Application No: _ _ _ _ _ _
(Office use only)

THERAPEUTIC USE EXEMPTIONS (TUE)

APPLICATION FORM

TUE applications WILL NOT be reviewed unless additional medical evidence is submitted with this application to justify the need for Therapeutic Use Exemption. Medical evidence to confirm the diagnosis should include:

- ☐ Comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies.
- ☐ Copies of original reports, letters and specialist reviews.
- ☐ Clinical justification of the use of a Prohibited Substance or Prohibited Method when there are reasonable alternative medications available.

Please refer to 6 Important Notes (page 4) and Medical Information to Support TUE Application which can be found on the WCF website.

Please complete all sections (in ENGLISH) and in BLOCK CAPITALS or TYPE.
Incomplete or illegible forms will be returned.

1 Athlete Information

Surname ..... Given Names: .....

Female ☐ Male ☐ *(X appropriate box)* Date of Birth: (dd/mm/yyyy) .....

Address: .....

City: ..... Country: ..... Postcode: .....

Tel: ..... Email: .....
(with international code)

Sport: ..... Discipline/Position: .....

Member Association: .....

Please mark the appropriate box below:

☐ 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 by the WCF is required. (Refer to http://www.worldcurling.org/TUEs to download WCF List of Events).

Please list upcoming event(s): .....

☐ None of the above

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:

.....

.....

.....

3 Medication details

	Prohibited Substance(s): Generic Name	Dose	Route	Frequency
1				
2				
3				

Intended duration of treatment *(please X appropriate box)*	once only ☐ emergency ☐ 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 doctor's declaration

I certify that I am a licensed Medical Doctor treating the applicant athlete and 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.

Name: .....

Medical Speciality: .....

Address: .....

.....

Tel: ..... Fax: .....

Email: .....

Signature of Medical Doctor: ..... Date: .....

Are the relevant medical reports and examination/test results attached to this application?

☐ **YES** ☐ **NO**

5 Athlete's declaration

I, ... certify that the information under Section 1 above is accurate and that I am requesting approval to use a Prohibited substance or Prohibited methods from the WADA Prohibited List. I authorise the release of personal medical information to the WCF and to members of the WCF TUE Committee as well as to any other relevant person who may be involved in the management, review or administration of my application in accordance with WCF Anti-Doping regulations, (including, where applicable, WADA or IOC staff and/or members of the WADA or IOC TUE Committees). I understand that members of WCF staff and TUE Committee involved in the administration of TUE applications, will not disclose any of my TUE related information beyond those persons with a need to know according to the WCF Anti-Doping regulations.

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 the WCF 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 Protection of Privacy and Personal Information, http://www.wada-ama.org/Documents/World_Anti-Doping_Program/WADP-IS-PPPI/WADA_IS_PPPI_2009_EN.pdf, 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 Important Notes

Note 1	**Diagnosis** Evidence confirming the diagnosis must 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.
Note 2	**Medical Evidence** If a permitted medication can be used in the treatment of the athlete's medical condition, please provide clinical justification for the requested use of the substance(s) on the World Anti-Doping Code Prohibited List. A statement, in English, by an appropriately qualified physician attesting to the necessity to use the Prohibited substance or Prohibited Method in the treatment of the Athlete and describing why an alternative, permitted medication cannot, or could not, be used in the treatment of this condition. Trials of Non-Prohibited therapies should be noted.
Note 3	**Medication Details** Provide details concerning the substance(s) on the World Anti-Doping Code Prohibited List for which approval is sought. Use generic/chemical names (INN) as well as commercial names and specify medication dose, route of administration, frequency and duration of administration of the treatment.

I would like the decision to be sent to: *(please tick as appropriate)*

My postal address ☐ My email address ☐ The notifying medical practitioner ☐

PLEASE SUBMIT THE COMPLETED SIGNED FORM ALONG WITH MEDICAL DOCUMENTATION TO THE WORLD CURLING FEDERATION AND KEEP A COPY FOR YOUR RECORDS.

WORLD CURLING FEDERATION
74 Tay Street, Perth, PH2 8NP, Scotland, UK
TUE email: tue@worldcurling.org Fax: +44 1738 451641 Tel: +44 1738 451630
http://www.worldcurling.org/anti-doping-medical