



## **THERAPEUTIC USE EXEMPTION (TUE) APPLICATION & NOTIFICATION FORM FOR IWAS OFFICIAL AND SANCTIONED EVENTS**

### INSTRUCTIONS

- Please read Section 6 (IPC Anti-Doping Code) carefully prior to completing this form
- Type information or write legibly in block letters using black ink in English
- Leave no blanks and answer all questions
- Section 1 must be completed by the athlete applying for a Therapeutic Use Exemption (TUE)
- Sections 2, 3 & 4 must be completed by the athlete's medical practitioner
- Section 5 must be signed by the athlete and the athlete's medical practitioner
- Section 6 must be completed and signed by the Medical Officer/Medical Representative of the IWAS national member organisation
- Completed TUE Applications & Notification Forms should be sent by the IWAS national organisation to:

Dr Oriol Martinez  
Sports Science & Medical Officer  
c/o IWAS Secretariat  
Olympic Village  
Guttman Road  
Aylesbury  
Bucks HP21 9PP  
UK  
Fax: +44 (0)1296 436484  
Email: [info@iwasf.com](mailto:info@iwasf.com)

**INCOMPLETE TUE APPLICATIONS & NOTIFICATION FORMS WILL NOT BE  
CONSIDERED AND WILL BE RETURNED TO THE NATIONAL MEMBER  
ORGANISATION**

**TUEs Applications MUST be returned 45 Days prior to the start of the Event.**

**1. Name Of Event:**

**2. ATHLETE INFORMATION**

I apply for approval from the IWAS for the therapeutic use of a prohibited substance on the World Anti-Doping Code Prohibited List

I notify the IWAS of the use of beta-2-agonists by inhalation or glucocorticosteroids by non-systemic routes

Family Name: _____		Given Names: _____	
Male <input type="checkbox"/>	Female <input type="checkbox"/>		
Address: _____			
City: _____		Postcode: _____	
Country: _____			
Date of Birth (dd/mm/yy)    _____ / _____ / _____			
Sport: _____		Discipline/Position: _____	
Sport Class(es) _____			
Type of Disability:			
Amputee <input type="checkbox"/>	Cerebral Palsy <input type="checkbox"/>		
Spinal Cord Injury <input type="checkbox"/>	Other* <input type="checkbox"/>		
*Please Specify _____			
Duration of Disability:		_____ / _____	
		Years	Months

### 3. NOTIFYING MEDICAL PRACTITIONER

Name, Qualification & Medical Speciality ( <i>see Note 1</i> ):	
_____	
Address: _____	
City: _____	Postcode: _____
Country: _____	
Email Address: _____	
Tel. Work: _____	Tel. Home: _____
Mobile: _____	Fax: _____

### 4. MEDICATION DETAILS:

Ensure only substances on the World Anti-Doping Code Prohibited List are detailed in this section (*see note 2*):

<b>Commercial Name</b>	<b>Generic Name</b>	<b>Dose of Administration</b>	<b>Route of Administration</b>	<b>Frequency of Administration</b>
1.				
2.				
3.				
<i>Anticipated duration of the above medication</i>				

Diagnosis of Athlete (*see note 3*):

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Enter reasons for not prescribing alternative therapies, if appropriate (*see Note 4*):

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**5. ADDITIONAL INFORMATION**

Provide evidence to substantiate the diagnosis and the necessity to use substances on the World Anti-Doping Code Prohibited List (*see Notes 3 & 4*).  
Attach additional information where necessary.

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**6. MEDICAL PRACTITIONER & ATHLETE 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 detailed in Section 1. is accurate and that I am requesting approval to use a Substance or Method from World Anti-Doping Code Prohibited List. I authorize the release of personal medical information to the Anti-Doping Organisation as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) under the provision of the IWAS Anti-Doping code. I understand that if I ever wish to revoke the right of the IWAS TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

**Signature of Athlete:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Parent/Guardian\*:** \_\_\_\_\_ **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)

**7. IWAS NATIONAL MEMBER ORGANISATION DETAILS**

All correspondence relating to this TUE application will be directed to the Doping Control/Medical Officer of the IWAS national member organisation as detailed below (*see Note 5*):

IWAS Doping Control/Medical Officer: \_\_\_\_\_  
*Name*

\_\_\_\_\_  
*Signature* *Date*

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_

## 8. NOTES

Note 1	<b><i>Name, Qualifications &amp; Medical Speciality</i></b> For example: Dr AB Cook, MD FRACP, Gastro-enterologist.
Note 2	<b><i>Medication Details</i></b> Provide details concerning the substance(s) on the World Anti-Doping Code Prohibited List for which approval is sought. Use generic names (INN) as well as commercial names and specify medication dose.
Note 3	<b><i>Diagnosis</i></b> Evidence confirming the diagnosis must be attached and forwarded with this application and must be in English. 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 where 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.
Note 4	<b><i>Medical Evidence</i></b> 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 substance(s) on the World Anti-Doping Code Prohibited List.
Note 5	<b><i>National Medical Officer</i></b> All applications must include a statement by the Medical Officer of the athlete's national organisation in membership with IWAS, attesting to the necessity of the use of substance(s) on the World Anti-Doping Code Prohibited List in the treatment of the athlete.

**9. DECISION (FOR IWAS SECRETARIAT USE ONLY)**

Application Complete:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
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Approved	<input type="checkbox"/>	Not Approved	<input type="checkbox"/>	Incorrect TUE	<input type="checkbox"/>
Name of IWAS TUE Committee Chairperson:					
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Signature of IWAS Committee Chairperson:					
<hr/>				Date:	<hr/>
Comments:					
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Date Detail passed to IPC and/or WADA