

Telephone: 021 686 1634
Fax: 086 242 7077
Email: rado-tue@saisd.org.za

South African Institute for
Drug-Free Sport



Therapeutic Use Exemption (TUE) Application Form

Please note the following:

- **Athlete** to complete sections **1, 5, 6** and **7**.
- **Physician** to complete sections **2, 3** and **4**.

1. Athlete Information

Surname: _____ Given Names: _____

Female Male

Date of Birth

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Address: _____

City: _____ Country: _____

Post Code: _____ Tel.: _____
(with International code, if applicable)

E-mail: _____

Sport: _____ Discipline/Position: _____

International or National Sport Organisation of the sport code that you are competing in:

Next competition date: _____

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.

Comment:

Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical information 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.

WADA maintains a series of guidelines to assist physicians in the preparation of complete and thorough TUE applications. These TUE Physician Guidelines can be accessed by entering the search term “Medical Information” on the WADA website: <https://www.wada-ama.org>. The guidelines address the diagnosis and treatment of a number of medical conditions commonly affecting athletes, and requiring treatment with prohibited substances.

3. Medication Details

Prohibited Substance(s): Generic Name/Active Ingredient*	Trade Name	Dosage	Route	Frequency	Date(s) of Treatment	Expected duration of Treatment

*If the medication is Methylphenidate, please note the SAIDS additional information on this.

4. Medical Practitioner's Declaration

I certify that the information at sections 4 and 5 above is accurate, and that the above-mentioned treatment is medically appropriate.

Name: _____

Medical Speciality: _____

Address: _____

Tel.: _____ Fax: _____

E-mail: _____

Signature of Medical Practitioner: _____ Date: _____

5. Retroactive Application

Is this a retroactive application?

Yes

No

If yes, on what date was treatment started?

Please indicate reason:

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 application(s)?

Yes

No

Kindly indicate the TUE approval number (if applicable): _____

For which substance or method? _____

To whom? _____ When? _____

Decision: Approved

Not approved

7. Athlete's Declaration

I, _____
certify that the information set out at sections 1, 2 and 3 is accurate. I authorise the release of personal medical information to the Anti-Doping Organisation (ADO) as well as to WADA authorised staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorised staff that may have a right to this information under the World Anti-Doping 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 organisations 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 organisations, 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 the Court of Arbitration for Sport (CAS).

Athlete's Signature: _____ **Date:** _____

Parent's/Guardian's Signature: _____ **Date:** _____

(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)

**Please submit the completed form to
e-mail: rado-tue@said.org.za or fax-to-email : 086 242 7077
and keep a copy for your records.**