Therapeutic Use Exemptions (TUE) Application Form

Please complete all sections in capital letters or typing. Athlete to complete sections 1 and 6; physician to complete sections 2, 3, 4 and 5. Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.

1. Athlete Information

Surname:		Given Name:	
Sex:	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy):	
Preferred method of communication:		☐ Email ☐ Canada Post	
Email Address:			
Mailing Address:			
City:		Province/State:	
Country:		Postal Code:	
Telephone:			
Sport:		Discipline / Position:	
Are you in you a CPA /NPC or IFBB Pro League member?			
If you know you will be competing at an international event, enter the event name and date:			
If you are an athlete with a disability, indicate disability:			

Have you submitted any previous TUE application?	☐ Yes	☐ No
For which substances?		
To which organization?		
When?		
Decision	☐ Approved	☐ Not approved

2. Medical Information (to be completed by your physician)

Diagnosis -please attach sufficient medical information
If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication:

Comment:

Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical information 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. Prohibited Substances can be found at www.globaldro.com

3. Medical Details (to be completed by your physician)

Prohibited Substance(s): Generic name	Dose	Route of Administration	Frequency of Administration	Duration of Treatment
Enter all that apply	e.g., 200 mg	e.g., inhalation, local injection	e.g., BID, QID	e.g., one-time use, emergency, one year
1.				
2.				
3.				

4. Physician's Declaration (to be completed by your physician)

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.			
Surname:		Given Name:	
Medical Specialty:			
Address:			
City:		Province/state:	
Country:		Postal Code:	
Telephone:		Email Address:	
Signature:		Date (dd/mm/yyyy):	

5. Diagnosing physician (if different from treating physician)

Surname:		Given Name:	
Medical Specialty:			
Address:			
City:		Province/state:	
Country:		Postal Code:	
Telephone:		Email Address:	

6. Athlete's Declaration

I,_____certify that the information set out at section 1, is accurate. I authorize the release of personal medical information to the CPA/NPC/IFBB Pro League drug testing committee.
I consent to my physician(s) releasing to the above persons any health information that they deem necessary in order to consider and determine my application.
I understand that my information will only be used for evaluating my TUE request and in the context of potential anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my health 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 my ADO in writing of that fact. I understand and agree that it may be retained for the sole purpose of establishing a possible anti-doping CPA/NPC/IFBB Pro league rule violation.

I consent to the decision on this application being made available to all ADOs. I understand and accept that the recipients of my information and of the decision on this application may be located outside of 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 authorize the release of my medical information to members of the Health Care Team attending Natural sanctioned contests where I may participate, to my Physician, and to my national organization.		
☐	I do not wish to have this information shared with anyone but the CPA/NPC/IFBB Pro League.		
Athlete's Signature:		Date (dd/mm/yyyy):	
(If the athlete is a minor or has a disability preventing him/her from signing this form, a parent or guardian is to sign together with, or on behalf of, the athlete.)			
Surname:		Given Name:	
Parent/Guardian's signature:		Date (dd/mm/yyyy):	