World Drug Free Powerlifting Federation (W.D.F.P.F.)

Abbreviated
Therapeutic Use Exemptions
ATUE

Please complete all sections <u>in capital letters or typing</u>

Beta-2 agonists by inhalation □	**Glucocorticosteroids by non-systemic routes*** □

All routes other than orally, rectally, intravenously and intramuscularly.
Dermatological glucocorticosteroids do not require any TUE

1. Athlete Information

Surname:_____ Given Names: _____

Female □ Male □ Date of Birth (d/m/y): _____

Address: _____

City: _____ Country: _____ Postcode: _____

Tel.: _____ E-mail: _____
(with international code)

Sport: _____ Discipline/Position: _____

International or National Sport Organisation: _____

If athlete with disability, indicate disability: _____

2. Medical information

Diagnosis:_____

_____

_____

_____

N.B. Any TUE may be reviewed at any time, by the W.D.F.P.F. and/or WADA

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Prohibited Substance(s): **Generic name**	Dose	Route	Frequency
1.			
2.			
3.			
Intended duration of treatment: *(please tick appropriate box)*	Once only ☐ emergency ☐ Or duration (week/month):_____		

3. Medical practioner's and athlete'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: _____

Medical specialty: _____

Address: _____

Tel: _____ **Fax:** _____

E-mail: _____

Signature of Medical Practioner: _____ **Date:** _____

I, _____ certify that the information under 1 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 the Anti-Doping Organization (ADO) as well as to WADA staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO under the provisions of the *Code*. I understand that if I ever wish to revoke the right of these organizations to obtain my health information on my behalf, I must notify my medical practitioner and my ADO in writing of that fact.

Athlete's signature: _____ **Date:** _____

Parent's/Guardian's signature: _____ **Date:** _____
(If the athlete is a minor, 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)

Incomplete Applications will be returned and will need to be resubmitted.

Please submit the completed form to the ADO (Drug Control Officer of the BDFPA, see www.bdfpa.co.uk) **and keep a copy of the completed form for your records.**

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