International Paralympic Committee

Therapeutic Use Exemption (TUE) Application Form

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)

Sport: ..... Discipline/Position: .....

Indicate disability and class: .....

International or National Sport Organisation: .....

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.

.....

.....

.....

International Paralympic Committee

Adenauerallee 212-214 Tel. +49 228 2097-130

53113 Bonn, Germany Fax +49 228 2097-212

www.paralympic.org

antidoping@paralympic.org

3 Medication details

Prohibited substance(s): *Generic name*	Dose	Route	Frequency
1.			
2.			
3.			

Intended duration of treatment: (*Please tick appropriate box*)	once only ❑ date…/…./…. emergency ❑ or duration (week/month): …….

Have you submitted any previous TUE application: **yes ❑** **no ❑**

For which substance? ……

To whom? ……When? ……

Decision: Approved ❑ Not approved ❑

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 speciality: .....

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 staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADOs under the provisions of the Code. I understand that if I ever wish to revoke the right of these organizations to obtain my health information on my behalf, I must notify my medical practitioner and my ADO in writing of that fact.

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:

Note 1	Diagnosis *Evidence confirming the diagnosis must 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 ADO and keep a copy for your records.

The application must include a comprehensive medical history and the results of all examinations, laboratory investigations and imaging studies relevant to the application.

The minimal requirements for the medical file to be used for the TUE process in the case of asthma and its clinical variants must be fulfilled.
Please submit completed form to antidoping@paralympic.org.