FEDERATION INTERNATIONALE DE VOLLEYBALL

M-8 THERAPEUTIC USE EXEMPTION FORM
Formulaire d'autorisation d'usage à des fins thérapeutiques

Before taking into consideration this demand, the FIVB requires the athlete's medical file.

I apply for approval from FIVB for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods, and according to the FIVB Medical Regulations that is subject to the Therapeutic Use Exemption application process.

Please complete all sections in capital letters or typing. Athlete to complete sections 1, 4, 5 and 7; physician to complete sections 2, 3 and 6. Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.

1. Athlete Information

First Name: _____ Last Name: _____

☐ Male ☐ Female Date of Birth (dd/mm/yy): _____

Address: _____

ZIP and City: _____ Country: _____

Tel. Home: _____ Mobile: _____

Tel. Work: _____ Fax: _____

E-mail: _____

National Federation: _____

Sport: ☐ Volleyball ☐ Beach Volleyball

Please tick the appropriate box

☐ I am part of the FIVB Registered Testing Pool for Beach Volleyball or Volleyball

☐ I am part of a National Anti-Doping Organization Testing Pool

☐ I am participating in a FIVB or continental Event for which a TUE granted pursuant to the FIVB Medical Regulations is required[1].

Name of FIVB or continental Event: _____

☐ None of the above.

If any disability, please indicate disability: _____

1 *International Events for which a certificate of Therapeutic Use from FIVB is required are defined as being those Events where the FIVB or its Confederations are "the ruling body for the Event or appoint the technical officials for the Event". FIVB Events are listed on the FIVB website: www.fivb.com*

2. Medical practitioner's information

First Name: _____ Last Name: _____

Medical specialty: _____

Address: _____

ZIP and City: _____ Country: _____

Tel. Work/Mobile: _____ Email: _____

Signature of Medical Practitioner: _____

3. Medical Information

Diagnosis with sufficient medical information[2]:

_____

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

_____

_____

_____

_____

Medical details:

Medication	Prohibited Substance(s) Generic name	Dose	Route of administration	Frequency	Duration of Treatment

Intended duration of treatment: ☐ Once only ☐ Emergency
(Please tick appropriate box)
☐ Or duration (week/month): _____

Additional information: _____

2 *Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence must 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.*

3 *WADA maintains a series of guidelines to assist physicians in the preparation of complete and thorough TUE applications. These TUE Physician Guidelines can be accessed by entering the search term "Medical Information" on the WADA website: https://www.wada-ama.org. The guidelines address the diagnosis and treatment of a number of medical conditions commonly affecting athletes, and requiring treatment with prohibited substances.*

4. Retroactive applications

Is this a retroactive application? ☐ **YES** ☐ **NO**

If yes, when started the treatment? _____

Please indicate reason:

☐ 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 :

_____

_____

_____

5. Previous applications

Have you submitted any previous TUE application(s)? ☐ YES ☐ NO

For which substance/method? _____

To whom? _____

When? _____

Decision: ☐ Approved ☐ Not approved

6. Medical practitioner's declaration

I,_____ certify the above-mentioned substance/s for the above named athlete is accurate and have been/are to be administered as the correct treatment for the above named medical condition. I further certify that the use of alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical conditions.

Specify reasons: _____

Signature and date of Medical Practitioner: _____

Medical Stamp:

7. Athlete's declaration

I,_____ certify that all the information 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 FIVB and other responsible Anti-Doping Organization (ADO) 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.

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 possible anti-doping 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 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 FIVB 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 understand and agree that my TUE related data will be made accessible through ADAMS to the authorized ADO, to WADA and to the Therapeutic Use Exemption Committee.

I consent to the decision on this application being made available to all ADO's 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 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 exclusively to WADA or CAS.

Athlete signature: _____ Date: _____

Parent's/Guardian's Signature: _____ Date: _____

(If the athlete is a minor or has disability preventing him/her to sign this form, a parent or guardian shall sign together or on behalf of the athlete).

All Applications must be submitted in English

Incomplete and/or illegible Applications will be returned and will need to be resubmitted