.....

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**5. Medical practitioner's and athlete's declaration**

I, ..... certify the above-mentioned substance/s for the above-named athlete has been/are to be administered as the correct treatment for the above-named medical condition.

**Signature of Medical Practitioner:** ..... **Date:** .....

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 as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) under the provisions of the Code. I understand that if I ever wish to revoke the right of the Anti-Doping Organization TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

**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)**

**6. Notes:**

<b>Note 1</b>	Name, qualifications and medical specialty For example: Dr AB Cook, MD FRACP, Gastro-enterologist.
<b>Note 2</b>	Diagnosis <i>Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies. Copies of the original reports or letters should be included when possible. Evidence should be as objective as possible in the clinical circumstances and in the case of non-demonstrable conditions independent supporting medical opinion will assist this application.</i>
<b>Note 3</b>	NSO Chief Medical Officer <i>Where possible the Chief Medical Officer (CMO) of the sport involved should be notified of the application to the Anti-Doping Organization. When appropriate, the application should include a statement by the Medical Officer of the Athlete's national sport governing body, attesting to the necessity of the otherwise Prohibited Substance or Prohibited Method in the treatment of the athlete.</i>
<b>Note 4</b>	Medication details <i>Provide details concerning all prohibited substances or methods for which approval is sought. Use generic names (INN) and specify medication dose.</i>
<b>Note 5</b>	<i>If a permitted medication can be used in the treatment of the athlete's medical condition, please provide clinical justification for the requested use of the prohibited medication.</i>

***Incomplete Applications will be returned and will need to be resubmitted.***

Please submit the completed form to the Anti-Doping Organization and keep a copy of the completed form for your records.

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**7. TUEC Decision (for office use only)**

**Date Received:**

**Application Complete:**  yes  no

**Office Notes:** .....

.....

.....

.....

**Name of TUEC Representative(s):** .....

**Signature(s):** .....

.....

**Date:** .....

Anti-Doping Organization:  
Approval No:

## CERTIFICATE OF APPROVAL FOR THERAPEUTIC USE

The athlete has received approval for the use of the prohibited substance(s) listed below under the conditions stipulated in this document.

### Athlete Details

Title: .....  
Surname: ..... Given Names: .....  
Date of Birth: ..... Sport: .....

**Prohibited Substance(s):** .....

Dose and method of administration: / .....

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Duration of approval: .....

Approval expiry date .....

Any specific conditions attached to this approval: .....

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### ATTENTION ATHLETE

Please carry a copy of this form with you at all times.  
This form should be presented to the doping control officer at the time  
of testing.

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Appendix 2

## **Therapeutic Use Exemptions Abbreviated Process (beta-2 agonists by inhalation, glucocorticosteroids by non-systemic routes)**

*I apply for approval from (Anti-Doping Organization) for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods that is subject to the Abbreviated Therapeutic Use Exemption Application Process.*

**Please complete all sections**

### **1. Athlete Information**

Surname: .....	Given Names: .....	
Female <input type="checkbox"/> Male <input type="checkbox"/> (tick appropriate box)		
Address: .....		
City: .....	Country : .....	Postcode: .....
Date of Birth (d/m/y): .....		
Tel. Work: .....	Tel. Home : .....	Mobile: .....
E-mail: ..... Fax: .....		
Sport: ..... Discipline/Position: .....		
National Sporting Organization: .....		
If athlete with disability, indicate disability: .....		

### **2. Notifying medical practitioner**

Name, qualifications and medical speciality (see note 1): .....	
.....	
Address: .....	E-mail address: .....
.....	.....
Tel. Work: .....	Tel. Home: .....
Mobile: .....	Fax: .....

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**3. Medical information**

Diagnosis: .....

Medical examination(s)/test(s) performed: .....

.....

Prohibited substance(s):	Dose of administration	Route of administration	Frequency of administration
<b>Anticipated duration of this medication plan</b>			

**Additional information**

.....  
.....  
.....

**4. Medical practitioner's and athlete's declaration**

I, ..... certify the above-mentioned substance/s for the above named athlete has been/are to be administered as the correct treatment for the above named medical condition. I further certify that the use of alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical condition. Specify reasons: .....

**Signature of Medical Practitioner:** ..... **Date:** .....

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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 as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) as well as to other Anti-Doping Organizations under the provisions of the Code. I understand that if I ever wish to revoke the right of the Anti-Doping Organization TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

**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)***

**Note 1**

*Name, qualifications and medical specialty*

For example : Dr AB Cook, MD FRACP, Gastro-enterologist.