

# Abbreviated Therapeutic Use Exemption Form

All applicable areas must be completed. Incomplete forms will be returned. Please print clearly.

Send completed forms to the CCES by: Fax: (613) 521-3134 Email: [tue-aut@cces.ca](mailto:tue-aut@cces.ca) Mail: 350-955 Green Valley Cr., Ottawa, ON, K2C 3V4

## 1. Athlete Information

Last Name:..... First Name:.....(check  )  Male  Female  
 Date of Birth (dd/mm/yy): ...../...../..... Sport: ..... Discipline/ Position:.....  
 Street Address :..... City:..... Province:..... Postal Code:.....  
 Tel: Home : (.....)..... Work/School : (.....)..... Mobile: (.....)..... E-mail:.....  
 If athlete with a disability, indicate disability: ..... National Sport Organization: .....

## 2. Medical Information

Diagnosis:.....  
 Medical examination/test performed:.....

Prohibited Substances Indicate <input checked="" type="checkbox"/> beside those that apply	Dose of Administration	Route of Administration	Frequency of Administration	Duration of this Medication Plan
<input type="checkbox"/> Formoterol (e.g. Oxeze Turbuhaler)		inhalation		
<input type="checkbox"/> Salbutamol (e.g. Ventolin Inhaler)		inhalation		
<input type="checkbox"/> Salmeterol (e.g. Serevent Inhaler)		inhalation		
<input type="checkbox"/> Terbutaline (e.g. Bricanyl Inhaler)		inhalation		
<input type="checkbox"/> Glucocorticosteroid please specify:				

Additional Information:.....

## 3. Physician's Information and Declaration

Name, qualifications and medical specialty:.....Fax: (..... ).....  
 Tel: Home:(.....)..... Work: (.....)..... Mobile: (.....)..... E-mail:.....  
 Address:..... City:..... Province:..... Postal Code:.....  
 I certify the above-mentioned substance/s for the above named athlete has been/are 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:** ...../...../.....

## 4. 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 CCES as well as to WADA staff and to the WADA Therapeutic Use Exemption Committee (TUEC) as well as to other Anti-Doping Organizations (ADO) under provisions of the World Anti-Doping Code. I understand that if I ever wish to revoke the right of the CCES 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/Guardian's signature:** ..... **Date:** ...../...../.....

(If the athlete is a minor, a parent or guardian shall also sign this form. If the athlete has a disability preventing him/her to sign this form, a parent or guardian shall sign together or on behalf of the athlete.)

Abbreviated Therapeutic Use Exemptions are valid under the domestic doping control program for the duration of the treatment as prescribed by the physician up to a maximum of one year. Annual renewal is the athlete's responsibility to maintain.