For office use only: Application No.

Therapeutic Use Exemptions (TUE) Application Form
Tennis Anti-Doping Programme

Please complete ALL sections in CAPITAL LETTERS or typing. Incomplete applications will be returned. To complete this document electronically, please type where indicated, and do NOT insert additional lines. This document must be submitted in 3 pages.

Sections 1 and 7 to be completed by the player

1. PLAYER INFORMATION

Family Name(s):		First Name(s):	
Female ☐ Male ☐ *(select appropriate box)*		Date of birth (dd/mm/yy):	
Address:			
		City:	
State and Country:		Post/ZIP Code:	
If player with disability, indicate disability:			
*Please write ALL telephone and fax numbers including Country Code and Area Code, and select **one** option where the reply is to be sent to by selecting the appropriate box*			
Contact Tel:		Mobile/Cell:	
☐ Email:			
☐ Fax:		Attention:	
Application history			
Are you a member of the Registered Testing Pool:		☐ Yes ☐ No	
Have you previously submitted a TUE Application:		☐ Yes ☐ No	
For which substance(s)?		To which organisation?	
Certificate number:		Decision:	☐ Approved ☐ Not Approved
Valid from:		Expiry date:	

Sections 2-6 to be completed by the medical practitioner

2. NOTIFYING MEDICAL PRACTITIONER

Family Name(s):		First Name(s):	
Qualifications (e.g. MD):			
Medical Speciality (e.g. gastroenterologist):			
Address:			
		City:	
State and Country:		Postcode:	
*Please write ALL telephone and fax numbers including Country Code and Area Code, and select **one** option where the reply is to be sent to by selecting the appropriate box*			
Contact Tel:		Mobile/Cell	
☐ Email:		Attention:	
☐ Fax number:		☐ Select box to receive a copy of correspondence to player	

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3. MEDICATION INFORMATION: DIAGNOSIS WITH SUFFICIENT MEDICAL INFORMATION

Evidence confirming the diagnosis must be provided in support of this application. In those cases where this evidence is not written in English, a summary in English must be enclosed. This should include a comprehensive medical history and summarise the results of all relevant examinations, laboratory investigations and imaging studies as described in the WADA guidelines *Medical Information to Support the Decisions of TUECs*. 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 should be provided.

Patient's Name:	
Female ☐ Male ☐ *(select appropriate box)*	Date of birth (dd/mm/yy):
Diagnosis:	

Medical Examination(s)/Test(s) Performed: Please specify the examination(s)/test(s) and attach a copy of the Examination(s)/Test(s) report(s) with your application.

Physical examination	☐ Yes. Specify _____ and attach a copy. ☐ N/A
Laboratory investigation	☐ Yes. Specify _____ and attach a copy. ☐ N/A
Imaging studies	☐ Yes. Specify _____ and attach a copy. ☐ N/A
Psychiatric/psychological report	☐ Yes. Specify _____ and attach a copy. ☐ N/A
Other relevant medical examination	☐ Yes. Specify _____ and attach a copy. ☐ N/A

N.B. All TUEs are subject to review at any time by the ITF TUE Committee and/or WADA TUE Committee.

4. MEDICATION DETAILS

Prohibited Substance(s)/Methods(s) Generic Name	Dosage, Strength & Frequency (including number of e.g. pills/puffs)	Route of administration	TUE/treatment start date (dd/mm/yy)	TUE/treatment end date (dd/mm/yy)
Example: Dexamethasone	*1 × 8 mg. Once only*	*Intravenous*	*01/01/10*	*01/03/10*

If a non-Prohibited Substance(s)/Method(s) can be used to treat the specified medical condition, provide clinical justification for the requested Prohibited Substance(s)/Method(s) below:

5. RETROACTIVE APPROVAL

Is this a retroactive application? ☐ Yes (if yes, please state one reason below and provide explanation on next page) ☐ No (if no, please continue to section 6)

Emergency treatment or treatment of an acute medical condition was necessary	☐
Insufficient time/opportunity to submit, or for the TUE Committee to consider, an application prior to Sample collection	☐
The rules permit the Player to apply for a retroactive TUE	☐
Other (please explain here):	☐

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Retroactive approval (continued)
Reason(s) for submitting a retroactive application:

6. MEDICAL PRACTITIONER'S DECLARATION

I,	(First name)		(Family name)

certify that the above-mentioned treatment is medically appropriate and that the use of alternative substances/medications not on the WADA Prohibited List would be unsatisfactory for this condition.

Please indicate the medical condition(s) below:

Medical Practitioner's Signature:		Date (dd/mm/yy):	

7. PLAYER'S DECLARATION

I,	(First name)		(Family name)

certify that the information set out in this form is accurate. I authorize the release of personal medical information to the Anti-Doping Organization (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 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 consent to the decision on this application being made available to all ADOs, or other organizations, 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.

Player's Signature:		Date (dd/mm/yy):	
If the player is a minor or has a disability preventing him/her from signing this form, a parent or guardian shall sign together with, or on behalf of, the player.			
Parent's/Guardian's Signature:		Date (dd/mm/yy):	

Please submit the COMPLETED form (keeping a copy for your records) to:

International Doping Tests & Management
IDTM Drug Information Centre
Telephone: +46 8 555 10 999 (24 hours) Fax: +46 8 555 10 995
Email: tennis@idtm.se