



# THERAPEUTIC USE EXEMPTION APPLICATION FORM



Please **PRINT** clearly using **BLOCK CAPITALS**

## 1. Athlete Information

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_

(tick) Male  Female  Date of Birth (dd/mm/yy): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Country: \_\_\_\_\_ Post Code: \_\_\_\_\_

Tel: (with int. code) \_\_\_\_\_ E-mail: \_\_\_\_\_

Sport: \_\_\_\_\_ Discipline/Position: \_\_\_\_\_

Club/Team: \_\_\_\_\_ National Governing Body: \_\_\_\_\_

If athlete with a disability, please indicate disability: \_\_\_\_\_

## 2. Medical Information (attach any additional information on a separate sheet if necessary)

**Evidence confirming the diagnosis must be attached and forwarded with this application.**

When filling this Form for Asthma Inhalers containing Beta-2 Agonists, please refer to the *ISC Asthma TUE Application Instructions* for further information, as published on [www.irishsportsCouncil.ie/Anti-Doping](http://www.irishsportsCouncil.ie/Anti-Doping) or contact the Anti-Doping Unit

Diagnosis of condition or injury sustained: \_\_\_\_\_

Supporting Medical Information: \_\_\_\_\_

***The medical evidence should include a medical history and/or 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 with this application.***

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

***Each TUE Application must be accompanied by medical records, including results of any relevant tests. A brief medical history is also required, where appropriate.***

***If you are on your International Federation's Registered Testing Pool and/or participate at International Event, you must apply to your International Federation!***

### 3. Medication Details

Prohibited Substances including Brand Name	Dosage e.g. 200mcg	Route of Admin. e.g. Intra-muscular	Frequency of Admin. e.g. BD	Date of Admin.	Intended duration of Treatment e.g. Emergency / Once only / Two weeks

4. Have you submitted any previous TUE application: Yes  No

For which substance? \_\_\_\_\_ To whom? \_\_\_\_\_

When? \_\_\_\_\_ Decision: Approved  Not approved

### 5. Medical Practitioner's Declaration

Name, qualifications & medical speciality: \_\_\_\_\_  
(e.g. Dr AB Cook, MD FRACP, Gastroenterologist)

Address: \_\_\_\_\_

\_\_\_\_\_ Email: \_\_\_\_\_

Work Tel: \_\_\_\_\_ Mobile: \_\_\_\_\_ Fax: \_\_\_\_\_

I certify that I am the athlete's **prescribing** doctor. I further 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.

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### 6. Athlete's Declaration

I certify that the information under section 1 is accurate and that I am requesting approval to use a Substance or Method from the WADA Prohibited List. I authorise the release of personal medical information to the Irish Sports Council (ISC), the ISC Therapeutic Use Exemption Committee, the World Anti-Doping Agency (WADA), the WADA Therapeutic Use Exemption Committee, the WADA Anti-Doping Administration and Management System (ADAMS) and also to other Anti-Doping Organisations under the provisions of the Code. I understand that this may require the transfer of my health information outside the European Economic Area. I understand that if I ever wish to revoke the right of any of the above listed organisations to obtain my health information on my behalf, I must notify my medical practitioner and the ISC in writing of that fact. I understand and agree that if a TUE is granted, such TUE and the related information will be stored electronically in ADAMS for a minimum period of 8 years, the period of 8 years being the period within which an action can be commenced following a violation of an anti-doping rule contained in the Code. I hereby release WADA as well as the ISC and TUE Committees from all claims, demands, liabilities, damages, costs and expenses that I may have arising in connection with the processing of my TUE related data through ADAMS.

Athlete's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

(If the athlete is a minor or has a disability preventing him/her from signing this form, a parent/guardian shall sign together with or on behalf of the athlete)

**Please submit the completed form to the address below and keep a copy for your records.**

TUE Secretariat, Irish Sports Council, Top Floor, Block A, West End Office Park, Blanchardstown, Dublin 15.

Tel: 01 8608818

Email: [antidoping@irishsportsCouncil.ie](mailto:antidoping@irishsportsCouncil.ie)

Fax: 01 8608860

Web: [www.irishsportsCouncil.ie](http://www.irishsportsCouncil.ie)

**INCOMPLETE APPLICATIONS WILL BE RETURNED AND WILL NEED TO BE RESUBMITTED!**