

Therapeutic Use Exemptions (TUE) Application Form The Board of Control for Cricket in India (BCCI)

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 hereby apply for approval from the Board of Control for Cricket in India (BCCI) for the therapeutic use of a substance and/or method on the WADA Prohibited List.

SECTION 1 and 6 should be completed by the athlete

1. PLAYER INFORMATION

| | | | |
|--|---------------------------|--|---|
| Family Name(s): | | First Name(s): | |
| Female <input type="checkbox"/> Male <input type="checkbox"/> (select appropriate box) | Date of birth (dd/mm/yy): | | |
| Address: | | | |
| State and Country: | City & Post Code | | |
| If player with disability, indicate disability: | | | |
| Sport: | Discipline/Position | | |
| International or national Sports Organization | | | |
| <input type="checkbox"/> I am part of an International Federation Registered Testing Pool | | <input type="checkbox"/> I am part of a National Anti-Doping Organization Testing Pool | |
| <input type="checkbox"/> I am participating in an International Federation event for which a TUE granted pursuant to the International Federation's rules is required. Name of the competition | | | |
| <input type="checkbox"/> None of the above | | | |
| <i>Please include Country Code and Area Code, and select one option where the reply to be sent to</i> | | | |
| Contact Tel: | | Mobile/Cell: | |
| <input type="checkbox"/> E-mail address : | | <input type="checkbox"/> Fax number: | |
| <i>Application history</i> | | | |
| Have you previously submitted a TUE Application: | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| For which substance(s) | (generic name) | To which organisation? | |
| When was it submitted? | | Decision: | <input type="checkbox"/> Approved <input type="checkbox"/> Not Approved |

SECTION 3 to 5 should be completed by the medical practitioner

2. NOTIFYING MEDICAL PRACTITIONER

| | | | |
|--|--------------------|--------------------------------------|-------------------------|
| Family Name(s): | | First Name(s): | |
| Qualifications(MD): | Medical Speciality | | e.g. gastroenterologist |
| Address: | | | |
| State and Country: | City & Postcode: | | |
| <i>Please include Country Code and Area Code, and select one option where the reply to be sent to</i> | | | |
| Contact Tel: | | Mobile/Cell | |
| <input type="checkbox"/> E-mail: | | <input type="checkbox"/> Fax number: | |

3. MEDICATION INFORMATION: DIAGNOSIS WITH SUFFICIENT MEDICAL INFORMATION

Evidence confirming the diagnosis must be provided in support of this application. In those cases where this evidence is not written in English, a summary in English should be enclosed. The medical evidence should include a comprehensive 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 should be provided.

| | | | | |
|--|---------------------------------------|--------------------|--|--|
| Patient's Name: | | | | |
| Female <input type="checkbox"/> Male <input type="checkbox"/> (select appropriate box) | Date of birth (dd/mm/yy): | | | |
| Diagnosis: | | | | |
| Medical Examination(s)/Test(s) Performed: Please indicate the name of the tests and <u>attach a copy of the examination reports</u> when you submit TUE form if the athlete has any. | | | | |
| Physical examination | <input type="checkbox"/> Yes, specify | and attach a copy. | | |
| | <input type="checkbox"/> N/A | | | |
| Laboratory investigation | <input type="checkbox"/> Yes, specify | and attach a copy. | | |
| | <input type="checkbox"/> N/A | | | |
| Imaging studies | <input type="checkbox"/> Yes, specify | and attach a copy. | | |
| | <input type="checkbox"/> N/A | | | |
| Psychiatric/psychological report | <input type="checkbox"/> Yes, specify | and attach a copy. | | |
| | <input type="checkbox"/> N/A | | | |
| Others relevant medical examination | <input type="checkbox"/> Yes, specify | and attach a copy. | | |
| | <input type="checkbox"/> N/A | | | |
| N.B. All TUEs are subject to review at any time by the BCCI TUEC and/or WADA TUEC. | | | | |

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> Dexamethasone | 1 × 8 mg once only | Intravenous | 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:

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): |

5. 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> | | |
| | | |
| <p>I authorize the release of personal medical information to the Board of Control for Cricket in India (BCCI) 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 provisions of the Code.</p> <p>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 BCCI 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.</p> <p>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 to WADA or CAS.</p> | | |
| 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:
International Doping Tests & Management,
Email: tuebcci@idtm.se Fax: +46 8 555 10 995**