



Therapeutic Use Exemptions TUE

Please complete all sections in capital letters or typing.

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.

1. Athlete Information

Surname: _____	Given Names: _____	
Female <input type="checkbox"/> Male <input type="checkbox"/>	Date of Birth (day - month - year): _____	
Address: _____		
City: _____	Country: _____	Postal Code: _____
Tel: _____	Email: _____	

Sport: _____	Discipline/Position: _____	
International or National Sports Organization: _____		
If you are an athlete with an impairment, please indicate the impairment:		



2. Medical Information

(Continue on separate sheet if necessary)

Diagnosis:

If a permitted medication can be used to treat the medical condition, please provide clinical justification for the requested use of the prohibited medication:

Note

Diagnosis

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.



3. Medication Details

Prohibited substance(s)/ <i>Substance(s)</i> : <i>(Generic name)</i>	Dose	Route	Frequency	Expiry Date

4. Medical Practitioner's Declaration

I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate.

Name: _____

Medical Specialty: _____

Address: _____

Tel: _____

Fax: _____

E-mail: _____

Signature of Medical Practitioner: _____

Date: _____



5. Retroactive Applications

Is this a retroactive application? Yes No

If yes, on what date was treatment started?

Please indicate reason (check the applicable box):

Emergency treatment or treatment of an acute medical condition was necessary

Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection

Advance application not required under applicable rules

Other, please explain:



6. Previous Applications

Have you submitted any previous TUE applications?

YES

NO

For which substance? _____

To whom _____

When _____

Decision: Approved

Not Approved



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)



B A D C
BAHAMAS ANTI-DOPING COMMISSION



Completion of this TUE Application does not guarantee a TUE will be granted. In the absence of a signed Certificate of Approval for Therapeutic Use granted by BADC, athletes do not have permission to use a Prohibited Substance and/or Method.

Please submit your application to the Bahamas Anti-Doping Commission and keep a copy for your records.

By Hand:

Bahamas Anti-Doping Commission
Betty Kelly Kenning Aquatic Center
National Stadium
University Blvd
Nassau, Bahamas

By Fax: (242) 325-2634

By E-mail: **info@bahamasadc.org**

For more information and to check your medications on our website at www.bahamasadc.org, click on **TEST YOUR DRUG**

STRICTLY CONFIDENTIAL