Application No.:

Therapeutic Use Exemption

TUE

TUE Application Template

Please complete all sections <u>in capital letters or typing</u>
and read the last page <u>Notes</u> before filling in the Application

1. Athlete Information

Surname: _____ Given Names:_____
Female: ___ Male:___ Date of Birth (d/m/y): _____
Address: _____
City: _____ Country: _____ Postcode: _____
Tel.:_____ E-mail: _____
(with international code)
Nationalities: _____ Sport Nationality: _____
Sport:_____
International and National Sport Organization: _____
If athlete with disability, indicate disability: _____

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
_____
_____
_____
_____

STRICTLY CONFIDENTIAL

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FI-00920 Helsinki,
Finland

Phone
+358-9 454 214 25
Fax
+358-9 454 214 50

E-mail
office@floorball.org
Web-site
www.floorball.org

Bank
Credit Suisse, CH-8700 Küsnacht
Account No. 4818-559200-11
Swift Code: CRESCHZZ87B
IBAN: CH13 0481 8055 9200 1100 0

Application No.:

3. Medication details (see Note 2.)

Prohibited substance(s): Generic name (INN)	Dose: (incl. unit of measure)	Route of administration:	Frequency of administration:
1.			
2.			
3.			

Intended duration of treatment: (Please tick appropriate boxes)	once only ☐ emergency ☐ before exercise ☐ daily taken ☐ or duration (week/month):_____

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

For which substance(s)?_____

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.

Last name: _____ First name: _____

Medical speciality: _____

Address: _____

Country: _____ City: _____ Post code: _____

Tel.:_____ Fax: _____

E-mail: _____

Signature of Medical Practitioner: _____ **Date:** _____

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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 Anti-Doping Organization (ADO) as well as to WADA staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO under the provisions of the Code. I understand that if I ever wish to revoke the right of these organizations to obtain my health information on my behalf, I must notify my medical practitioner and my ADO 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 or guardian shall sign together with or on behalf of the athlete)

6. Notes:

Note 1	**Diagnosis** *Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include:* *1) a comprehensive medical history* *2) the results of all relevant examinations* *3) laboratory investigations and/or imaging studies* *The minimum medical evidence required for inhaled Beta-2 agonists (terbutaline, high dose of salbutamol or formoterol etc. (see IFF website www.floorball.org -> Anti-doping) include:* *1) A complete medical history* *2) A comprehensive report of the clinical examinations with specific focus on the respiratory system* *3) A report of spirometry with the measure of the Forced Expiratory Volume in 1 second (FEV1)* *4) If airway obstruction is present, the spirometry will be repeated after inhalation of a short acting Beta-2 agonist to demonstrate the reversibility of bronchocontriction* *5) In the absence of reversible airway obstruction, a bronchial provocation test is required to establish the presence of airway-hyper responsiveness* *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.*
Note 2	**Medication details** *Provide details concerning all prohibited substances or methods for which approval is sought. Use generic names (International Nonproprietary Names, INN) and add also the name of the medication. Specify the medication dose and mark the unit of measure. Route of administration should be marked with words, not with numbers.*

<u>Incomplete Applications will be returned and will need to be resubmitted</u>.

Please submit the completed form to the ADO and keep a copy for your records

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