

**CONFIDENTIAL**



**DRUG FREE SPORT NZ**

**Drug Free Sport NZ**

Ph: 09 5215706 Fax: 09 5215726

**Therapeutic Use Exemption  
Abbreviated Application Form**

(IN COMPLIANCE WITH WORLD ANTI-DOPING CODE 2004 - INTERNATIONAL STANDARD FOR THERAPEUTIC USE EXEMPTIONS)

**Who must this form be submitted to?**

National Athlete Drug Free Sport NZ	International Athlete International Federation (copy to DFSNZ)
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**Note:** Topical glucocorticosteroids including skin creams, nasal sprays and ear/eye drops do not require a TUE. Oral Prednisone and other forms of systemic glucocorticosteroids require a Standard TUE. Refer to [www.drugfreesport.org.nz](http://www.drugfreesport.org.nz) for further clarification.

**Please complete all sections – Please Write Clearly**

**1. Athlete Information**

Last Name: ..... First Name: ..... Female  Male  [Tick one]  
Date of Birth (d/m/y): ...../...../..... Sport:..... Discipline/Position:.....  
Street Address: ..... City: .....  
Country: ..... Mobile: .....  
Tel. (Hm): ..... Tel. (Wk): ..... E-mail: .....  
National Sporting Organisation: .....  
If athlete with disability, indicate disability: .....

**2. Medical Information**

Diagnosis: ..... Medical examination(s)/test(s) performed: .....  
.....[Please attach a separate sheet if required.]

Prohibited Substance(s) Indicate <input checked="" type="checkbox"/> beside those that apply	Dosage	Route of administration	Frequency of administration	Anticipated duration of this medication plan
<input type="checkbox"/> Salbutamol (eg, Ventolin)		Inhalation		
<input type="checkbox"/> Terbutaline (eg, Bricanyl)		Inhalation		
<input type="checkbox"/> Salmeterol (eg, Serevent)		Inhalation		
<input type="checkbox"/> (E)Formoterol (eg, Oxis)		Inhalation		
<input type="checkbox"/> Corticosteroid (non systemic) Please specify:				

Additional Information: [Please attach a separate sheet if required.]

**3. Physician's Information & Declaration**

I certify the above-mentioned substance(s) for the above-named athlete has been/is to be administered as the correct treatment for the above-named medical condition. I further certify that the use of the alternative medications not on the World Anti-Doping Agency (WADA) Prohibited List would be unsatisfactory for the treatment of the above-named medical condition. Specify reason:  
.....  
Physician's Signature: .....  
Date:.....

Name:.....  
Qualifications:.....  
Address:.....  
Phone:.....  
Fax:.....  
E-Mail.....

**4. Athlete's Declaration**

I, certify that the information under 1 above 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 Drug Free Sport NZ as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) as well as to other Anti-Doping Organisations under the provisions of the Code. I understand that if I ever wish to revoke the right of the Anti-Doping Organisation TUEC or WADA TUEC to obtain my health information on my behalf, I must notify my medical practitioner in writing of that fact.

Athlete's Signature: ..... Date: .....

Parent's/Guardian's Signature: ..... Date: .....

(If the athlete is under 18 years of age or has a disability preventing him/her to sign this form, a parent or guardian shall sign together with or on behalf of the athlete.)