



FISA - International Rowing Federation
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Abbreviated Therapeutic Use Exemptions ATUE

Please complete all sections in capital letters (typing preferred)

Beta-2 agonists by inhalation <input type="checkbox"/> only: formoterol, salbutamol, salmeterol, terbutaline No other beta-agonist on this form	Glucocorticosteroids by <input type="checkbox"/> non-systemic routes *
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* This includes inhalation, nasal spray, eye and ear drops, peri- or intra-articular injection.
 * Dermatological glucocorticosteroids do not require any TUE

1. Athlete Information

Surname: Given Names:

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

Address:

City: Country : Postcode:

Tel. home: Tel. work: Mobile:
 (with international code)

Email: Fax:

Sport: Discipline/Position:

National federation:

2. Medical information

Diagnosis:

Medical information / Diagnostic tests performed: *Pulmonary function tests are valid for 4 years*

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N.B. Any ATUE may be reviewed at any time, by FISA and/or WADA

Prohibited substance(s): <i>Generic name</i>	Dose	Route	Frequency
1.			
2.			
3.			
Intended duration of treatment: (Please tick appropriate box)	once only <input type="checkbox"/> emergency <input type="checkbox"/> or duration (week/month):		

3. Medical practitioner's and athlete's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medications not on the Prohibited List would be unsatisfactory for this condition.

Name:

Medical Speciality:

Address:

Tel.: **Fax:**

E-mail:

Signature of Medical Practitioner: **Date:**

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. I authorize the release of personal medical information to the Anti-Doping Committee of FISA as well as to WADA staff and to the WADA TUEC (Therapeutic Use Exemption Committee) as well as any other anti-doping organization under the provisions of the 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 FISA in writing of that fact.

Athlete's signature: **Date:**

Parent's/Guardian'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)

Incomplete Applications will be returned and need to be resubmitted.

STRICTLY CONFIDENTIAL

Please submit the completed form to FISA and keep a copy for your records.