



## Therapeutic Use Exemption TUE

Please complete all sections in capital letters or typing.

### 1 Athlete Information

Family Name	_____
Given Names	_____
Gender:	Female                      Male
Date of Birth	_____
	(dd/mm/yyyy)
Address	_____
	_____
City	_____
Country	_____
Postal Code	_____
Telephone:	_____
	(include International Dialing Code)
Email:	_____
Sport	_____
Event	_____
International or National Sport Organisation:	_____
If Athlete with a Disability, indicate disability:	_____

**2 Medical Information**

**Diagnosis with sufficient medical information (see note 1):**

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

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**3 Medication Details**

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

<b>Intended duration of treatment:</b>	Once only                      emergency
<b>(Please tick appropriate box)</b>	Or duration (week/month): .....

<b>Have you submitted any previous TUE applications:</b>	<b>Yes</b>	<b>No</b>
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 specialty \_\_\_\_\_

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

Telephone: \_\_\_\_\_ 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 authorise the release of personal medical information to IIGA as well as to IIGA Court and IIGA Drug Appeal Court and to other ADO's under the provisions of the WADA Code, IIGA Executive Committee and the IIGA Medical Commission. I understand that if I ever wish to revoke the right to these organisations to obtain my health information on my behalf, I must notify my medical practitioner and the IIGA 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:**

<b>Note 1</b>	<b>Diagnosis</b>  <b>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.</b>
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**Incomplete or illegible notification will be returned and will need to be resubmitted.**

Please submit the completed form to the IIGA Medical Commission and keep a copy for your records.

This form is to be sent to:

IIGA Medical Commission - Dr Carl Clinton  
Accident and Emergency Jersey General Hospital,  
Gloucester Street,  
St Helier,  
Jersey,  
Channel Islands, JE1 3QS