INTERNATIONAL GOLF FEDERATION

STRICTLY CONFIDENTIAL
Application No_____

APPLICATION FORM FOR THERAPEUTIC USE EXEMPTION

Please complete all sections **in English**, in CAPITAL LETTERS or typing.
Incomplete applications will be returned and will have to be resubmitted.

1. PLAYER INFORMATION

Family Name		**Given Name(s)**	
Date of Birth		**Gender**	**MALE** ☐ **FEMALE** ☐
Nationality			
Address			
City			
Zip/Postcode		**Country**	
Telephone No (with international code)		**Cell/ Mobile** (with international code)	
Email			
Reply to be sent by:	**Email** **SMS** **Tel**		
Golf Organization:			

Please mark appropriate box:

☐ I am part of the IGF Registered Testing Pool

☐ I am part of a National Anti-Doping Organization Testing Pool, without a TUE in place

☐ I am participating in an IGF event for which a TUE granted pursuant to IGF rules is required. (None of the above)

Name of the event: ……..

Date of the event: ……..

If you are a Player with an impairment, please indicate impairment……..
……...

Complete on-line, save and submit form as an email attachment to antidoping@igfmail.org
or print and submit by fax or post
You are advised to keep a copy of this application for your own records.

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2. RELEVANT MEDICAL CONDITION & MEDICATION DETAILS

Use one form per Medical Condition

MEDICAL CONDITION	
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:	

Prohibited substance(s)/method(s): GENERIC NAME	**DOSE**	**ROUTE OF ADMINISTRATION**	**FREQUENCY**
1.			
2.			
3.			

Have you submitted a previous TUE application for the medical condition above?			No ☐ Yes ☐
If Yes, for which substance or method?			
To Whom?		**When?**	
Decision:	Not Approved ☐ Approved* ☐ *if approved what duration does the approval have		dd/mm/yyyy **Date approval ends**

Intended duration of treatment	Once only ☐ or duration (days/weeks/months) Emergency treatment: No ☐ Yes ☐
Is this a retroactive application?	No ☐ Yes* ☐ If Yes, date of treatment started

In case of emergency treatment or treatment of an Acute Medical Condition or Exceptional Circumstances (for retroactive approval), please indicate all relevant information to explain the emergency and/or why a TUE application could not be submitted in advance.

Emergency treatment or treatment of an acute medical condition was necessary ☐
Due to other exceptional circumstances, insufficient time/opportunity to submit application ☐
Advance application not required under applicable rules ☐
Other ☐
Please explain……..
……

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3. PHYSICIAN'S INFORMATION & DECLARATION

Full Name		**Professional Registration No**	
Address			
Telephone		**Email**	
Fax		**Mobile/Cell**	
Qualifications			
Medical Speciality			
I certify that the above mentioned treatment is medically appropriate and that the use of alternative medication not on the WADA prohibited list would be unsatisfactory for the treatment of the medical condition (state condition) below			
I have attached additional information	Yes No (note no of pages here)		
Signature of Medical Practitioner:		**Date:** dd/mm/yyyy	

4. PLAYER'S DECLARATION

I, certify that the information above is accurate. I request approval to use the stated medication for therapeutic purposes only and consent to my physician releasing to the persons or organisations below, any health information they deem necessary in order to consider and determine my application.

I voluntarily authorise release of my personal medical information to the IGF and its TUE Committee, as well as WADA authorised staff/TUE Committee and to other Anti-Doping Organisations with a right to this information under the provisions of the WADA Code and/or International Standard for TUEs. I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my 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 the IGF 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 consent to the decision on this application being made available to ADOs, or other organisations, with Testing authority and/or results management authority over me. I understand and accept that the recipients of my information and of the decision on this application may be located outside the country where I reside. In some of these countries data protection and privacy laws may not be equivalent to those in my country of residence. 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. Nothing precludes my right to seek redress in a court of law where data privacy legislation has been breached.

I understand and agree that I should obtain medical advice from a qualified medical practitioner before starting or stopping any medication and/or treatment in relation to this application.

Player's signature: **Date:** dd/mm/yyyy

If applicant is under 18 years of age or has a disability preventing him signing this form, a parent or guardian shall sign together with or on behalf of the applicant:

Parent's/Guardian's Name: **Date:** dd/mm/yyyy

Signature:

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