

# Therapeutic Use Exemptions Standard Process

*I apply for approval for the therapeutic use of a prohibited substance on the World Anti-Doping Agency (WADA) List of Prohibited Substances and Prohibited Methods that is subject to the Abbreviated Therapeutic Use Exemption Application Process.*

**Please complete all sections**

## 1. Athlete Information

Last Name: ..... First Name..... M.I.....

Female  Male  (check appropriate box)

Address:.....<sup>TM</sup>

City: ..... State : ..... Zip code: .....

Date of Birth (month/day/year): .....

Tel. Work: (.....)..... Tel. Home : (.....)..... Mobile: (.....).....

E-mail: ..... Fax: (.....).....

Sport:.....

National Governing Body: USA Powerlifting International Federation: International Powerlifting Federation.

If athlete with disability, indicate disability: .....

## 2. Notifying medical practitioner

Name, qualifications and medical specialty (e.g. J.S. Smith, M.D.. FRACP, Gastro-Enterologist):

.....  
.....

Address: .....

.....

E-mail address: .....

Tel. Work: (.....)..... Fax: (.....).....

## 3. Medical information

Diagnosis\*.....

Medical examination(s)/test(s) performed:

.....  
.....

**\*Evidence confirming the diagnosis must be attached and be forwarded with this application. The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory 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 cause of non-demonstrable conditions independent supporting medical condition will assist with this application.**

Prohibited Substance(s)**	Dose	Route of Administration	Frequency

\*\*Provide details concerning all prohibited substances or methods for which approval is sought. Use generic names (INN) and specify medication dose, route of administration, and frequency. Provide anticipated duration of treatment separately for each medication for which approval is requested if the durations for different medications is expected to differ.

Anticipated Duration of this Medication Plan: .....

.....

**Previous/Current TUE requests: Yes No (circle one)**

If yes, date:.....

Anti-doping agency/Sports federation applied to:.....

(Attach previous TUE's either granted of applied for)

**Please describe reasons for not alternative therapies have not been prescribed and/or medications which are not prohibited have not been utilized instead of the prohibited substance or method requested in this TUE application (include information sufficient to demonstrate clinical justification for the medication or method requested) :**

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**Please send you completed form to:**

Mark Rodacker, M.D., Chair  
USAPL TUE Committee  
USA Powerlifting  
PO Box 668  
Columbia City, IN 46725  
Telephone: (260) 248-4889  
Fax: (260) 248-4879

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**For TUE Committee Use Only:**

Date Application Received:.....

Therapeutic Use Exemption Granted:  Yes  No

Reason Declined:.....

TUE Representative Signature:..... Date:.....

