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Application No:
[For internal IAAF use only]

IAAF Therapeutic Use Exemptions (TUE)

Application Form

I hereby apply for approval for the therapeutic use of a prohibited substance or prohibited method on the IAAF Prohibited List

Please complete all sections in CAPITAL LETTERS or typing

☐ I am included in IAAF Registered Testing Pool **or**

☐ Preparing for IAAF International Competition (which competition . . . .)

1. Athlete information

First Name: . . . . Last Name: . . . .

Female ☐ Male ☐ Discipline: . . . .

Address: . . . .

City: . . . . Country: . . . .

Postal Code: . . . . Date of birth (dd/mm/yy): . . . .

Tel.: *(with international code)*. . . . . Mobile: . . . .

E-mail: . . . . National Federation: . . . .

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

Prohibited substance(s) **(see Note 2)**: Commercial name/Generic name e.g: Humuline©/Insulin/Salbutamol	Dose of administration	Route of administration	Frequency of administration
1.			
2.			
3.			

Intended duration of treatment **(see Note 3):**	Once only ☐ Emergency ☐ Or duration (week / month): . . . .

Additional information: . . . .

. . . .

. . . .

Have you submitted any previous TUE application? ☐ yes ☐ no (tick appropriate box)

For which substance(s)? . . . .

Organisation (to whom TUE application was sent) . . . .

When (dd/mm/yy): . . . .

Result (attach previous TUE(s) where applicable): Approved ☐ Not approved ☐

Has the athlete's National Federation Team Doctor been notified of this application?

Yes: ☐ No: ☐

Name of National Federation's Team Doctor **(see Note 4)**: . . . .

4. Medical practitioner's declaration

I certify that the above-mentioned medication(s) for the above-named athlete is 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 IAAF Prohibited List would be unsatisfactory for the treatment of the above-named medical condition **(see Note 5)**.

Name, qualifications and medical speciality **(see Note 6)**: . . . .

. . . .

Address: . . . .

City: . . . . State/Province: . . . . Country . . . .

Postal Code: . . . . E-mail: . . . .

Tel.: *(with international code)* . . . . Mobile: . . . .

Signature of medical practitioner: . . . . Date: . . . .

5. Athlete's declaration

I, ... certify that the information in section 1 above is accurate and that I am requesting for approval to use a prohibited substance or prohibited method in the IAAF Prohibited List. I authorize the release of my personal medical information to the members of the IAAF Therapeutic Use Exemption Sub-Commission (IAAF TUESC), as well as to any other relevant persons (including, where applicable, WADA or IOC staff and/or members of the WADA or IOC Therapeutic Use Exemption Committees) who may be involved in the management, review or administration of my application in accordance with the IAAF Procedural Guidelines. I understand that, if I ever wish to revoke the right of the IAAF TUESC to obtain any health information on my behalf, I must notify my medical practitioner in writing of the fact. As a consequence of such a decision, I understand that I will not receive approval for a TUE (or renewal of an existing TUE).

I further authorise for the decision of the IAAF TUESC to be notified to other relevant organisations in accordance with IAAF Rule 34.9.

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)

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Notes:

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 clinical examinations, investigations, specialist medical reports and imaging studies. Copies of 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.* For applications for the use of Beta-2-agonists only: To constitute a **complete application**, International-Level athletes must include the following documentation required by the IAAF Beta-2-Agonists Protocol: 1. Detailed Medical Records 2. Provocation Test Results **Both must be filled in on appendix A of this Application Form** Refer to the IAAF Beta-2 Agonists Protocol in the "athletes area" of www.iaaf.org/antidoping for further more detailed information on the documentation that is required.
Note 2	Medication details *Provide details concerning all medications or treatments.* *Provide both the commercial and generic name (INN) of the medication and specify the medication dose, the route of administration and the frequency of administration.*
Note 3	Change of Prescription *Note that a new TUE application is required for any change in prescription.*
Note 4	National Federation Team Doctor *Whenever possible, the National Federation Team Doctor should be notified of the application and the application should include a statement by the Team Doctor attesting to the necessity of the otherwise prohibited substance or prohibited method in the treatment of the athlete.*
Note 5	*If a permitted medication can be used in the treatment of the athlete's medical condition, please provide clinical justification (on page 1) for the requested use of the prohibited medication.*
Note 6	Name, qualifications and medical specialty *For example: Dr AB Cook, MD FRACP, Gastro-enterologist.* *Dr JA Gonzalez, MBBS, FACSM, Sports Physician*

WARNING: Incomplete Applications will be returned and will need to be re-submitted.

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Please submit the completed form to the IAAF Medical and Anti-Doping Department (see contact details below) and keep a copy of the form for your records:

IAAF Medical and Anti-Doping Department

17, Rue Princesse Florestine

BP 359 – MC 98007

Monaco

Confidential Fax: +377 93 50 83 95

If there are further questions arising from this Form or regarding the relevant procedures for standard applications for TUEs, please contact the IAAF for further information on: +377 93 10 88 89 (tel) or tue-application@iaaf.org (e-mail).

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Appendix A

International Association of Athletics Federations

INHALED BETA-2-AGONIST APPLICATION FOR ASTHMA TREATMENT

Medical Records FORM

NAME OF THE ATHLETE: ____
DATE OF BIRTH: ____________________ COUNTRY: _____________________

Diagnosis:

Age of onset:

Symptoms spontaneous or exercise related:

Coughing during or post-exercise:	Yes or No	Dyspnoea:	Yes or No
Shortness of breath:	Yes or No	Wheezing:	Yes or No
Chest tightness:	Yes or No	Excess sputum:	Yes or No

If yes, specify:

Identified triggering factors :

Past history of atopic disorders and/or childhood asthma:

Past physical examinations:

Results of skin prick tests or RAST to document the presence of allergic hypersensitivity:

Details of all consultations with qualified physicians in the treatment of asthma

Details of any attendance in hospital emergency departments for treatment or admission to hospital for treatment of acute exacerbation of asthma.

Details of the individual's currently prescribed medication and any other medication prescribed in the past years, with particular details in the last 6 months.

Details of medication in the 3 months prior to provocation test:

PFTesting information Date of test: . . . . . / . . . . . / . . . . .

☐ Bronchodilator test: FEV_1 after bronchodilator: change compared to baseline: . . . . %
☐ Methacholine challenge test
PD_{20} = ... µmol or . . . . µg / PC_{20} = ... mg/mL
☐ Eucapnic Voluntary Hyperpnoea: FEV_1 decrease of . . . . % within . . . . min
☐ Exercise challenge: FEV_1 decrease of . . . . % within . . . . . . min
☐ Hypertonic saline test: FEV_1 decrease of . . . . % within . . . . . . min
☐ Mannitol test: FEV_1 decrease of . . . . % within . . . . . . min

Date:

Physician Name:

Physician Signature: