CARIBBEAN RADO | REGIONAL ANTI-DOPING ORGANIZATION

**Application Form**

**THERAPEUTIC USE EXEMPTION**
**TUE**

**Please complete all sections <u>in capital letters or type</u>**

## 1. Athlete Information

Surname: _____ Given Names: _____.

Female Male Date of Birth (d/m/y)_____

Address: _____

City:_____ Country:_____ Postcode:_____

Tel.: _____ E-mail: _____
(*with international code*)

Sport: _____ Discipline/Position: _____

International or National Sport Organization: _____

Please mark the appropriate box:

☐ I am part of an International Federation Registered Testing Pool

☐ I am part of a National Anti-Doping Organization Testing Pool

☐ I am participating in an International Federation event for which a TUE granted pursuant to the International Federation's rules is required[1] - Name of the competition:_____

☐ None of the above

If athlete with disability, indicate disability: _____

[1] Refer to your International Federation for the list of designated events

## 2. Medical information

Diagnosis with sufficient medical information (see note 1):

_____
_____
_____
_____

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

_____
_____
_____

## 3. Medication details

| **Prohibited substance(s): Generic name** | **Dose** | **Route** | **Frequency** |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |

| | |
|---|---|
| **Intended duration of treatment:** (Please tick appropriate box) | once only emergency<br><br>or duration (week/month):_____ |

**Have you submitted any previous TUE application: yes no**

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: _____
Tel.: _____
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 authorize the release of personal medical information to the Caribbean RADO as well as to WADA authorized staff, to the WADA TUEG (Therapeutic Use Expert Group and to other Anti-Doping Organization (ADO) TUECs and authorized staff that may have a right to this information under the provisions of the Code.

I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my information; (2) exercise my right of access and correction or (3) revoke the right of these organizations 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 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 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:

| | |
|---|---|
| **Note 1** | **Diagnosis**<br>*Evidence confirming the diagnosis shall 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.* |

**Incomplete Applications will be returned and will need to be resubmitted.**

**Please submit the completed form to the Caribbean RADO** caribrado@caribsurf.com or by fax 1-246-271-0544 **and keep a copy for your records.**