

Therapeutic Use Exemptions Abbreviated Process

(Beta-2 agonists by inhalation, glucocorticosteroids by non-systemic routes)

I apply for approval for the therapeutic use of a prohibited substance on the World Anti-Doping Agency (WADA) List of Prohibited Substances and Prohibited Methods that is subject to the Abbreviated Therapeutic Use Exemption Application Process.

Please complete all sections

1. Athlete Information

Last Name: First Name M.I.TM

Female Male (check appropriate box)

Address:

City: State : Zip code:

Date of Birth (month/day/year):

Tel. Work: (.....)..... Tel. Home : (.....)..... Mobile:(.....).....

E-mail: Fax: (.....).....

Sport:.....

National Governing Body: USA Powerlifting International Federation: International Powerlifting Federation.

If athlete with disability, indicate disability:

2. Notifying medical practitioner

Name, qualifications and medical specialty (e.g. J.S. Smith, M.D., FRACP, Gastro-Enterologist):

.....
.....

Address:

.....

E-mail address:

Tel. Work:(.....)..... Fax:(.....).....

3. Medical information

Diagnosis:.....

Medical examination(s)/test(s) performed:

.....

Prohibited Substance(s)	Dose	Route of Administration	Frequency

Anticipated Duration of this Medication Plan:

.....

Additional information:.....

.....

4. Medical practitioner and athlete's declaration

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 alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical condition. Specify reasons:

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Signature of Medical Practitioner:

Date:

I, certify that the information under 1, above, 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 USA Powerlifting, the International Powerlifting Federation, and WADA as necessary for the evaluation of my request for TUE, and for the purposes of informing these agencies of either the granting or refusal of my request for TUE. I understand that if I ever wish to revoke this consent, that I will be ineligible for exemption from disciplinary action that may result from use the prohibited substance or method. On receipt of such revocation, my TUE becomes null and void on the date received. I acknowledge that I may not compete if using a prohibited method or substance until such time as my requested TUE has been granted.

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

Parent/Guardian's signature:.....**Date:**.....
(If the athlete is a minor, or has a disability preventing him/her signing this form, a parent or guardian must sign on behalf of the athlete)

Please send you completed form to:

Mark Rodacker, M.D., Chair
USAPL TUE Committee
USA Powerlifting
PO Box 668
Columbia City, IN 46725
Telephone: (260) 248-4889
Fax: (260) 248-4879



For TUE Committee Use Only:

Date Application Received:.....

Therapeutic Use Exemption Granted: Yes No

Reason Declined:.....

TUE Representative Signature:.....Date:.....