WORLD BRIDGE FEDERATION
International Sport Federation (IF) recognized by the International Olympic Committee

Application No:.....
(office use only)

Therapeutic Use Exemptions (TUE) Application Form

Please complete all sections in capital letters or by typing
Athlete to complete sections 1, 5, 6, 7 and sign section 7
Medical Practitioner /Physician to complete section 2, 3, 4 and sign section 4
Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.

1. Athlete Information

Surname: ..... Given Names: .....

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

Address: .....

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

Tel..... E-mail: .....
(with international code)

National Sport Organization: .....

Please specify the name of the next WBF International-Event in which you are scheduled to participate (if applicable):

.....

If you are an athlete with an impairment, please indicate the impairment:

....

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2. Medical information

Diagnosis:

(Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical evidence must 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. In the case of non-demonstrable conditions independent supporting medical opinion will assist this application)

……..

……

……..

If a permitted medication can be used to treat the medical condition, please provide clinical justification for the requested use of the prohibited medication

……

……

……..

……

3. Medication details

Prohibited substance(s) / method(s): ***Generic name***	**Dose**	**Route of Administration**	**Frequency**	**Duration of Treatment**
1.				
2.				
3.				
4.				

4. Medical practitioner's declaration

I certify that the information at sections 2 and 3 above is accurate, that the above-mentioned treatment is medically appropriate, and that an alternative non-prohibited medication has been considered and deemed inappropriate for this person.

Name:……

Medical speciality: ……..

Address: ……..

Tel.:……. **Fax:** ……

E-mail: ……

Signature of Medical Practitioner: ……**Date:** ……

5. Retroactive application

Is this a retroactive application?

☐ **Yes (Date on which treatment started (d/m/y): _____)**

☐ **No**

Indicate for which reasons you are applying for a retroactive TUE:

☐ **Emergency treatment;**

☐ **Treatment of an acute medical condition;**

☐ **Due to exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection;**

☐ **Advance application was not required under the WA Anti-Doping Rules;**

☐ **Other reason(s):**

_____

6. Previous application (s)

Have you submitted any previous TUE application: yes ☐ no ☐

For which substance or method ?
……

To whom?……..When?……

Approved ☐ Not approved ☐

7. Athlete's declaration

I, …… certify that the information set out at section 1, 5 and 6 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 WBF as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other Anti-Doping Organization(s) (ADO) TUECs and authorized staff that may have a right to this information under the World Anti-Doping Code ("Code") and/or its International Standards.

I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping violation investigations and procedures. I understand that if I ever wish (1) to obtain more information about the use of my information; (2) exercise my right of access and correction or (3) revoke the right of these organizations to obtain my health information, I must notify my medical practitioner and WBF in writing of that fact. I understand and agree that it may be necessary for TUE-related information submitted prior to revoking my consent to be retained for the sole purpose of establishing a possible anti-doping rule violation, where this is required by the Code.

I consent to the decision on this application being made available to all ADOs, or other organizations with Testing authority and/or results management authority over me.

I understand and accept that the recipients of my information and of the decision on this application may be located outside the country where I reside. In some of these countries data protection and privacy laws may not be equivalent to those in my country of residence.

I understand that if I believe that my personal information is not used in conformity with this consent and the International Standard for the Protection of Privacy and Personal Information I can file a complaint to WADA and CAS

Athlete's signature: …… Date: ……

Parent's/Guardian's signature: …… Date: ……

(if the athlete is a minor or has an impairment preventing him/her signing this form, a parent or guardian shall sign together with or on behalf of the athlete)

Please submit the completed form and related medical evidences requested to support this application to:
Dr Jaap Stomphorst, Postbus 10500, 8000GM Zwolle, The Netherlands,
or by email to: j.stomphorst@isala.nl.
Keep a copy of the completed form for your records

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