



Therapeutic Use Exemption (TUE) Application Form
For Use of Prohibited Substances

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: _____ (day / month / year) |
| Address: _____ | |
| City: _____ | Country: _____ Postcode: _____ |
| Tel: + _____ (with international code) | Email: _____ |
| Sport: _____ | Discipline/Position: _____ |
| International or National Sport Organization: _____ | |
| Please mark the appropriate box: | |
| <input type="checkbox"/> I am part of an International Federation or ICSD 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 or ICSD event for which a TUE granted pursuant to the International Federation or ICSD's rules is required ¹ | |
| Name of the competition: _____ | |
| <input type="checkbox"/> None of the above | |
| If athlete with disability, indicate disability: _____ | |

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



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2. Medical Information

Diagnosis with sufficient medical information (*see note 1 on page 4*):

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

Emergency

Duration (week/month): _____

Have you submitted any previous TUE application: Yes

No

For which substance? _____

To whom? _____ When? _____

(day / month / year)

Decision: Approved

Not approved



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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: + _____

Email: _____

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

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 ICSD Anti-Doping Organization as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other Anti-Doping Organization 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 the ICSD Anti-Doping Organization 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 remained 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: _____
(day / month / year)

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

(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)



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6. Note

| | |
|---------------|---|
| Note 1 | Diagnosis Evidence confirming the diagnosis shall 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. |
|---------------|---|

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

**Please submit the completed form to the ICSD Anti-Doping Organization
(controls@ciss.org) and keep a copy for your records.**

International Committee of Sports for the Deaf
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Frederick, Maryland 21701
USA

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e-mail: controls@ciss.org
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