

Therapeutic Use Exemptions

Abbreviated Process

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

I apply for approval from (Anti-Doping Organization) for the therapeutic use of a prohibited substance on the 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

Surname: Given Names:

Female Male (tick appropriate box)

Address:

Country: Postcode:

Date of Birth (d/m/y):

Tel. Work: Tel. Home: Mobile:

Sport: Discipline/Position:

National Sporting Organisation:

If disabled Athlete, indicate disability:

e-mail:

2. Notifying medical practitioner

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

.....

Address:

..... Email address:

Tel. Work: Tel. Home:

Mobile: Fax:

Application No.:

3. Medical information

Diagnosis:
Medical examination/test performed:
.....

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

Additional information

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.....

5. 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:
Signature of Medical Practitioner: Date:

Application No.:

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 as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) as well as to other Anti-Doping Organization 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.

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)

Note 1

Name, qualifications and medical speciality
For example, Dr. AB Cook, MD FRACP, Gastro-enterologist.

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

Please submit the completed form to the Anti-Doping Organization and keep a copy of the completed form for your records.

International Softball Federation
1900 South Park Road
Plant City, FL 33563
Tel: 813.864.0100
Fax: 813.864.0105
Email: info@internationalsoftball.com

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