نموذج تسليم طلب استثناء للاستخدم العلاجي

لابد من استكمال جميع البيانات الخاصة بنموذج التسليم وكذلك طلب الاستثناء

اسم اللاعب:
اسم اللعبة:
اسم النادي :
اسم الاتحاد:
تاريخ الأرسال للجنة:
اسم المرسل :
رقم الهاتف :
رقم الفاكس :
البريد الألكتروني:

تاريخ استلام الطلب من قبل اللجنة السعودية للرقابة على المنشطات :
اسم المستلم :

تاريخ استلام الطلب من قبل للجنة الاستثناء للإستخدام العلاجي:
اسم المستلم :

حالة الطب : مكتمـل ☐ غير مكتمل ☐

تاريخ إعادة الطلب لإكمال النوقص:

تاريخ استلام الطلب بعد التعديل :

حالة الطب : مكتمـل ☐ غير مكتمل ☐

تاريخ إعادة الطلب لإكمال النوقص:

تاريخ تسليم الطلب للجنة السعودية للرقابة على المنشطات :
اسم المستلم

حالة الطب : موافقة ☐ رفض ☐

مقرر لجنة الاستثناء للاستخدام العلاجي

عمر بن محمد العمر

Saudi Arabian Anti Doping Commute

Therapeutic Use Exemptions

TUE

Please complete all sections in capital letters or typing

1. Athlete Information

Surname: .... **Given Names**: ....

(As in the passport)

Male ☐ **Female** ☐ **Date of Birth (d/m/y)** :...

National ID : ....

Address: ....

City: .... **Country:** .... **Postcode:** ....

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

(with international code)

Sport: .... **Discipline/Position:** ....

International or National Sport Organization: ....

If athlete with disability, indicate disability: ....

2. Medical Information

Diagnosis with sufficient medical (Clinical) Information:

....

....

....

....

....

Relevant Investigations: Lab ☐ **Radiology** ☐ **Other**...

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 details

Prohibited substance(s): *Generic name*	Dose	Route	Frequency	Date
1.				
2.				
3.				

Have you submitted any previous TUE application: Yes ☐ **No** ☐

For which Substance?

....

To Whom? .... When ? ....

Decision: Approved ☐ Not approved ☐

Intended duration of treatment: (*Please tick appropriate box*)	Once only ☐ Emergency ☐ Or duration (Week/month) : ....

4. Medical practitioner'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.

Name.. ....
Medical specialty: ....
Address: ....
Tel...
Fax: ....
E-mail: ....
Signature of Medical Practitioner: .... Date: ....

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.

Name…… ……………………………
Medical specialty: ……………………………………………………………………………………………… ……………………………………………
Address: …… ……………………………………
Tel…………………………………………………………………………………
Fax: ……………………………………………………………………………………
E-mail: ……………………………………………………………………………………
Signature of Medical Practitioner: …………………………………………………… Date: ……………………………………………

5. 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 Anti-Doping Organization (ADO) as well as to WADA staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO 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 in writing of that fact.

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)

6. Note

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 ADO and keep a copy for your records.