



Australian Government

Australian Sports Drug
Medical Advisory Committee

ASDMAC
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APP

Application for a Therapeutic Use Exemption of a Prohibited Substance and/or Prohibited Method

Please complete ALL sections in CAPITAL LETTERS or typing.

NOTE: This application will be reviewed by a panel of medical professionals, bound by strict confidentiality. Please supply relevant medical details and reports to allow ASDMAC to formulate an informed decision on this application. If no supporting medical documents are attached, the application will be returned to the applicant.

Please keep a copy of any documents submitted for your records.
For more information, visit the ASDMAC website www.asdmac.gov.au

1. Athlete Information				
Title Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>		Surname		Given Name(s)
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth (dd/mm/yyyy)		
Address				
Suburb			State	Postcode
Email				
Phone (h)			Mobile	
Sport			Discipline/position	
National Sporting Organisation				
Athlete with a disability		If yes please indicate disability		
Yes <input type="checkbox"/> No <input type="checkbox"/>				
Current level of competition				
International <input type="checkbox"/>		National <input type="checkbox"/>		Other <input type="checkbox"/>
State <input type="checkbox"/>		Club <input type="checkbox"/>		
If you are competing internationally you need to check with your International Federation to determine if you need to lodge a TUE with the International Federation or with ASDMAC.				
International Federation Registered Testing Pool Member*: Yes <input type="checkbox"/> No <input type="checkbox"/>				
ASADA Registered Testing Pool Member*: Yes <input type="checkbox"/> No <input type="checkbox"/>				
*If you are unsure of whether you are a member of your International Federation's or ASADA's Registered Testing Pool/s, please contact your National Sporting Organisation or ASADA to check.				

2. Notifying medical practitioner (please write clearly using block letters or practice stamp)		
Surname	Given Name(s)	
Specialty and qualifications		
Address		
Suburb	State	Postcode
Email		
Phone (w)	Mobile	

3. Previous TUE		
<p>Have you previously had, or do you currently have, any TUE(s)? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please attach any current or relevant TUE(s) to this application or please fill out the following information in relation to those applications:</p>		
Date	Anti-Doping Organisation/TUE Committee	Substance
<p>Have you previously had any TUE applications rejected? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If yes, please fill out the following information in relation to those applications:</p>		
Date	Anti-Doping Organisation/TUE Committee	Substance

4. Retroactive TUE	
<p>Is this application for a retroactive TUE? No - go to Q5 <input type="checkbox"/> Yes - indicate below</p> <p>A retroactive TUE is for treatment involving a prohibited substance or method that has already commenced and can only be sought for the following circumstances:</p> <p><input type="checkbox"/> Yes - Emergency treatment or treatment of an acute medical condition was necessary</p> <p><input type="checkbox"/> Yes - "Exceptional circumstances" means that there was insufficient time for ASDMAC to consider the application</p>	
<p>If the retroactive request is for a substance/method detected as a result of doping control, please state:</p> <p>date of sample collection: _____ substance/method detected: _____</p>	

5. Medication/Treatment details (please write clearly using block letters)

Medication/Treatment	Prohibited Substances/Method	Dose & Frequency	Route of Administration	Duration

6. Diagnosis with medical information (please write clearly using block letters)

Evidence confirming the applicant's diagnosis (in the form of a typed letter) **MUST BE ATTACHED** to this application.

The medical evidence should include clinical history and the results of all examinations, investigations, imaging studies and specialist medical reports. Copies of the 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. Any additional investigations, examinations or imaging studies requested by ASDMAC will be undertaken at the expense of the applicant or his/her National Sporting Organisation.

If a permitted substance or method is available to treat the medical condition, provide clinical justification for the requested use of the prohibited substance or method:

Full details of all medications or treatments that have been trialed:

Additional comments:

7. Athlete application, authority and declaration

I _____ declare that the information I provide in connection with this application is accurate and complete. I request that ASDMAC provide me with an approval to use a substance or method that is prohibited by the rules of my sport. I consent to personal information relating to me being disclosed to, and used by relevant persons, bodies and agencies as appropriate for the consideration of this application (and any appeal) and the implementation, co-ordination, administration, monitoring and enforcement of the therapeutic use exemptions under the relevant national and international anti-doping programs of my sport. I understand that these bodies and agencies may include the Australian Sports Anti-Doping Authority, Commonwealth Minister for Sport, Sporting Administration Bodies as defined under section 4 of the ASADA Act including, but not limited to, the Australian Sports Commission, the World Anti-Doping Agency, other national and international anti-doping agencies and organisations, the relevant national and international sporting administration organisations of my sport and any body authorised to conduct an appeal of ASDMAC's decision in respect of this application. I understand that relevant persons include, but is not limited to, ASDMAC staff, medical practitioners consulted by ASDMAC and ASDMAC's agents. I understand that if I wish to revoke the consent I must notify my medical practitioner and ASDMAC in writing to highlight that effect.

Athlete's signature:

Date:

Parent's / Guardian's signature:
(athletes under 18 yrs of age)

Date:

8. Medical practitioner's declaration

I, _____ declare the abovementioned medication/s for the above named athlete is the medically appropriate treatment for the above named medical condition. I further certify that the use of alternative medications or methods not on the WADA Prohibited List would be unsatisfactory for the treatment of the above medical condition.

Signature of medical practitioner:

Date:

9. Application checklist (please complete before sending application)

1. Athlete details complete	<input type="checkbox"/>
2. Medical practitioner details complete	<input type="checkbox"/>
3. TUE application details complete	<input type="checkbox"/>
4. Retroactive TUE	<input type="checkbox"/>
5. Medication details including all medications and treatments tried (generic names and doses)	<input type="checkbox"/>
Separate diagnosis and medical evidence attached:	
(a) Comprehensive medical history;	<input type="checkbox"/>
(b) Results of examinations, laboratory investigations, imaging studies and/or specialist medical reports;	<input type="checkbox"/>
(c) Copies of original reports or letters (where appropriate).	<input type="checkbox"/>
6. Diagnosis with medical information	<input type="checkbox"/>
7. Athlete declaration signed	<input type="checkbox"/>
8. Medical practitioner declaration signed	<input type="checkbox"/>