Therapeutic Use Exemption (TUE) Application Form

For Use of Prohibited Substances

Please complete all sections in capital letters or typing. Athlete to complete sections 1, 5, 6 and 7; physician to complete sections 2, 3 and 4. Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.

1. Athlete Information

Surname: _____ Given Names: _____

Female ☐ Male ☐ Date of Birth: _____ (day / month / year)

Address: _____

City: _____ Country: _____ Postcode: _____

Tel: + _____ (with international code) Email: _____

Sport: _____ Discipline/Position: _____

International or National Sport Organization: _____

If you are an Athlete with an impairment, please, indicate the impairment: _____

2. Medical Information (continue on separate sheet if necessary)

Diagnosis:

_____

_____

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

_____

_____

_____

_____

Comment:

Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical information must 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. In the case of non-demonstrable conditions, independent supporting medical opinion will assist this application.

WADA maintains a series of guidelines to assist physicians in the preparation of complete and thorough TUE applications. These TUE Physician Guidelines can be accessed by entering the search term “Medical Information” on the WADA website: https://www.wada-ama.org. The guidelines address the diagnosis and treatment of a number of medical conditions commonly affecting athletes, and requiring treatment with prohibited substances.

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3. Medication details

Prohibited substance(s): Generic name	Dose	Route of Administration	Frequency	Duration of Treatment
1.				
2.				
3.				

4. Medical practitioner's declaration

I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate.

Name: _____

Medical specialty: _____

Address: _____

Tel: + _____

Fax: + _____

Email: _____

Signature of Medical Practitioner: _____ Date: _____
(day / month / year)

5. Retroactive applications

Is this a retroactive application?

Yes: ☐ No: ☐ If yes, on what date was treatment started?

_____
(day / month / year)

Please indicate reason:

- ☐ Emergency treatment or treatment of an acute medical condition was necessary
- ☐ Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection
- ☐ Advance application not required under applicable rules
- ☐ Other

Please explain: _____

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6. Previous applications

Have you submitted any previous TUE application(s)?

Yes: ☐ No: ☐

For which substance or method? _____

To whom? _____ When? _____
(day / month / year)

Decision:

Approved ☐

Not approved ☐

7. Athlete's declaration

I, _____, certify that the information set out at sections 1, 5 and 6 is accurate. 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 World Anti-Doping Code ("Code") and/or the International Standard for Therapeutic Use Exemptions.

I consent to my physician(s) releasing to the above persons any health information that they deem necessary in order to consider and determine my application.

I understand that my information will only be used for evaluating my TUE request and in the context of potential anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my health 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 consent to the decision on this application being made available to all ADOs, or other organizations, with Testing authority and/or results management authority over me.

I understand and accept that the recipients of my information and of the decision on this application may be located outside the country where I reside. In some of these countries data protection and privacy laws may not be equivalent to those in my country of residence.

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: _____
(day / month / year)

Parent's/Guardian's Signature: _____ Date: _____
(day / month / year)

(If the Athlete is a Minor or has an impairment preventing him/her signing this form, a parent or guardian shall sign on behalf of the Athlete)

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Please submit the completed form (page 1 to 3) to the ICSD Secretariat (office@ciss.org) and keep a copy for your records.

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