

## DECLARATION OF USE

**This form applies to Glucocorticosteroids used by non systemic routes:**  
intraarticular, periarticular, peritendinous, epidural, intradermal, inhaled\*

***(A TUE request is still required for oral, IV, IM or rectal routes)***

### 1. PLAYER DETAILS

Surname: \_\_\_\_\_

First name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

National Federation: \_\_\_\_\_

### 2. MEDICAL INFORMATION

Diagnosis: \_\_\_\_\_

Substance name: \_\_\_\_\_

Dosage: \_\_\_\_\_ Administration route: \_\_\_\_\_

Date administered: \_\_\_\_\_

\* Inhaled GCS must be declared on application for beta-2-agonist in asthma

### 3. PHYSICIAN CONTACT DETAILS

Surname: \_\_\_\_\_ First name: \_\_\_\_\_

Medical speciality: \_\_\_\_\_

Address: \_\_\_\_\_

Tel: \_\_\_\_\_ Email: \_\_\_\_\_

Player signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_