

## Application Form Therapeutic Use Exemptions (TUE) 2011 Champions League Twenty20 (CLT20)

Please complete ALL sections in **CAPITAL LETTERS** or **typing**. Incomplete applications will be returned. To complete this document electronically, please type where indicated, and do NOT insert additional lines. This document must be submitted in 3 pages.

I apply for approval from the Champions League Twenty20 (CLT20) for the therapeutic use of a prohibited substance on the WADA List of Prohibited Substances and Prohibited Methods.

### 1. PLAYER INFORMATION

Family Name(s): _____	First Name(s): _____
Female <input type="checkbox"/> Male <input type="checkbox"/> <i>(select appropriate box)</i>	Date of birth (dd/mm/yy): _____
Address: _____	
City: _____	
State and Country: _____	Post Code: _____
<i>Please write ALL telephone and fax numbers including Country Code and Area Code</i>	
Contact Tel: _____	Mobile/Cell: _____
Email: _____	Fax number: _____
If player with disability, indicate disability:  <i>Reply to be sent to: (Please select <b>one</b> option by selecting the appropriate box)</i>	
<input type="checkbox"/> Fax number: _____	Attention: _____
<input type="checkbox"/> E-mail address: _____	

### 2. NOTIFYING MEDICAL PRACTITIONER

Family Name(s): _____	First Name(s): _____
Qualifications (e.g. Dr. A.B. Cook, MD): _____	
Medical Speciality (e.g. gastroenterologist): _____	
Address: _____	
City: _____	
State and Country: _____	Post Code: _____
<i>Please write ALL telephone and fax numbers including Country Code and Area Code</i>	
Contact Tel: _____	Mobile/Cell: _____
E-mail: _____	Fax number: _____
<i>Reply to be sent to: (Please select <b>one</b> option by selecting the appropriate box)</i>	
<input type="checkbox"/> Fax number: _____	Attention: _____
<input type="checkbox"/> E-mail address: _____	

**3. MEDICATION 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, a summary in English should 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 where possible. Evidence should be as objective as possible in the clinical circumstances and, in the case of non-demonstrable conditions, independent supporting medical opinion is requested in support of this application.

Diagnosis: \_\_\_\_\_

Medical Examination(s)/Test(s) Performed: \_\_\_\_\_

N.B. Any TUE may be reviewed at any time by the Champions League Twenty20 (CLT20) and/or WADA.

**4. MEDICATION DETAILS**

Prohibited Substance(s)/Methods(s) Generic Name	Dosage, Strength & Frequency (including number of e.g. pills/puffs)	Route of administration	Treatment starts (dd/mm/yy)	Treatment finishes (dd/mm/yy)
<i>Example:</i> Prednisone	1x20 mg once daily	Oral	01/01/10	01/03/10

**Complete this section ONLY in the case of emergency treatment/exceptional circumstances\***

\* In case of Emergency Treatment or Treatment of an Acute Medical Condition or Exceptional Circumstances (for retroactive approval), please indicate all relevant information to explain the emergency and/or why the TUE application could not be submitted in advance of the treatment

If a non-Prohibited Substance(s) can be used to treat the specified medical condition, provide clinical justification for the requested prohibited substance(s)/medication(s) below:

Have you previously submitted a TUE Application:  Yes  No

For which substance (generic name)? \_\_\_\_\_

To which organisation was it submitted? \_\_\_\_\_

When was it submitted: \_\_\_\_\_

Decision:  Approved  Not Approved

**5. MEDICAL PRACTITIONER'S DECLARATION**

I, _____ (First name) _____ (Family name)
Certify that the above mentioned treatment is medically appropriate and that the use of alternative substances/medications not on the WADA Prohibited List would be unsatisfactory for this condition: <i>Please indicate the medical condition below:</i>
Medical Practitioner's Signature: _____ Date (dd/mm/yy): _____

**6. PLAYER'S DECLARATION**

I, _____ (First name) _____ (Family name)
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: <i>Please indicate the name of the substances (Generic Name):</i>
I authorise the release of personal medical information to the Champions League Twenty20 (CLT20) and/or IDTM as well as to WADA and CLT20 staff and committees and to other Anti-Doping Organisations (ADO) under the provisions of the WADA Code. I understand that if I wish to revoke the right of these organisations to obtain my health information, sent either by me or on my behalf, I must notify my medical practitioner, CLT20 and IDTM in writing.
I am aware that CLT20 and IDTM will be processing and/or evaluating my proposed use of a substance or method prohibited by the current WADA International Standard for Therapeutic Use Exemptions ("TUE") in connection with this application. I understand that CLT20 and IDTM are not providing medical advice to me in connection with this TUE Application. I understand and agree that I should get medical advice from a qualified health professional before taking or stopping any medication or course of treatment in relation to this TUE application. I also understand that no decision with respect to this TUE application is in any way indicative whether I should or should not follow the medical advice which I have received or will receive with respect to 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, and anyone entitled to act on my behalf, hereby release and discharge the CLT20 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.
Player's Signature: _____ Date (dd/mm/yy): _____
<i>If the player is a minor or has a disability preventing him/her from signing this form, a parent or guardian shall sign together with, or on behalf of, the player.</i>
Parent's/Guardian's Signature: _____ Date (dd/mm/yy): _____

**Please submit the COMPLETED form (keeping a copy for your records) to:**

**Dr Vece Paes, Champions League Twenty20, c/o 4<sup>th</sup> Floor, Cricket Centre, Wankhede Stadium, D Road, Churchgate, Mumbai – 400020, India. Fax: +91 22 22800354, with a scanned copy to be simultaneously sent to [vece.paes@bcci.tv](mailto:vece.paes@bcci.tv)**