



Therapeutic Use Exemptions - TUE

Please complete all sections in capital letters or typing

1. Athlete Information

Surname : First Names :

woman :

man :

Birth date (d/m/y):

Address :

town..... country :post code:

Nr of FILA license card

Tel .: E-mail :
(with international code)

Fax

Sport: Wrestling ... Wrestling style:

Weight category :

National Federation :(country) :

2. Medical information

Diagnosis with sufficient medical information (see note 1):

.....

.....

.....

.....

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

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.....

.....

3. Medication details

| <u>Prohibited substance(s):</u> <u>Generic name</u> | Dose | Route | Frequency |
|--|--|--------------|------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| <u>Intended duration of treatment:</u> <u>(Please tick appropriate box)</u> | once only <input type="checkbox"/> emergency..... <input type="checkbox"/> or duration (week/month) : | | |

4. Medical practitioner's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.

Name : First name :

Medical speciality :

Address :

Tel . : Fax :

e-mail :

Signature of Medical Practitioner: Date:

5. Athlete's declaration

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

Athlete's signature: Date:.....

Parent's/Guardian's signature: Date:.....

if the athlete is a (minor a parent or guardian shall sign together with or on behalf of the athlete)

6. **Note :**

Note 1

Diagnosis :

Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should 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 and in the case of non-demonstrable conditions independent supporting medical opinion will assist this application.

Incomplete Applications will be returned and will need to be resubmitted.

Please submit the completed form to the ADO and keep a copy for your records.

IMPORTANT

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Application forms must be filled in electronically or with a typewriter. They are available on FILA Internet site at the address : <http://fila-wrestling.com>

Please indicate the chemical composition of the substances or products used for therapeutic purpose.

Incomplete applications will be returned and will need to be resubmitted.

These authorizations are granted provided the quantities of the substances taken by the athlete do not exceed the quantity allowed for each substance

FROM NOW ON, AND FOR EACH APPLICATION FOR AN AUTHORIZATION FOR THERAPEUTICAL USE EXEMPTION (TUE), AN EXHAUSTIVE LIST OF THE LABORATORY ANALYSIS AND THE RESPIRATORY FUNCTIONING INVESTIGATIONS CARRIED OUT AND THEIR RESULTS WILL BE REQUIRED BY THE HEAD DOCTOR OF THE FILA TUE COMMISSION IN ORDER TO ENABLE HIM TO ESTIMATE PRECISELY THE STATE OF HEALTH OF THE ATHLETES

