THERAPEUTIC USE EXEMPTIONS (TUE)

Please complete all sections in capital letters or typing

1. Athlete Information

Surname: …….. First Names: ……

Date of birth …… F ❑ M ❑ Nationality: …….

Address: …….

Phone: …… Email ……

Sport: …PESCA SPORTIVA……... Name of Club: ……

National Sport Organization: FEDERAZIONE PESCA SPORTIVA REP. SAN MARINO.

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.

Terapia:

Sostanza …… Dose ……

Vie di somministrazione …….. unica somministrazione ……..

Data inizio ……. Durata ……

Sostanza …… Dose ……

Vie di somministrazione …….. unica somministrazione ……..

Data inizio ……. Durata ……

Vie di somministrazione …….. unica somministrazione ……..

Data inizio ……. Durata ……

3. Medication details

Prohibited substance (s) generic name	dose	Route of administration	Frequency of administration

Intended duration of treatment/durata del trattamento previsto (please tick appropriate box)

- ❑ once only
- ❑ emergency date: …….. time: ……
- ❑ duration (days or weeks or months): ……

In case of emergency treatment of an acute medical condition or exceptional circumstances, please provide all relevant information regarding the emergency or why there was not sufficient time submit a TUE application.

……
……...

Have you made a TUE application before?

Yes ❑ No ❑

If yes, date: ……

For which substance? ……

To whom? …… When? …….

Decision: Approved ❑ Not approved ❑

4. Medical practitioner's declaration (dichiarazione del medico)

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.
Dichiaro che il trattamento di cui sopra è clinicamente appropriato e che l'uso di farmaci alternativi non sulla lista proibita sarebbe insoddisfacente per questa condizione.

Name: ……. ……

Medical speciality: …….. ……

Address: ……..…….

Phone …..……. EMail ……

date …….. Signature of medical practitioner

5. Player's declaration

I, ……., certify that the information given under point 1 is accurate and that I am requesting approval to use a substance or method on the WADA Prohibited List. I authorise 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 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 my medical practitioner and my ADO 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 must sign together with or on behalf of the athlete)

6. Note

Note 1: Diagnosis
Evidence confirming the diagnosis must be attached and forwarded with this application. Medical evidence should include a comprehensive medical history and the results of all relevant examination , laboratory investigations and imaging studies. Copies of the original reports or letter 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.

Incomplete applications will be returned and will need to be resubmitted

Please submit the completed form to**:**
si prega di inviare il modulo compilato a:

……

And keep a copy of the completed form for your records
Tenere una copia per se stessi