Australian Government
Australian Sports Drug
Medical Advisory Committee

**ASDMAC**
Unit 14, 5 Tennant St Fyshwick ACT 2609
PO Box 1744 Fyshwick ACT 2609
**T** +61 (0) 2 6222 4283
**W** www.asada.gov.au
**E** asdmac@asada.gov.au

**APP**

# Therapeutic Use Exemptions (TUE) APPLICATION FORM

Please complete ALL sections in CAPITALS or typing. Illegible or incomplete applications will NOT be processed and will be returned.

***NOTE:*** **This application will be reviewed by a panel of medical practitioners, bound by strict confidentiality. Please supply relevant medical details and reports to allow ASDMAC to formulate an informed decision on this application. If no supporting medical documents are attached, the application will be returned to the applicant.**

Please keep a copy of any documents submitted for your records.

## 1. Athlete Information

Surname: _____ Given Name: _____

Female ☐ Male ☐ Date of Birth (d/m/y): _____

Title: Mr ☐ Mrs ☐ Miss☐ Ms☐

Address: _____

Suburb:_____ State:_____ Postcode:_____

Phone (H): _____ Mobile:_____

E-mail:_____

Sport: _____

National Sporting Organisation: _____

**Current Level of Competition:**

International ☐ National☐ State☐ Club☐ Other☐

If you are an athlete with a disability, please indicate the disability:

_____

## 2. Medical information *(continue on separate sheet if necessary)*

Diagnosis:

_____

Note: In attached medical documents please provide clinical justification for the requested use of the prohibited medication and why a permitted medication cannot be used._____

**Comment:**

*Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical information must 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. In the case of non-demonstrable conditions, independent supporting medical opinion will assist this application.*

WADA maintains a series of guidelines to assist physicians in the preparation of complete and thorough TUE applications. These TUE Physician Guidelines can be accessed by entering the search term "Medical Information" on the WADA website: https://www.wada-ama.org. The guidelines address the diagnosis and treatment of a number of medical conditions commonly affecting athletes, and requiring treatment with prohibited substances.

## 3. Medication details

| **Prohibited Substance(s): Generic name** | **Dose** | **Route of Administration** | **Frequency** | **Duration of Treatment** | **Date Medication Commenced** |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## 4. Medical practitioner's declaration

**I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate.**

Name: _____

Medical specialty: _____

Address: _____

Tel.: _____

Mobile: _____

E-mail: _____

Signature of Medical Practitioner: _____ Date: _____

ASDMAC correspondence will be by email. Please ensure that you list a valid email address.

## 5. Retroactive applications

| **Is this a retroactive application?** | **Please indicate reason:** |
|---|---|
| **Yes:** ☐ | ☐ Emergency treatment or treatment of an acute medical condition was necessary |
| **No:** ☐ | ☐ Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection |
| **If yes, on what date was treatment started?** _____ | ☐ Advance application not required under applicable rules (Planned Retroactive TUE) |
| | ☐Other: Please explain: _____ _____ _____ |

**If the retroactive request is for a substance/method detected as a result of doping control, please state:**

date of sample collection: _____

substance/method detected: _____

## 6. Previous applications

**Have you submitted any previous TUE application(s)?**

Yes ☐ No ☐

If yes, please attach any current or relevant TUE(s) to this application or please fill out the following information in relation to those applications:

For which substance or method? _____

To whom? _____Date? _____

Decision: Approved ☐ Not approved ☐

## 7. Athlete's declaration

I, _____, certify that the information set out at sections 1, 5 and 6 is accurate. 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 World Anti-Doping Code *("Code")* and/or the International Standard for Therapeutic Use Exemptions.

I consent to my physician(s) releasing to the above persons any health information that they deem necessary in order to consider and determine my application.

I understand that my information will only be used for evaluating my TUE request and in the context of potential anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my health 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 consent to the decision on this application being made available to all ADOs, or other organizations, with Testing authority and/or results management authority over me.

I understand and accept that the recipients of my information and of the decision on this application may be located outside the country where I reside. In some of these countries data protection and privacy laws may not be equivalent to those in my country of residence.

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 an impairment preventing him/her signing this form, a parent or guardian shall sign on behalf of the Athlete)

## 8. Application checklist (please complete before sending application)

| | |
|---|---|
| 8.1 - Athlete information complete | ☐ |
| 8.2 - Medical information complete | ☐ |
| 8.3 - Medication details complete | ☐ |
| 8.4 - Medical Practitioner declaration complete | ☐ |
| 8.5 - Retroactive Applications complete | ☐ |
| 8.6 - Previous Applications complete | ☐ |
| 8.7 - Athletes Declaration complete | ☐ |