



Therapeutic Use Exemptions Application Form

I apply for approval from the Medical Commission for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods.

Please complete all sections

1. Competitors Information

Surname:		GivenNames:	
Female <input type="checkbox"/>	Male <input type="checkbox"/> (tick appropriate box)		
Address:			
City:		Country:	
Date of Birth (d/m/y):			
Tel. Work:	Tel. Home:	Mobile:	
E-mail:		Fax:	
National Bridge Organization:			
If Competitor 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:	
.....	

Application No.:

3. Medication details (see note 4)

Prohibited Substance (s):	Dose of administration	Route of administration	Frequency of administration
1.			
2.			
3.			
4.			

Anticipated duration of this medication plan	
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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:

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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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Application No.:

5. Medical practitioner's and competitors

I, certify the above-mentioned substance/s for the above-named competitor 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.

Competitor's signature: **Date:**

Application No.:

6. TUEC Decision (for office use only)

Date Received:

Application Complete: yes no

Office Notes:

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Name of TUEC Representative(s):

Signature(s):

.....

Date:

Please send this form, duly completed to:

Prof. Paolo Walter Gabriele
President EBL Medical Commission
Via Bellini 5 – 03043 Cassino FR, Italy
Email: pw.gabriele@unicas.it

To arrive no later than 21 days before the start of the competition being entered