

## **THERAPEUTIC/INADVERTENT USAGE OF BANNED SUBSTANCES**

Participants subjected to drug testing who give an adverse analytical finding for the use of a banned substance or substances, and who have a medical certificate issued to them by a qualified medical practitioner may:

1. Refer the medical certificate to the appointed Anti-Doping Commission hearing.
2. Provide additional verifying facts and information that may support the particulars in the medical certificate and substantiate the use of such banned substance or substances by the participant for therapeutic and/or medical purposes only.

**The IWF Masters Anti Doping Sub Committee expect all participants selected for drug testing who are using therapeutic medicine to submit an IWF Masters TUE Form (see form attached) and a medical certificate from their doctor to the Doping Control Officer at the time of the test.**

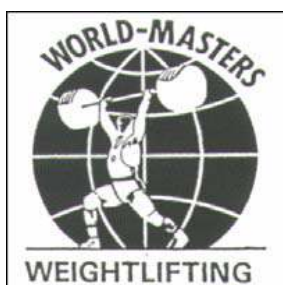
The IWF Masters Anti-Doping Sub Committee may at its discretion seek the advice and assistance of the appointed qualified medical practitioner to enable a decision to be reached in the hearing. Where therapeutic/inadvertent use of a banned substance or substances is proven, the IWF Masters Anti-Doping Commission may:

1. take no further action.
2. provide counseling and take no additional action, or
3. impose a suitable sanction.

**Note:** The refusal by a participant to provide a sample will make any medical certificate inadmissible.

## **EDUCATION:**

The IWF Masters will promote the education of Masters participants with regard to drugs in Sports. In particular, the IWF Masters will affirm that no one should cease taking prescribed medication to compete in any IWF Masters sanctioned event unless their personal physician recommends they cease the medication.



# IWF-Masters Anti-Doping Organization

## Therapeutic Use Exemptions

### TUE - 2013

#### Appendix 1

**Please complete all sections, both sides, in capital letters or typing**

#### **1. ATHLETE INFORMATION:**

Surname (Family Name): \_\_\_\_\_

Given Names: \_\_\_\_\_

Date of Birth (d/m/y): \_\_\_\_\_ Female ☐ Male ☐

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Province: \_\_\_\_\_ Country: \_\_\_\_\_

Postal-code: \_\_\_\_\_ Telephone: (country code) \_\_\_\_\_

E-mail: \_\_\_\_\_@\_\_\_\_\_

National Sport Organization: Name, Address, & e-mail: \_\_\_\_\_

#### **2. MEDICAL INFORMATION:**

Diagnosis with sufficient medical information (see Note: next section):

.....  
.....  
.....  
.....

If there are any "permitted medication/s" that are indicated, or being used, in the treatment of this type of medical condition, provide clinical justification for the requested use of the "prohibited" medication.

.....  
.....  
.....

#### **NOTE: 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.*

### 3. MEDICATION DETAILS: Generic Name -- mandatory

Prohibited substance(s)	Dose	Route	Frequency

<b>Intended duration of treatment:</b> (Please tick appropriate box)	Once only <input type="checkbox"/> Emergency <input type="checkbox"/> Ongoing Duration <input type="checkbox"/> <i>state length:</i> (week/s—month/s): ..... <i>start date:</i> .....
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<b>Have you previously submitted any TUE applications?:</b> yes <input type="checkbox"/> no <input type="checkbox"/>	
Which substance(s)?	
.....To whom?.....When?.....	Approved <input type="checkbox"/> Not approved <input type="checkbox"/>
.....To whom?.....When?.....	Approved <input type="checkbox"/> Not approved <input type="checkbox"/>

### 4. **MEDICAL PRACTITIONER'S DECLARATION:** (Please attach page from prescription pad)

I certify that the above-mentioned treatment is medically appropriate/necessary and that the use of alternative medication, that is not on the prohibited list, would be unsatisfactory for this condition.

**Name:** .....

**Medical Specialty:** ..... **Degree:** .....

**Address:** .....

**Tel.:** (country code) ..... **Fax:** .....

**E-mail:** .....

**Signature of Medical Practitioner:** ..... **Date:** .....

### 5. ATHLETE'S DECLARATION:

I, \_\_\_\_\_ certify that the information under section "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 IWF and its representative Anti-Doping Organization/s (ADO) as well as to WADA staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO's 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/s in writing of that fact.

**Athlete's signature:** ..... **Date:** .....

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

**Please submit the completed form to the applicable ADO and keep a copy for yo**