



Application No.:

Abbreviated Therapeutic Use Exemptions ATUE

Please complete all sections in capital letters, incomplete applications will be returned to the athlete

beta-2 agonists by inhalation <input type="checkbox"/>	glucocorticosteroids by non-systemic routes * <input type="checkbox"/>
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* All routes other than orally, rectally, intravenously and intramuscularly. Dermatological glucocorticosteroids do not require a TUE

1. Athlete Information

Surname: Given Names:

Female Male Date of Birth (d/m/y):

Address:

City: Country: Postcode:

Tel: Email:
(with international code)

Sport: Discipline:

International Federation/Governing Body:

Are you competing at an international or national level or below?

Please circle: International National Domestic/Local

If you are an athlete with a disability, please indicate disability:

2. Medical information

Diagnosis:

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N.B. Any ATUE may be reviewed at any time, by the ADO and/or WADA

Please submit the completed form to your Governing Body or UK Sport
Please keep a copy for your records.

TUE, Drug-Free Sport, UK Sport, 40 Bernard St, London WC1N 1ST
or via fax to +44 (0) 800 298 3362

Prohibited substance(s): <i><u>Generic name</u></i>	Dose	Route	Frequency
1.			
2.			
3.			
Intended duration of treatment: <i>(Please tick appropriate box)</i>	once only <input type="checkbox"/> emergency <input type="checkbox"/> or duration (week/month):		

3. Medical practitioner's and athlete'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: Address: Tel.: Fax: E-mail: Signature of Medical Practitioner: Date:	Medical Speciality:
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I, certify that the information under Section 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 (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.	
Athlete's signature:	Date:
Parent/Guardian 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.	

Office use only	Form complete? Y / N	Expiry date:
UK Sport TUE Number:	Signature:	

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