Therapeutic Use Exemption (TUE) Checklist and Application

Attention Deficit Disorder (ADD) and
Attention Deficit and Hyperactivity Disorder (ADHD)

CANADIAN CENTRE FOR ETHICS IN SPORT
CENTRE CANADIEN POUR L'ÉTHIQUE DANS LE SPORT
201-2723 chemin Lancaster Rd
Ottawa ON Canada K1B 0B1
Tel/Tél + 1 613 521 3340
+ 1 800 672 7775
Fax/Téléc + 1 613 521 3134
info@cces.ca www.cces.ca

Step 1: Read all about Therapeutic Use Exemptions (TUE)

- Before submitting your application, visit www.cces.ca/medical to review your requirements and the application process.
- To assist physicians in the preparation of complete and thorough TUE applications, WADA maintains a series of TUE application guidelines for a number of medical conditions commonly affecting athletes. These TUE Physician Guidelines can be accessed by entering the search term "Medical Information" on the WADA website: www.wada-ama.org.

Step 2: **Complete the TUE application form**

- The CCES will accept applications submitted on the CCES TUE application form or an IF TUE application form, provided all required information is included.
- All information on the form must be legible (typed or block letters preferred).
- All fields must be properly completed, and the form must be dated and signed by the athlete and the prescribing physician.
- Illegible and/or incomplete forms will be returned to the athlete unprocessed.

Step 3: **Put together a medical file**

The documents included in your medical file must confirm your diagnosis and prescription and include:

- A letter from the treating physician confirming that the athlete's medical condition was evaluated within the last year, including the date of the appointment (See Annex 1 for sample);
- A description of the condition prior to the use of the medication, including the age of onset and family history (pertaining to learning, organization and/or developmental problems);
- Clinical history including measures and the criteria used for the diagnosis of ADD/ADHD (psychoeducational and consultative reports) and interpretation of results. If there is more than one evaluation or evaluator, include all documentation. All diagnostic, psychoeducational, and consultative reports must be included with the application;
- Summary of school progress with and without medication including comments and observations on the use and non-use of the medication during non-academic times;
- The rationale for the prescription of medication including dosage and frequency, the response to the medication, and the need for medication at non-academic times. If alternative medications and/or therapies were used, evaluation of their efficacy should also be included.

Step 4: Submit your completed TUE application form and medical file

- Fax: 613-521-3134;
- Email: tue-aut@cces.ca; or
- Mail: Attn: Athlete Services, CCES, 201-2723 Lancaster Road, Ottawa, ON, K1B 0B1.

Please note:

- The CCES will confirm receipt of your TUE application by email within two business days. If you do not receive a confirmation of receipt within that time frame, please contact the CCES.
- The CCES will contact you once a decision has been rendered on the application, or if more information has been deemed necessary.
- A complete TUE application can take up to 21 days to review.
- Incomplete applications will be returned and will need to be resubmitted with further information.
- Keep a copy of your application form and medical file for your records.
- Medical costs incurred for the completion of the TUE application form or additional investigations, examinations, or imaging studies are the responsibility of the athlete.

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Send completed forms to the CCES by: Fax: (613) 521-3134; Email: tue-aut@cces.ca; or
Mail: Attn: Athlete Services, CCES, 201-2723 Lancaster Road, Ottawa, ON, K1B 0B1.
Please complete all sections clearly in block letters or type. Keep a copy for your records.

1. Athlete Information

Surname:		Given Name(s):	
Gender:	☐ Male ☐ Female	Date of Birth (dd/mm/yyyy):	dd / mm / yyyy
Preferred method of communication:		☐ Email ☐ Canada Post	
Email Address:			
Mailing Address:			
City:		Province/State:	
Country:		Postal Code:	
Telephone:			
Sport:		Discipline / Position:	
Are you in your international federation's registered testing pool?		☐ Yes ☐ No ☐ Unsure	
If you know you will be competing at an international event, enter the event name and date:			
If you are an athlete with an impairment, indicate the impairment:			

Have you submitted any previous TUE applications?	☐ Yes	☐ No
For which substance(s) or method(s)?		
To which organization?		
When was it submitted?		
Decision	☐ Approved	☐ Not approved

2. Medical Information **(To be completed by your physician)**

Diagnosis: **Attention Deficit and Hyperactivity Disorder (ADHD)** Check the appropriate box below.			
Specify presentation type:		**Please indicate if:**	
☐	Combined Presentation	☐	Symptoms have been present since childhood
☐	Predominately Inattentive Presentation	☐	Symptoms are a significant impairment if not treated
☐	Predominately Hyperactive-Impulsive Presentation		

Clinical Reports and Investigations:

The following documentation <u>must be included</u> in the TUE application:

☐ History and examination letter that summarizes the clinical history related to ADHD and the need for medication as it pertains to learning, organization and/or developmental problems,

** See Annex A: Physician letter template for reference*

☐ Copy of original evaluation report by an experienced clinician (eg.: family physician, paediatrician, psychiatrist, psychologist, neuropsychologist),

The following information must be included in the application:

☐ Family and personal history (pertaining to learning, organization and/or developmental problems),

☐ Age of symptoms onset,

☐ Description of symptoms and impacts of the condition prior to the use of the medication,

☐ List of measures and criteria used for the diagnosis of ADD/ADHD and interpretation of results. List the questionnaires used in the process of evaluation and include copies of psychoeducational and consultative reports, when available.

