ABBREVIATED THERAPEUTIC USE EXEMPTION FORM

Please **PRINT** clearly using **BLOCK CAPITALS**

1. Athlete Information

Surname: _____ First Name: _____

(tick) Male ☐ Female ☐ Date of Birth (dd/mm/yy): _____

Address: _____

_____ Email: _____

Home Tel: _____ Work Tel: _____ Mobile: _____

Sport: _____ Discipline/Position: _____

Club/Team: _____ National Governing Body: _____

If athlete with a disability, please indicate disability: _____

2. Medical Information (attach any additional information on a separate sheet if necessary)

Condition / injury sustained: _____

(N.B. If Asthma, please state if Asthma is Exercise Induced / Intermittent / Persistent, etc.)

Details of Diagnosis: _____

(N.B. If Asthma, please state what tests have been carried out, e.g. Auscultatory Evidence of Wheeze / Peak Flow Test / Laboratory Exercise Challenge Test, etc.)

Prohibited Substances	Brand Name **e.g. Ventodisks**	Dosage **e.g. 200mcg**	Route of Admin.	Frequency of Admin. **e.g. BD**	Date of Admin.	Intended duration of Treatment **e.g. Emergency / Once only / One year**
Salbutamol			Inhalation			
Formoterol			Inhalation			
Salmeterol			Inhalation			
Terbutaline			Inhalation			
Glucocortico-steroid Please specify						

◄ ATTENTION DOCTORS, PLEASE REFER TO MIMS TO CHECK IF ► MEDICATIONS REQUIRE NOTIFICATION.

Additional Information: _____

_____

3. Physician's Information and Declaration

Name, qualifications & medical specialty: _____
(e.g. Dr AB Cook, MD FRACP, Gastroenterologist)

Address: _____

_____ Email: _____

Work Tel: _____ Mobile: _____ Fax: _____

I certify that I am the athlete's **prescribing** doctor. I further certify that the above-mentioned substance(s) for the above named athlete has been / are to be administered as the correct treatment for the above named medical condition. I further certify that the use of alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical condition.

Specify reason: _____

Physician's signature: _____ Date: _____/_____/_____

4. Athlete's Declaration

I certify that the information under section 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 the Irish Sports Council (ISC), the ISC Therapeutic Use Exemption Committee, the World Anti-Doping Agency (WADA), the WADA Therapeutic Use Exemption Committee and also to other Anti-Doping Organisations under the provisions of the Code. I understand that if I ever wish to revoke the right of any of the above listed organisations to obtain my health information on my behalf, I must notify my medical practitioner and the ISC 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/guardian shall sign together with or on behalf of the athlete)

Abbreviated TUE forms are valid under the Irish Anti-Doping Programme for the duration of the treatment as prescribed by the physician, up to a MAXIMUM OF TWO YEARS.
IT IS THE ATHLETE'S RESPONSIBILITY TO REAPPLY SHOULD THEIR TUE EXPIRE.

INCOMPLETE APPLICATIONS WILL BE RETURNED AND WILL NEED TO BE RESUBMITTED!

Please send to: TUE Secretariat
Irish Sports Council
Top Floor, Block A
West End Office Park
Blanchardstown

Tel: 01 8608829
Fax: 01 8608860
E-mail: **antidoping@irishsportscouncil.ie**
Web: **www.irishsportscouncil.ie**

If you require written approval, please send a stamped addressed envelope (S.A.E.) with your application. The section below will be completed & returned to you by post ONLY if you enclose a S.A.E.

(For Office Use Only) **Date Received** ☐

Approval Sent? ☐

The Irish Sports Council will only approve this application for Therapeutic Use Exemption for the duration stated by the physician in section 2 of this form, up to a maximum of two years. If the duration of the prescribed treatment stated on this form exceeds two years from ___/___/___, **the athlete must re-apply for Therapeutic Use Exemption prior to the expiry date.**

Signed _____ (Anti-Doping Unit)