THERAPEUTIC USE EXEMPTION (TUE)

Application form

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS OR TYPE.

INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED AND WILL NEED TO BE RESUBMITTED.

NB: Evidence confirming the diagnosis must be submitted 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, and in the case of non-demonstrable conditions, independent supporting medical opinion will assist this application.

1. Player Information

Surname: _____ First names: _____

❒ Female ❒ Male

Nationality:_____

Date of birth (dd/mm/yyyy): _____/_____/_____

Participating in which UEFA competition?_____

NB: UEFA can only treat TUE applications from players currently registered to participate in a UEFA competition

Name of club or national football association:_____

Reply to be sent to the above-mentioned club/national football association:

❒ **YES** ❒ Fax no. (please include country and area codes): _____

❒ By post: _____

_____

❒ **NO** If your reply is NO, please tick one of the boxes below and fill in the requested details

❒ Fax no. (please include country and area codes):_____

❒ By post: _____

_____

2. Medical information

Diagnosis with 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: _____

_____

_____

3. Medication details

Generic name of prohibited substance(s)	**Dose**	**Route of administration**	**Frequency of administration**
1.			
2.			
3.			

Intended duration of treatment (please tick appropriate box):

❒ Once only

❒ Duration (days/weeks/months): _____

4. Retroactive applications

Is this a retroactive application? ❒ Yes ❒ No

If yes, on what date was treatment started? (dd/mm/yyyy): _____/_____/_____

Please indicate the reason for the retroactive application:

❒ Emergency treatment or treatment of an acute medical condition was necessary

❒ Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection

❒ Other: _____

_____

_____

5. Previous applications

Have you made a TUE application before? ❒ Yes ❒ No

If yes, on what date? (dd/mm/yyyy): _____/_____/_____

For which substance or method? _____

❒ To an anti-doping organisation? Please specify: _____

❒ To my national football association

Decision: Approved ❒ Not approved ❒ *(if approved, please attach previous TUE(s))*

6. Medical practitioner's declaration

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.

Name: _____

Qualifications: _____

Medical speciality: _____

Address: _____

Email: _____

Tel. (work): _____
(Please include country and area codes)

Mobile: _____ Fax: _____

Signature of medical practitioner: _____ **Date:** _____

7. Player's declaration

I, _____, certify that the information given above is accurate. I authorise the release of my personal medical information to the UEFA Medical and Anti-Doping Unit and relevant UEFA bodies, as well as to authorised WADA staff, the WADA Therapeutic Use Exemption Committee (TUEC) and other anti-doping organisations' TUECs and authorised staff that may have a right to this information under the World Anti-Doping Code and/or International Standard for Therapeutic Use Exemptions.

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 information; (2) exercise my right of access and correction; or (3) revoke the right of these organisations to obtain my health information, I must notify my medical practitioner and UEFA 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 anti-doping organisations 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 countries whose data protection and privacy laws may not be the same as 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 or CAS.

Player's signature: _____ **Date:** _____

Parent/guardian's signature: _____ **Date:** _____
(If the player is a minor or has an impairment preventing him/her from signing this form, a parent or guardian shall sign with or on behalf of the player.)

Please fax the completed form to UEFA at +41 22 990 31 31 and keep a copy for your records

Treatment may be administered only upon receipt of TUE approval