BADC
BAHAMAS ANTI-DOPING COMMISSION

Therapeutic Use Exemptions
Autorisation d'Usage à des fins Thérapeutiques
TUE/*AUT*

Please complete all sections in capital letters or typing.
Veuillez remplir toutes les sections en majuscules ou en caractères d'imprimerie

Athlete to complete sections 1, 5 , 6 and 7; physician to complete sections 2, 3 and 4. Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.
Le sportif doit compléter les sections 1, 5, 6 et 7; le médecin doit compléter les sections 2, 3 et 4. Les demandes illisibles ou incomplètes seront retournées et devront être soumises à nouveau sous une forme lisible et complète.

1. Athlete Information/*Renseignements concernant le sportif*

Surname/ *Nom*: _____ Given Names/ *Prénoms*: _____

Female/ *Femme* ☐ Male/*Homme* ☐ Date of Birth (day-month-year) / *Date de naissance* (jour-mois-an): _____

Address/ *Adresse*:

City/ *Ville*: _____ Country/ *Pays*: _____ Postcode/ *Code postal*: _____

Tel./ Tél.: _____ E-mail/ *Courriel*: _____

*(with International code/*Avec code international*)*

Sport: _____ Discipline/Position: _____

International or National Sport Organization / *Organisation sportive internationale ou nationale*: _____

If you are an athlete with an impairment, please indicate the impairment / *Si vous êtes un sportif avec un handicap, veuillez préciser lequel*: _____

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2. Medical information/*Renseignements médicaux*

(Continue on separate sheet if necessary / continuez sur une feuille séparée si nécessaire*)*

Diagnosis / *Diagnostic* :

If a permitted medication can be used to treat the medical condition, please provide clinical justification for the requested use of the prohibited medication. / *Si un médicament autorisé peut être utilisé pour traiter la pathologie, veuillez fournir la justification clinique pour l'usage demandé du médicament interdit:*

Note	**Diagnosis / Diagnostic**
	Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical evidence must 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. In the case of non-demonstrable conditions, independent supporting medical opinion will assist this application. *Les éléments confirmant le diagnostic seront joints et transmis avec cette demande. Les preuves médicales comprendront un historique médical complet ainsi que les résultats de tous les examens, analyses de laboratoire et études par imagerie pertinents. Dans la mesure du possible, une copie de tous les rapports originaux ou lettres sera jointe. Les preuves seront aussi objectives que possible compte tenu des circonstances cliniques. Dans le cas de pathologies impossibles à démontrer, un avis médical indépendant sera joint à l'appui de cette demande.*

3. Medication details */Médicament(s) concerné(s)*

Prohibited substance(s)/*Substance(s) interdite(s)*: *Generic name/ Nom générique (DCI)*	Dose/ *Posologie*	Route/*Voie d'administration*	Frequency/ Fréquence	Expiry Date/*Date d'expiration*

4. Medical practitioner's declaration/*Attestation du médecin*

I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate. *Je certifie que le l'information mentionnée aux sections 2 et 3 ci-dessus est exacte, et que le traitement ci-dessus est médicalement adapté.*

Name/
Nom: _____

Medical Specialty/
Spécialité médicale: _____

Address/
Adressse: _____

Tel./ Fax:
Tél: _____ _____

E-mail/*Courriel*: _____

Signature of Medical Practitioner/ Date:
Signature du médecin: _____ _____

5. Retroactive applications / Demandes rétroactives

Is this a retroactive application?/ Cette demande est-elle rétroactive? *Yes / Oui* ☐ No / Non ☐ If yes, on what date was treatment started? / Si oui, à quelle date le traitement a-t-il commencé?	Please indicate reason / *Veuillez indiquer la raison*: Emergency treatment or treatment of an acute medical condition was necessary/*Urgence médicale ou traitement d'une pathologie aiguë* ☐ Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection/*En raison d'autres circonstances exceptionnelles, il n'y a pas eu suffisamment de temps ou de possibilités pour soumettre une demande d'AUT avant la collecte de l'échantillon* ☐ Advance application not required under applicable rules/*Demande avant utilisation de la substance non obligatoire en vertu des règles applicables* ☐ Other/*Autre raison* ☐ Please explain/*Veuillez expliquer*:

6. Previous application / Demandes antérieures

Have you submitted any previous TUE application/*Avez-vous déjà soumis une/des demande(s) d'AUT dans le passé?*:	Yes/ *Oui* ☐ No / Non ☐
For which substance/*Pour quelle substance*?	
To whom	When /
/A qui?	Quand?
Decision / Décision: Approved / Acceptée ☐ Not Approved / Refusée ☐	

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7. Athlete's declaration

I, certify that the information set out at sections 1, 5 and 6 is accurate. I authorize the release of personal medical information to the Anti-Doping Organization (ADO) as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorized 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.

Date	Print name (Last Name, First Name)
Date of Birth (Day-Month-Year)	Signature (or, if a minor, signature of legal guardian)

(If the Athlete is a Minor or has an impairment preventing him/her signing this form, a parent or guardian shall sign on behalf of the Athlete. / *Si le sportif est mineur ou présente un handicap l'empêchant de signer ce formulaire, un parent ou un tuteur doit le signer en son nom.*)