NB: Only questionnaires related to the treatment of ADHD recommended by the DSM 5 will be accepted by the CCES.

☐ Clinical effect of the medication on the symptoms and impacts of the condition as assessed in the last year:

- ✓ Explain the rationale for the prescription of medication, including dosage and frequency, the response to the medication, and the need for medication at non-academic times. If alternative medications and/or therapies were used, evaluation of their efficacy should be included.
- ✓ If the athlete is a student, provide a summary of school progress with and without medication including comments and observations on the use and non-use of the medication during non-academic times.

3. Medication Details **(To be completed by your physician)**

Prohibited Substance(s): Generic name	**Dose**	**Route of Administration**	**Frequency of Administration**	**Duration of Treatment**
Enter all that apply	e.g., 200 mg	e.g., inhalation, local injection	e.g., BID, QID	e.g., one-time use, emergency, one year
1.				
2.				
3.				

4. Physician's Declaration **(To be completed by your physician)**

I certify that the information in sections 2 and 3 above is accurate, and that the aforementioned treatment is medically appropriate.			
Surname:		Given Name(s):	
Medical Specialty:			
Address:			
City:		Province/State:	
Country:		Postal Code:	
Telephone:		Email Address:	
Signature:		Date (dd/mm/yyyy):	dd / mm / yyyy

5. Diagnosing physician **(if different from treating physician)**

Surname:		Given Name(s):	
Medical Specialty:			
Address:			
City:		Province/State:	
Country:		Postal Code:	
Telephone:		Email Address:	

6. Retroactive applications

Is this a retroactive application?	☐ Yes	☐ No
If yes, on what date was treatment started?	Date (dd/mm/yyyy):	dd / mm / yyyy

Please indicate the 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:

7. Consent to sharing information

I, _____ authorize the CCES to share my medical information associated with my Therapeutic Use Exemption application with my team's athletic and/or medical personnel or third party, specifically _____name_____. I understand that the CCES can contact this person(s) should more information be required or to provide an update on the status of this application.

Athlete's Signature:		Date (dd/mm/yyyy):	

8. Athlete's Declaration

I, _____, certify that the information set out in this form is accurate and I am requesting approval to use a substance or method from the World Anti-Doping Agency (WADA) Prohibited List. I authorize the release of personal health information to the Canadian Centre for Ethics in Sport (CCES) or to another Anti-Doping Agency (ADO) as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other CCES or ADO TUECs and authorized staff that may require access to this information under the World Anti-Doping Code ("*Code*") and/or the International Standard for Therapeutic Use Exemptions (ISTUE). I consent to my physician(s) releasing any personal information or personal health information that they deem necessary in order to consider and determine my application.

I consent to my physician(s) releasing any personal information or personal health information that they deem necessary to the CCES or ADOs to permit a TUEC to consider and determine my applications.

I consent to the use and disclosure of my personal information or personal health information by the CCES or other ADOs for the purposes described in this application or as otherwise required by this application. I consent to the CCES or other ADOs distributing my personal information or personal health information to third parties as required by the *Code*, ISTUE or for any other purpose arising from this application.

I understand and accept that the recipients of my personal health information and of the decision on this application may be located outside the province or 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 authorize CCES and/or other ADOs to use or distribute my personal health information to any province or country as required by the *Code*, ISTUE or for any other purpose arising from this application.

I understand that my information will only be used for evaluating my TUE request and in the context of potential anti-doping rule violation investigations and procedures. I understand that if I ever wish to (1) obtain more information about the use of my personal or personal 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, CCES and/or my ADO 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 consent to the decision on this application being made available to all ADOs, or other organizations, with testing authority and/or results management authority over me.

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 with WADA or CAS.

Check the box to authorize the release of personal health information:

☐ I authorize the release of my personal health information to members of the Health Care Team attending Major Games where I may participate, to my Team Physician, and to my national sport organization.

☐ I do not wish to have this information shared with anyone but the CCES, WADA, applicable TUECs and my international federation.

Athlete's Signature:		Date (dd/mm/yyyy):	dd / mm / yyyy

(If the athlete is a minor or has an impairment preventing him/her from signing this form, a parent or guardian is to sign together with, or on behalf of, the athlete.)

Surname:		Given Name(s):	
Parent/Guardian's signature:		Date (dd/mm/yyyy):	dd / mm / yyyy