INTERNATIONAL CHEER UNION

Therapeutic Use Exemption – Application Form

-Application for the use of prohibited substances/methods on WADA’s List of Prohibited Substances-

THERAPEUTIC USE EXEMPTIONS / TUE

Please complete all sections in capital letters or typing, and submit completed TUE Application to TUE.request@cheerunion.org:

1. ATHLETE DETAILS

Surname: ________________________ Given Name(s): ______________________________

Date of Birth (DD/MM/YY)_______________________ Female □ Male □

Address:_________________________________________________________________

_______________________________________________________________________

City: _______________________________ Country:_____________________________

Postal Code:____________________ Phone/Cell#______________________________

E-mail: __________________________________________________________________

International or National Sport Organization: _________________________________
Therapeutic Use Exemption – Application Form

Please mark the appropriate box:

☐ I am part of an International Federation Registered Testing Pool

☐ I am part of a National Anti-Doping Organization Testing Pool

☐ I am participating in an International Federation event for which a TUE was granted

Competition Name: _____________________________________________________________

Competition Date (DD/MM/YY): _______________________________________________

☐ None of the above

If an athlete with disability, indicate disability: ____________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________
___________________________________________________________

2. MEDICAL INFORMATION

Diagnosis with sufficient medical information (see “Note 1” at end of document):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

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 INFORMATION** *(Please add additional documentation, if more space is required)*

<table>
<thead>
<tr>
<th>Prohibited substance(s): Generic name</th>
<th>Dose</th>
<th>Method</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Intended duration of treatment:

*Please check appropriate box*

<table>
<thead>
<tr>
<th>a. One time- for an emergency only:</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of dose (DD/MM/YY)___________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. More than one time:</th>
<th>□</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of dose:</td>
<td></td>
</tr>
<tr>
<td>Start date (DD/MM/YY)</td>
<td></td>
</tr>
<tr>
<td>End date* (DD/MM/YY)</td>
<td></td>
</tr>
</tbody>
</table>

*If applicable (if not applicable, mark “ongoing”)*

---

**Have you submitted any previous TUE application:**

Yes □ No □

If “Yes”, for which substance(s)?

____________________________________________________________________

If “Yes”, to whom (person/organization) was the previous TUE application submitted?:

________________________________________________________________________

If “Yes”, what date was it submitted (DD/MM/YY)?: ________________

If “Yes”, for what Sport?______________ If “Yes”, what competition?______________

**Decision of previous TUE application:**

Approved □ Not approved □
4. **MEDICAL PRACTITIONER’S DECLARATION**

I certify that the stated treatment is medically appropriate and that use of alternative medication not on the WADA prohibited list would be unsatisfactory for this condition.

Name of Medical Practitioner / Authorized Agent:

Surname: ____________________________ Given Name(s): ______________________________________

Medical Specialty: ____________________________________________________________

Address: ________________________________________________________________________

City: ____________________________ Country: _________________________________

Postal Code: _________________ Phone/Cell# _________________________________

E-mail: __________________________ Fax# ______________________________________________________________________

Signature of Medical Practitioner / Authorized Agent:

________________________________________________________________________

Date (DD/MM/YY): ______________________________________________________________________

5. **ATHLETE’S DECLARATION**

I hereby apply for Therapeutic Use Exemption for substances or methods from the WADA Prohibited List as identified in this application, and declare that the information in Section 1 is accurate. I authorize the release of personal medical information to authorized staff within my respective National or Regional Anti-Doping Organisation (NADO / RADO), WADA, and my international federation, including all of these organisations’ Therapeutic Use Committees under the provisions of the Code.

I understand that my information will only be used for evaluating my Therapeutic Use Exemption 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 information; (2) exercise my right of access and correction; or (3) revoke the right of these organisations to obtain my health information, I must notify my medical
practitioner and my National or Regional Anti-Doping Organisation (NADO/RADO) 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 form, a parent or guardian shall sign together with or on behalf of the athlete)

**Please note - Important: Incomplete Applications will be returned unprocessed and will need to be resubmitted completed for consideration. Please submit the completed form to your National Cheer Federation and the International Cheer Union (TUE.request@cheerunion.org) and keep a copy for your records**

5. NOTE:

Note 1

Diagnosis

Evidence confirming the diagnosis shall 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.