Therapeutic Use Exemptions (TUE)

Application Form

Please complete all sections in capital letters or typing.
Please sign the form (point 6) and ask your doctor to sign (point 4).
Electronic signatures are accepted.

1. Athlete Information

Surname: _____ Given Names: _____

Female ☐ Male ☐ Date of Birth (d/m/y): _____

Postal Address: _____

City: _____ Country: Postcode: _____

Tel: _____ E-mail: _____

(with international code)

Discipline/Position: _____

National Federation Membership: _____

Please mark the appropriate box below:

☐ I am considered as International Level athlete based on one or more of the criteria mentioned below:

☐ I am part of the ISA Registered Testing Pool and/or Testing Pool;

☐ I participate in selected ISA International Events.

Please specify the name of the event (if applicable): _____

If you are an athlete with an impairment, please indicate the impairment:

_____

2. Medical information

Diagnosis (evidences confirming the diagnosis shall be transmitted along with this application. The medical evidences must include a comprehensive medical history and the results of all relevant examinations, laboratory investigation and imaging studies):

_____

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): ***Generic name***	**Dose**	**Route**	**Frequency**
1.			
2.			
3.			
4.			

Intended duration of treatment: (*Please tick appropriate box*)	once only ☐ emergency ☐ or duration (week/month/year):_____

Have you already a TUE for the same diagnosis: yes ☐ no ☐

Organization which granted TUE:_____

Date of expiral:_____

STRICTLY CONFIDENTIAL

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.

Surname: _____ Given Names: _____

Medical Specialty: _____

Postal Address: _____

City: _____ Country: _____ Postcode: _____

Tel: _____ Email: _____

Signature of Medical Practitioner: _____ Date: _____

5. Retroactive application

Is this a retroactive application? ☐ Yes (Date on which treatment started _____)

☐ No

Indicate for which reasons you are applying for a retroactive TUE:

☐ Emergency treatment;

☐ Treatment of an acute medical condition;

☐ Due to exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection;

☐ Advance application was not required under the ISA Anti-Doping Rules;

☐ Other reasons: _____

6. Athlete's declaration

I, _____ certify that the information set in this application 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 ISA and its National Federations and Member Associations, to other Anti-Doping Organization (ADO) included Major Event Organization, if applicable, as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorized staff under the provisions of the Code.

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 possible anti-doping violation investigations and procedures. I understand that if I ever wish (1) to 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 ISA 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 relevant National Federation and 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: _____

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)

Please submit the complete form and the medical evidences necessary to support the application to the following address: isa.dopingfree@gaisf.org