



web site: [www.iwsf.com](http://www.iwsf.com)  
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Please fill in the form using capital letter and send to address of [nenad.dikic@gmail.com](mailto:nenad.dikic@gmail.com)  
Dr. Nenad Dikic, Chair, IWSF TUE Committee, Palmoticeva 26, 11000 Belgrade, Serbia

## Therapeutic Use Exemptions TUE

Please complete all sections in capital letters or typing

### 1. Athlete Information

Surname: _____	Given Names: _____	
Female <input type="checkbox"/>	Male <input type="checkbox"/>	Date of Birth (d.m.y): _____
Address: _____		
Town: _____	Country: _____	Postcode: _____
Phone: _____ <small>(with international code)</small>	e-mail: _____	
Sport (and position): _____		
International or National Sporting Organization: _____		
If athlete has disability, indicate disability: _____		

### 2. Medical information

<b>Diagnosis with sufficient medical information (see Note 1):</b> _____ _____ _____ _____
<b>If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication</b> _____ _____ _____

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### 3. Medication details

Prohibited substance(s) <b>Generic name:</b>	Dosage	Volume	Route	Frequency
1.				
2.				
3.				

Intended duration of treatment: (check appropriate box)	once only <input type="checkbox"/>	emergency <input type="checkbox"/>
	or duration (week/month): _____	

Have you submitted any previous TUE application:	yes <input type="checkbox"/>	no <input type="checkbox"/>
For which substance?	_____	
To whom?	_____	When? _____
Decision:	Approved <input type="checkbox"/>	Not approved <input type="checkbox"/>

### 4. Medical practitioner's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medications not on the Prohibited List would be unsatisfactory for this condition.	
Name: _____	
Medical Speciality: _____	
Address: _____	
Phone: _____	Fax: _____
E-mail: _____	
Signature of Medical Practitioner: _____	Date: _____

### 5. Note:

<b>Note 1</b>	<p>Diagnosis</p> <p>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.</p>
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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 relevant parties only i.e. to my 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. I also understand that if I withdraw my consent to the release of my personal medical information, I may not receive approval for a TUE or the renewal of an existing TUE, since no TUE can be granted or renewed without the disclosure of comprehensive medical data.

I AM AWARE THAT AN APPLICATION FOR A TUE REQUIRES THE PROCESSING (FOR EXAMPLE TRANSMISSION, DISCLOSURE, USE AND STORAGE) OF ALL DATA PERTAINING TO SUCH APPLICATION THROUGH THE ANTIDOPING ADMINISTRATION AND MANAGEMENT SYSTEM (ADAMS) TO ENSURE HARMONIZED, COORDINATED AND EFFECTIVE ANTI-DOPING PROGRAMS FOR DETECTION, DETERRENCE AND PREVENTION OF DOPING. SIGNING THIS FORM WILL INDICATE THAT I HAVE BEEN SO INFORMED AND THAT I GIVE MY EXPRESS CONSENT TO SUCH PROCESSING OF DATA.

If I decide to use ADAMS, I understand and agree that my application for a TUE will only be considered following the submission in ADAMS, by myself or by my ADO, of the present completed application form, as well as all relevant documents related to the application.

I understand and agree that my TUE related data will be made accessible through ADAMS to the authorized ADO, to WADA and to the Therapeutic Use Exemption Committee.

I understand and agree that if a TUE is granted, such TUE and the related information will be stored electronically in ADAMS for a minimum period of 8 years, the period of 8 years being the period within which an action can be commenced following a violation of an anti-doping rule contained in the Code.

WADA, Anti-Doping Organizations and Therapeutic Use Exemption Committees will not disclose any of my TUE related information beyond those persons within their organization with a need to know according to the Code.

#### RELEASE

I hereby release WADA as well as ADOs and TUE Committees from all claims, demands, liabilities, damages, costs and expenses that I may have arising in connection with the processing of my TUE related data through ADAMS.

#### WITHDRAWAL OF CONSENT

If I have decided to use ADAMS, I understand that I may at any time revoke my consent for the processing of my TUE related data through ADAMS. I also understand that as a consequence of such withdrawal of consent, I will not receive approval for a TUE or a renewal of an existing TUE.

Date

Print name (Last Name, First Name)

Date of Birth  
(Day/Month/Year)

Signature (or, if a minor, signature  
of legal guardian)

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

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