



## Therapeutic Use Exemptions Application Form

I apply for approval from the Medical Commission for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods.

Please complete all sections

### 1. Competitors Information

Surname: .....		GivenNames: .....	
Female <input type="checkbox"/>	Male <input type="checkbox"/> (tick appropriate box)		
Address: .....			
City: .....		Country: .....	
Date of Birth (d/m/y): .....			
Tel. Work: .....		Tel. Home: .....	
		Mobile: .....	
E-mail: .....		Fax: .....	
National Bridge Organization:			
If Competitor with disability, indicate disability: .....			

### 2. Notifying medical practitioner

Name, qualifications and medical speciality (see note 1): .....	
.....	
.....	
Address: .....	
..... E-mail address: .....	
Tel. Work: .....	
Tel. Home: .....	
Mobile: .....	
Fax: .....	
*Diagnosis: .....	
.....	

Application No.:

**3. Medication details (see note 4)**

Prohibited Substance (s):	Dose of administration	Route of administration	Frequency of administration
1.			
2.			
3.			
4.			

<b>Anticipated duration of this medication plan</b>	
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Previous / Current TUE request(s):       yes       no

If yes:    Date: .....

          Anti-Doping Organization:

          Result (*attach previous TUE(s)*):

If appropriate, reasons for not prescribing alternative therapies: .....

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**4. Please note additional information and attach sufficient medical information to substantiate the diagnosis and the necessity to use a prohibited substance:**

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**Application No.:**

**5. Medical practitioner's and competitors**

I, ..... certify the above-mentioned substance/s for the above-named competitor has been/are to be administered as the correct treatment for the above-named medical condition.

**Signature of Medical Practitioner:** ..... **Date:** .....

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 as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) under the provisions of the Code. I understand that if I ever wish to revoke the right of the Anti-Doping Organization TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

**Competitor's signature:** ..... **Date:** .....

Application No.:

**6. TUEC Decision (for office use only)**

Date Received:

Application Complete:             yes             no

Office Notes: .....

.....

.....

.....

Name of TUEC Representative(s): .....

Signature(s): .....

.....

Date: .....

Please send this form, duly completed to:

**Dr. Jaap Stomphorst**  
**Isala Klinieken**  
**Sports medicine department**  
**PO Box 10500**  
**8000GM Zwolle, The Netherlands**  
**+31 38 4245689 (office hours)**  
**+31 61 2088836 (cell phone)**  
**email: [j.stomphorst@isala.nl](mailto:j.stomphorst@isala.nl)**

To arrive no later than 21 days before the start of the competition being entered