**INTERNATIONAL HOCKEY FEDERATION (FIH)**

**Therapeutic Use Exemptions (TUE)**

**Please complete all sections *in capital letters or typing***

**Use *English* or provide a translation of information in another language**

***Incomplete and/or illegible applications* will be returned and must be resubmitted**

**1 Athlete information**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname: |  | Given names: |  |
| Female: | [ ]  | Male: | [ ]  | Date of birth:(dd/dm/yyyy) |  |
| Address: |  |
| City: |  | Country: |  | Postcode: |  |
| Tel: |  | E-mail: |  |
| (with international code) |  |  |
| Sport: | Hockey | Position: |  |
| National Sporting Organisation: |  |
| Please mark the appropriate box: |
| [ ]  | I am part of the FIH Registered Testing Pool | [ ]  | I am participating in an FIH event requiring a TUE pursuant to FIH regulations |
| [ ]  | I am part of a National Anti-Doping Organisation Testing Pool | Name of competition: |
| [ ]  | None of the above |  |  |
| If athlete with disability, indicate disability: |  |
|  |

**2 Medical information**

|  |
| --- |
| **Diagnosis with sufficient medical information (**see note 1 at the end of this form**)**:  |
| **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**

|  |  |  |  |
| --- | --- | --- | --- |
| **Prohibited substances(s)****Generic name** | **Dosage**Choose appropriate: | **Frequency**Choose appropriate: | **Route of administration**Choose appropriate: |
|  | ccinhalationiu mgmlsprayμg | as neededevery # day(s)every # hour(s)every # week(s)pre-exercise# time(s)# times / day# times / week# year(s) | arterialepiduralinhalationintra-articularintra-dermalintramuscularintra-thecalintravenousmesotherapy | oralpara-tendiniouspercutaneousperi-articularperi-tendiniousrectalsubcutaneoussublingualtopical |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| Intended duration of treatment:(tick appropriate box) | once only | [ ]  | emergency | [ ]  |
| or duration (week/month): |  |
|  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Have you submitted any previous TUE application: | yes | [ ]  | no | [ ]  |
| For which substance: |  |
| To which organisation: |  | When: |  |
| Decision: | approved | [ ]  | not approved | [ ]  |

**4 Medical practitioner’s declaration**

|  |
| --- |
| I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medications not on the Prohibited List would be unsatisfactory for this condition. |
| Name: |  |
| Medical specialty: |  |
| Address: |  |
| Tel: |  | Fax: |  |
| E-mail: |  |
| Signature of Medical Practitioner: |  | Date: |  |
|  |  |  |  |

**5 Athlete’s declaration**

|  |
| --- |
| 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 - FIH) as well as to WADA authorised staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorised staff that may have a right to this information under the provisions of the Code. I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping 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 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 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 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. |
| 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 forma parent or guardian shall sign together with or on behalf of the athlete) |

**6 Note**

|  |  |
| --- | --- |
| **Note 1** | Diagnosis *Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should 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.* |

|  |  |
| --- | --- |
| **Please submit the completed form via your****National Hockey Association****and keep a copy for your records** | International Hockey Federation (FIH)Rue du Valentin 61CH 1004 Lausanne, SwitzerlandTel: +41 21 641 0606 Fax: +41 21 641 0607Email: dora.varga@fih.ch Or info@fih.ch Web: [www.fih.ch](http://www.fih.ch) |

*TUE application form – December 2014*