TUE Applicaton Form

THERAPEUTIC USE EXEMPTIONS
(TUE)

Please complete all sections in capital letters or typing

1. Athlete Information

Surname: _____ Given Names: _____

Female Male Date of Birth (d/m/y) _____

Address: _____

City: _____ Country: _____ Postcode: _____

Tel.: _____ E-mail: _____
(with international code)

Age: _____ CrossFit Games Division: _____

If athlete with disability, indicate disability: _____

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2. Medical information

Diagnosis with sufficient medical information (see note):

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
1.			
2.			
3.			

Intended duration of treatment: (Please tick appropriate box)	once only ☐ emergency ☐ or duration (week/month):

Have you submitted any previous TUE application? yes ☐ no ☐

For which substance?

To whom? When?

Decision: Approved ☐ Not approved ☐

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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.: _____ 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 or that is banned under CrossFit's drug testing policy. I authorize the release of personal medical information to CrossFit Inc. as well as Drug Free Sport authorized staff and to other authorized staff that may have a right to this information under the provisions of the CrossFit Games.

I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping 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 organizations to obtain my health information, I must notify my medical practitioner and CrossFit Inc. in writing of that fact.

Athlete signature: _____ **Date:** _____

Parent/Guardian 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

Diagnosis

Evidence confirming the diagnosis shall be attached and forwarded with 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 CrossFit Inc. and keep a copy for your records.