STANDARD 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)

Diagnosis of condition or injury sustained: _____

_____

Supporting Medical Information: _____

_____

_____

Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include a medical history and / or the results of all relevant examinations, laboratory investigations and imaging studies. Copies of the original reports or letters should be included where 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 with this application.

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

_____

_____

Incomplete applications will be returned and will need to be resubmitted!

Renewal of the TUE is the athlete's responsibility.

3. Medication details

Prohibited Substances including Brand Name	Dosage **e.g. 200mcg**	Route of Admin. **e.g. Intra-muscular**	Frequency of Admin. **e.g. BD**	Date of Admin.	Intended duration of Treatment **e.g. Emergency / Once only / Two weeks**

4. Have you submitted any previous TUE application: Yes ☐ No ☐

For which substance? _____

To whom? _____ When? _____

Decision: Approved ☐ Not approved ☐

5. Medical Practitioner's 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 treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.

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

6. 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)

Please submit the completed form to the address below and keep a copy for your records.

TUE Secretariat, Irish Sports Council, Top Floor, Block A, West End Office Park, Blanchardstown, Dublin 15

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