Confidential

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Therapeutic Use Exemption Application Form

(Please complete all 3 pages)

(In compliance with the World Anti-Doping Code 2015 – International Standard for Therapeutic Use Exemptions)

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

Athlete Information

Surname:			
Given names:			
Female/Male:			
Birth date:			
Address:			
Postcode:			
Email:			
Tel: Home:			
Tel: Mobile:			
Sport:		Discipline / position	

Medical Information

Diagnosis with sufficient medical information *

* Evidence confirming the applicant's diagnosis must be attached and forwarded with this application.
The medical evidence should include clinical history and the results of all examinations, investigations, imaging studies and specialist medical reports. Copies of the original reports or consultation notes 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.

N.B If a permitted medication can be used to treat the medical condition, provide clinical justification for the intended use of the prohibited medication.

NOTE TO MEDICAL PRACTITIONER: Retroactive applications will only be considered in cases of emergency treatment or when exceptional circumstances apply. Refer Page 2. Please contact DFSNZ (www.drugfreesport.org.nz) or 0800-378437) if additional information is required.

OFFICE USE ONLY:

APPLN RECEIVED	/ /	CERT. #		SUBMITTED	Yes / No
APPLN APPROVED	Yes / No				

Drug Free Sport New Zealand, PO Box 17451, Greenlane, Auckland 1546.
Ph: 09 5820388, 0800 DRUGFREE (0800 378437) Fax: 09 5800381

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Retroactive Application

Is this a retroactive application?	
Yes / No	
If Yes, on what date was treatment started?	
If Yes, please indicate the reason:	Emergency treatment or treatment of an acute medical condition? **Yes / No** Other exceptional circumstances, insufficient time or opportunity to submit an application prior to sample collection **Yes / No** Advance application not required under applicable rules **Yes / No**
Please explain:	

Medication Details

Prohibited substance(s) Generic name	Dose of administration	Route of administration	Frequency of administration
Anticipated duration of this medication plan	Once / Emergency / or duration (week/month):		

Previous / current TUE request(s)? Yes / No:	
If Yes, date:	/ /
Anti-doping organisation:	
Results approved: Yes / No	
Has the national sporting organisation's (NSO) Chief Medical Officer been notified? Yes / No	
Additional information:	

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Medical Practitioner's Declaration

I, _____ certify 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.

Medical specialty and qualifications:			
Address:			
Email:			
Tel:			
Fax:			
Signature:		Date:	

TUE applications must be supported with detailed medical evidence outlining the diagnosis and the need for the prohibited medication. Incomplete applications will be returned and will need to be resubmitted.

Athlete's Declaration

I, _____, certify that the information set out at sections 1, 5 and 6 is accurate. I authorise the release of personal medical information to the Anti-Doping Organisation (ADO) as well as to WADA authorised staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorised 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 organisations 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 organisations, 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)

Please remember to keep a copy of the completed form for your records. Submit by fax, email or post to:

Drug Free Sport New Zealand, PO Box 17451, Greenlane, Auckland 1546

Fax: 09 5800381 **Email:** TUE@drugfreesport.org.nz