**Application No.:**

Appendix 2

# Therapeutic Use Exemptions
## Abbreviated Process
### (beta-2 agonists by inhalation, glucocorticosteroids by non-systemic routes)

*I apply for approval from (Anti-Doping Organization) for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods that is subject to the Abbreviated Therapeutic Use Exemption Application Process.*

**Please complete all sections**

## 1. Athlete Information

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

Female ❑ Male ❑ (*tick appropriate box*)

Address: .....

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

Date of Birth (d/m/y): .....

Tel. Work: .....Tel. Home : ..... Mobile: .....

E-mail: ..... Fax: .....

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

National Sporting Organization: .....

If athlete 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: .....

**Application No.:**

## 3. Medical information

Diagnosis: .....

Medical examination(s)/test(s) performed: .....

.....

| **Prohibited substance(s):** | **Dose of administration** | **Route of administration** | **Frequency of administration** |
|---|---|---|---|
| | | | |
| **Anticipated duration of this medication plan** | | | |



### Additional information

.....

.....

.....

## 4. Medical practitioner's and athlete's declaration

I, ..... certify the above-mentioned substance/s for the above named athlete has been/are to be administered as the correct treatment for the above named medical condition. I further certify that the use of alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical condition. Specify reasons: .....

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

**Application No.:**

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) as well as to other Anti-Doping Organizations 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.

**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)***

| | |
|---|---|
| ***Note 1*** | *Name, qualifications and medical specialty*<br>For example : Dr AB Cook, MD FRACP, Gastro-enterologist. |