CCES Canadian Centre for Ethics in Sport
Centre canadien pour l'éthique dans le sport

# Therapeutic Use Exemption Application

Send completed forms to the CCES by: Fax: (613) 521-3134 Email: tue-aut@cces.ca

Mail: Attn: Athlete Services Manager, CCES, 350-955 Green Valley Cres, Ottawa, ON, K2C 3V4

Keep a copy for your records. Please complete all sections clearly in block letters or typing.

## 1. Athlete Information

| Surname: | | Given Name: | |
|---|---|---|---|
| Gender: | ☐ Male ☐ Female | Date of Birth (d/m/y): | |
| Preferred method of communication: | | ☐ Email ☐ Canada Post | |
| Email Address: | | | |
| Mailing Address: | | | |
| City: | | Province/State: | |
| Country: | | Postal Code: | |
| Telephone: | | | |
| Sport: | | Discipline / Position: | |
| International or National Sport Organization: | | | |
| If athlete with disability, indicate disability: | | | |

## 2. Medical Information **(To be completed by the prescribing physician)**

| Diagnosis (please attached 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: |

Enregistré par le ONGC Certificat 001044
ISO 9001:2000
CGSB Registered Certificate 001044

## 3. Medication Details **(To be completed by the prescribing physician)**

| Prohibited Substance(s): Generic name | Dose | Route of Administration | Frequency of Administration | Duration of Treatment |
|---|---|---|---|---|
| Enter all that apply | e.g., 200 mg | e.g., inhalation, local injection : | e.g., BID, QID | e.g., one-time use, emergency, one year |
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

| Have you submitted any previous TUE application? | ☐ Yes | ☐ No |
|---|---|---|
| For which substances? | | |
| To which organization? | | |
| When? | | |
| Decision | ☐ Approved | ☐ Not approved |

## 4. Medical Practitioner's Declaration **(To be completed by the prescribing physician)**

| I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the WADA Prohibited List would be unsatisfactory for this condition. | | | |
|---|---|---|---|
| Surname: | | Given Names: | |
| Medical Specialty: | | | |
| Address: | | | |
| City: | | Province/state: | |
| Country: | | Postal Code: | |
| Telephone: | | Email Address: | |
| Signature: | | Date (d/m/y): | |

## 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.

| | |
|---|---|
| ☐ | I authorize the release of my medical information to members of the Health Care Team attending Major Games where I may participate, to my Team Physician, and to my NSO and IF. |
| ☐ | I do not wish to have this information shared with anyone but the CCES. |

| | | | |
|---|---|---|---|
| Athlete's Signature: | | Date (d/m/y): | |

*(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.)*

| | | | |
|---|---|---|---|
| Surname: | | Given Name: | |
| Parent/Guardian's signature: | | Date (d/m/y): | |

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## 6. Notes

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.

Incomplete applications will be returned and will need to be resubmitted.

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

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|---|---|---|
| (DISPONIBLE EN FRANÇAIS)<br>January 2009 | Application No: | |