



THERAPEUTIC USE EXEMPTION DECLARATION & APPLICATION FORM (TUEDA)

Please complete all sections in capital letters or typing. Illegible forms will be returned. NB - TUEDA FORMS AND ALL REPORTS AND ACCOMPANYING DOCUMENTS MUST BE COMPLETED IN ENGLISH.

PART A – PLAYER INFORMATION

A1. Personal Information

Surname:	Given Names:
.....	Date of Birth (d/m/y):
Address:	
City:	Country: Postcode:
Tel.: E-mail:	
<i>(with international code)</i>	
Member no:	
International or National Sport Organisation:	

A2. Relevant Medical Condition and Medication Details

Please tick relevant boxes below to indicate the types of medication you are declaring or applying for exemption. Use one form per medical condition.

<p>ASTHMA MEDICATIONS</p> <p>Beta₂agonists by inhalation Glucocorticosteroids by inhalation <input type="checkbox"/></p>	<p>Beta₂agonists & glucocorticosteroids by inhalation only (e.g. inhalers for asthma) N.B. Physician to complete Section B2 & B3. File of additional medical evidence required for Beta₂ Agonists. See part B4 Medical File.</p>
<p>GLUCOCORTICOSTEROIDS</p> <p>By intra muscular injection By local (ligament or tendon) injection By intra-articular (joint) injection By intravenous injection Oral (tablet) or rectal administration <input type="checkbox"/></p>	<p>Glucocorticosteroids (cortisone hydrocortisone)</p> <p>Glucocorticosteroids preparations administered by dermatological (skin cream), nasal (nose drops or sprays), eye (ointment or drops) routes do NOT require any TUE declaration or application. N.B. Physician to complete Section B2 & B3</p>
<p>OTHER MEDICATION(S) <input type="checkbox"/></p>	<p>All other medications containing prohibited substances. N.B. physician to complete Section B2 & B3</p>

A4. Player's declaration

I, certify that the information above is accurate and that I am requesting approval to use the medication for therapeutic purposes only. If required, I consent to the release of my personal medical information to the Independent Therapeutic Use Exemption Committee appointed by the Sunshine Tour. I understand that I have the right to revoke this authorization and to do so, I must notify the Chief Medical Officer in writing of that fact.

Player's signature:

Date:

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.

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

Please submit the completed form to the South African Institute for Drug-Free Sport for the attention of Pamela Isaacs:

Postal: PO Box 2553, Clareinch, 7740

Tel: 021 761 8034

Fax: 021 761 8148

E-mail: pamela@drugfreesport.org.za

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PART B: PRESCRIBING PHYSICIAN'S INFORMATION AND DECLARATION

B1. Introduction

To Dr

Patient's Name Date of Birth.....

In order to comply with the Sunshine Tour Anti-Doping policy I am required to declare medications and submit a request for approval for certain medications which contain prohibited substances. Please assist me by providing the following information.

I consent to the release of this information.

Signed..... Date

B2. Diagnosis

Diagnosis with sufficient medical information:

Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include a comprehensive medical history and results of all relevant examinations, laboratory investigations and imaging studies.

Copies of the original report 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.

If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication and confirmation as to why a permitted alternative is not appropriate:

Date treatment commenced.....

Once only Emergency or Duration.....

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B3. Physician's Declaration

I certify that the above mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition. I note that the Sunshine Tour Chief Medical Officer may contact me to review information further.

Name.....

Professional Registration Number.....

Medical Speciality.....

Address.....

.....

Tel..... Fax.....

E-mail.....

I have attached additional information: Yes No (note no of pages here____)

Signature of Medical Practitioner..... Date.....

B4. Medical File – For Asthmatics – Asthma Medical File for Beta₂Agonists

The following information must be recorded in a medical file, reviewed annually, and available on request

- A complete medical history
- A comprehensive report of the clinical examination with specific focus on the respiratory system
- A report of spirometry with the measure of the Forced Expiratory Volume in 1 second (FEV₁)
- If airway obstruction is present, the spirometry will be repeated after inhalation of a short acting Beta₂ agonist to demonstrate the reversibility of bronchoconstriction
- In the absence of reversible airway obstruction, a bronchial provocation test is required to establish the presence of airway hyper-responsiveness
- Exact name, speciality, address, contact details of the examining physician

Glucocorticosteroids

Supporting medical evidence required for the use of glucocorticosteroids by certain routes of administration

- By local (ligament or tendon) injection (complete this form)
- By intra-articular (joint) injection (complete this form)
- By intravenous injection (complete this form & additional medical evidence)
- Oral (tablet) or rectal administration (complete this form & additional medical evidence)
- By intra muscular injection (complete this form & additional medical evidence)