

Standard Application Form

Therapeutic Use Exemptions

International Archery Federation (FITA)

Please complete ALL sections in **CAPITAL LETTERS** or **typing**. Incomplete applications will be returned and will need to be resubmitted.

I apply for approval from the International Archery Federation (FITA) for the therapeutic use of a prohibited substance on the World Anti-Doping Agency (WADA) List of Prohibited Substances and Prohibited Methods.

1. Athlete Information

| | |
|--|---------------------------------|
| Family Name(s): _____ | First Name(s): _____ |
| Female <input type="checkbox"/> Male <input type="checkbox"/> (tick appropriate box) | |
| Date of Birth (dd/mm/yy): ____ / ____ / ____ | |
| Address: _____ | |
| City: _____ | Country: _____ Post Code: _____ |
| Please write ALL telephone and fax numbers including Country code and area code: | |
| Contact Tel: _____ | Mobile telephone: _____ |
| Email: _____ | Fax Number: _____ |
| Sport: _____ | Discipline/Position: _____ |
| International or National Sporting Organization: _____ | |
| If athlete with disability, indicate disability: _____ | |
| Reply to be sent to: (Please select one option by ticking the appropriate box) | |
| <input type="radio"/> Fax: _____ | Attention: _____ |
| <input type="radio"/> Email: _____ | |
| <input type="radio"/> Other: _____ | |

2. Notifying Medical Practitioner

| | |
|---|---------------------------------|
| Family Name(s): _____ | First Name(s): _____ |
| Qualifications (For example Dr.AB Cook, MD): _____ | |
| Medical Speciality: _____ | |
| (For example: Gastro-Enterologist): _____ | |
| Address: _____ | |
| City: _____ | Country: _____ Post Code: _____ |
| Please write ALL telephone and fax numbers including Country code and area code: | |
| Contact Tel: _____ | Mobile Telephone: _____ |
| Email: _____ | Fax: _____ |

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3. Medical Information: Diagnosis with sufficient medical information

Evidence confirming the diagnosis **must be attached and forwarded with this application.** In those cases where the evidence is not written in English or French, a summary in English or French language must be enclosed. The medical evidence should include a comprehensive, relevant medical history and summarise 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.

| | |
|--|--|
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| | |

4. Medication Details:

| Prohibited Substance(s) <i>Generic Name</i> | Dose of Administration | Route of Administration | Frequency | Treatment Starts (dd/mm/yy) | Treatment finishes (dd/mm/yy) |
|--|------------------------|-------------------------|-----------|--------------------------------|----------------------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Please tick appropriate box: once only emergency

In case of Emergency Treatment or Treatment of an Acute Medical Condition or Exceptional Circumstances, please indicate all relevant information to explain the emergency or the insufficient time to submit the TUE application.

| | |
|--|--|
| | |
| | |

If a permitted medication can be used to treat the medical condition, provide clinical justification for the requested use of the prohibited medication.

| | |
|--|--|
| | |
| | |

Have you submitted any previous TUE application? Yes* No

For which substance? (write generic name) _____

To whom was it submitted? _____

When was it submitted? _____

Decision: Approved Not Approved

* A copy must be attached and forwarded with this application

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6. Medical Practitioner's declaration

| | |
|---|---|
| I, _____ <div style="display: flex; justify-content: space-around; font-size: small;"> _____ _____ </div> <i>First name</i> <i>Family name</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. |
| (Please indicate medical condition) | |
| Signature of Medical Practitioner: _____ | Date: _____ |

7. Athlete's declaration

| | |
|--|---|
| I, _____ <div style="display: flex; justify-content: space-around; font-size: small;"> _____ _____ </div> <i>First name</i> <i>Family name</i> | certify that the information in Section 1 is accurate and that I am requesting approval to use the following Substance(s) or Method(s) from the WADA Prohibited List: |
| <input type="checkbox"/> I also confirm that I am an International Level Athlete, or intend to participate at FITA International Events, or have otherwise been authorised by my National Archery Federation, which is a FITA Member Association, to submit this application for the use of the substance(s) below: | |
| Please indicate the name of the substances (Generic Name) | |
| I authorize the release of personal medical information to the FITA as well as to WADA staff, to the WADA TUEC and to other Anti-Doping Organization (ADO) under the provisions of the WADA 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 the IWF in writing of that fact. | |
| I am aware that the FITA and International Doping Tests & Management ("IDTM"), will be processing and/or evaluating my proposed use of a substance or method prohibited by the current WADA International Standard in connection with this Therapeutic Use Exemption ("TUE") application. I understand that the FITA and IDTM are not providing medical advice to me in connection with this TUE application. I know that I must get medical advice from a qualified health professional before taking or stopping any medication or course of treatment for a condition that I may have. I also understand that no decision by the FITA and/or IDTM respecting my TUE application is in any way indicative whether I should or should not follow the medical advice which I have received or will receive respecting any condition that I may have. | |
| Having read this waiver and knowing these facts, and in consideration of your reviewing and acting upon my TUE, I, for myself and anyone entitled to act on my behalf, do hereby release and discharge the FITA and IDTM and all employees, designees, agents or representatives of any of them, including those persons who actually consider and process my TUE, from all claims or liabilities of any kind arising out of or connected in any way with this TUE application, even if such claims or liability may arise out of negligence or carelessness on the part of the persons or entities named in this waiver. | |
| Athlete'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. | |
| Parent's/Guardian's signature: _____ | Date: _____ |

Please submit the COMPLETED form and keep a copy for your records. The form shall be sent to:

International Doping Tests & Management, IDTM

Telephone: +46 8 555 109 00 Fax: + 46 8 555 109 27 Email: tuefita@idtm.se

Strictly Confidential