INTERNATIONAL GOLF FEDERATION

STRICTLY CONFIDENTIAL
Application No_____

APPLICATION FORM FOR THERAPEUTIC USE EXEMPTION

Please complete all sections **in English**, in CAPITAL LETTERS or typing.
Player to complete sections 1, 5, 6 and 7; physician to complete sections 2,3 and 4.
Illegible or incomplete applications will be returned and will need to be resubmitted in legible and complete form.

1. PLAYER INFORMATION

Family Name		**Given Name(s)**	
Date of Birth (d/m/y)		**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**		
National or International 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.

2. MEDICAL INFORMATION

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 information should include: **a comprehensive medical history and 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. 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:	

3. MEDICATION DETAILS

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

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4. MEDICAL PRACTITIONER'S DECLARATION

Full Name		**Professional Registration No**	
Address			
Telephone		**Email**	
Fax		**Mobile/Cell**	
Qualifications			
Medical Speciality			
I certify that the information in sections 2 & 3 above is accurate and that the above-mentioned treatment is medically appropriate. I confirm 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	

5. RETROACTIVE APPLICATIONS

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

Please indicate reason;
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, there was insufficient time or opportunity to submit an application prior to sample collection

☐ Advance application not required under applicable rules

☐ Other

Please explain……
……

6. PREVIOUS APPLICATIONS

Have you submitted any previous TUE applications?			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**	

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7. PLAYER'S DECLARATION

I, _____, certify that the information set out at sections 1, 5 and 6 is accurate. I authorize the release of personal medical information to the International Golf Federation as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorized staff that may have a right to this information under the World Anti-Doping Code *("Code")* and/or the International Standard for Therapeutic Use Exemptions. These people are subject to a professional or contractual confidentiality obligation.

I consent to my physician(s) releasing to the above persons any health information that they deem necessary in order to consider and determine my application.

I understand that my information will only be used for evaluating my TUE request and in the context of potential anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my health information; (2) exercise any rights I may have, such as my right of access, rectification, restriction, opposition, or deletion; or (3) revoke the right of these organizations to obtain my health information, I must notify my medical practitioner and my ADO 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 purpose of investigations or proceedings related to a possible anti-doping rule violation, where this is required by the *Code*, *International Standards*, or national anti-doping laws; or to establish, exercise or defend a legal claim involving me, WADA, and/or an ADO.

I consent to the decision on this application being made available to all ADOs, or other organizations, 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 my information will be stored in ADAMS, which is hosted by WADA on servers based in Canada, and will be retained for the duration as indicated in the WADA International Standard for the Protection of Privacy and Personal Information (ISPPPI).

I understand that if I believe that my Personal Information is not used in conformity with this consent and the ISPPPI, I can file a complaint to WADA (privacy@wada-ama.org), or my national regulator responsible for data protection in my country.

I understand that the entities mentioned above may rely on and be subject to national anti-doping laws that override my consent or other applicable laws that may require information to be disclosed to local courts, law enforcement, or other public authorities. I can obtain more information on national anti-doping laws from my International Federation or National Anti-Doping Agency.

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

If applicant is a Minor or has an impairment preventing him/her signing this form, a parent or guardian shall sign or on behalf of the applicant.

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

Signature:

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