

# Therapeutic Use Exemptions Abbreviated Process

(Beta-2 agonists by inhalation, glucocorticosteroids by non-systemic routes)

*I apply for approval for the therapeutic use of a prohibited substance on the World Anti-Doping Agency (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

Last Name: ..... First Name ..... M.I. ....

Female  Male  (check appropriate box)

Address: .. ..

City: ..... State : ..... Zip code: .....

Date of Birth (month/day/year): .....

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

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

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

National Governing Body: .....

If athlete with disability, indicate disability: .....

## 2. Notifying medical practitioner

Name, qualifications and medical speciality (see note 1): .....

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Address: .....

..... E-mail address: .....

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

Mobile: ..... Fax: .....

### 3. Medical information

Diagnosis:.....

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

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

#### Additional information

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### 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:

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**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 including its Therapeutic Use Exemption Committee (TUEC) as well as to WADA staff and to the WADA TUEC 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. I acknowledge this is effective upon receipt (if complete) by the appropriate Anti-Doping Organization.

For International-level athletes and those who compete internationally, the appropriate Anti-Doping Organization is your International Federation. You may not compete while using any of the allowable medication until a complete form is received by your IF. For National-Level Athletes must submit the Form to USADA. International Athletes may submit the completed Form to USADA and USADA will forward your Form to your IF.

**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)*

<b>Note</b> <b>1</b>	Name, qualifications and medical specialty For example: Dr AB Cook, MD FRACP, Gastro-enterologist.
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**Please send your form to the U.S. Anti-Doping Agency**  
2550 Tenderfoot Hill Dr., Suite 200  
Colorado Springs, CO 80906  
**Telephone:** 1-866-601-2632 (toll-free) or 1-719-785-2000  
**Drug Reference Line:** 1-800-233-0393 or drugreference@usantidoping.org  
**Fax:** 1-719-785-2001  
**Email:** webmaster@usantidoping.org  
**Website:** www.usantidoping.org