Appendix 1 **Application No.:**

# Therapeutic Use Exemptions
## Application Form

*I apply for approval from the Medical Commission for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods.*

**Please complete all sections**

## 1. Competitors Information

Surname: …………………………………………… GivenNames: …………………………………………..

Female ❑ Male ❑ *(tick appropriate box)*

Address: …………………………………………………………………………………………………………………………

City: ……………………………………………… Country: ……………………………………………………

Date of Birth (d/m/y): …………………………………

Tel. Work: ………………………….. Tel. Home: ……………………….. Mobile: ……………………………………………

E-mail: ……………………………………………… Fax: ………………………………………………..

National Bridge Organization:

If Competitor with disability, indicate disability: ……………………………………………………………………………..

## 2. Notifying medical practitioner

Name, qualifications and medical speciality (*see note 1*): ……………………………………………………………

…………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………

Address: ……………………………………………………………………………………………………………………

……………………………………………………… E-mail address: …………………………………………………………

Tel. Work: ………………………………………… Tel. Home: ………………………………………………………………

Mobile: …………………………………………… Fax: ……………………………………………………………………..

*Diagnosis: …………………………………………………………………………………………………………………

………………………………………………………………………………………………………………………………..

Application No.:

3. Medication details (*see note 4)*

| Prohibited Substance (s): | Dose of administration | Route of administration | Frequency of administration |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

| **Anticipated duration of this medication plan** | |
|---|---|

Previous / Current TUE request(s): ❑ yes ❑ no

If yes: Date: ……………………………………………………………………………………………………………

Anti-Doping Organization:

Result (*attach previous TUE(s)):*

If appropriate, reasons for not prescribing alternative therapies: ……………………………………………………………

……………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………

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4. **Please note additional information and attach sufficient medical information to substantiate the diagnosis and the necessity to use a prohibited substance:**

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**Application No.:**

## 5. Medical practitioner's and competitors

I, ………………………………………………………………………………… certify the above-mentioned substance/s for the above-named competitor has been/are to be administered as the correct treatment for the above-named medical condition.

**Signature of Medical Practitioner:** …………………………………………………… **Date:** ………………………………………

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 as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) under the provisions of the Code.
I understand that if I ever wish to revoke the right of the Anti-Doping Organization TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

**Competitor's signature:** ………………………………………………………………… **Date:** ……………………………….

Application No.:

6. TUEC Decision (*for office use only*)

Date Received:

Application Complete: ❑ yes ❑ no

Office Notes: ..........................................................................................................................

..........................................................................................................................

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..........................................................................................................................

Name of TUEC Representative(s): ...........................................................................................

Signature(s): ...........................................................................................

...........................................................................................

Date: ...................................................................

Please send this form, duly completed to:

Dr. Jaap Stomphorst
Isala Klinieken
Sports medicine department
PO Box 10500
8000GM Zwolle, The Netherlands
+31 38 4245689 (office hours)
+31 61 2088836 (cell phone)
email: j.stomphorst@isala.nl

To arrive no later than 21 days before the start of the competition being entered