



**THERAPEUTIC USE EXEMPTIONS  
TUE**

Please complete all sections in capital letters or typing

**1. Athlete Information**

Surname: \_\_\_\_\_ Given Names: \_\_\_\_\_

Female  Male  Date of Birth (d/m/y) \_\_\_\_\_

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

City: \_\_\_\_\_ Country: \_\_\_\_\_ Postcode: \_\_\_\_\_

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

Club \_\_\_\_\_ National Federation: \_\_\_\_\_

International or National Sport Organization: \_\_\_\_\_

Please mark the appropriate box:

I am part of an International Federation Registered Testing Pool

I am part of a National Anti-Doping Organization Testing Pool

I am participating in an International Federation event for which a TUE granted pursuant to the International Federation's rules is required - Name of the competition: \_\_\_\_\_

None of the above

- Date of the competition: \_\_\_\_\_



**2. Medical information**

Diagnosis with sufficient medical information (see note 1):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**

<b>Prohibited substance(s): Generic name</b>	<b>Dose</b>	<b>Route</b>	<b>Frequency</b>
1.			
2.			
3.			

<b>Intended duration of treatment:</b> (Please tick appropriate box)	once only <input type="checkbox"/>	emergency <input type="checkbox"/>
	or duration (week/month): _____	

<b>Have you submitted any previous TUE application:</b>	yes <input type="checkbox"/>	no <input type="checkbox"/>
For which substance? _____		
To whom? _____	When? _____	
Decision:    Approved <input type="checkbox"/> Not approved <input type="checkbox"/>		

#### 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: \_\_\_\_\_

E-mail: \_\_\_\_\_

Signature of Medical Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_

#### 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 Anti-Doping Organization (ADO) as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO 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 my ADO 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 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)



6. Note:

<b>Note 1</b>	<b>Diagnosis</b> <i>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.</i>
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**This application must be sent, preferably by e-mail, to FIBA  
(called above “ADO” or “International Federation”):**

**FIBA  
53, avenue Louis-Casaï  
P.O. Box 110  
1216 Cointrin / Geneva  
SWITZERLAND**

**Fax: +41-22-545 00 99  
E-mail: [tue@fiba.com](mailto:tue@fiba.com)**

**Important** : Illegible and/or incomplete applications will be returned and need to be resubmitted.