



Therapeutic Use Exemption (TUE) Checklist and Application

Medical Marijuana

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/Télé + 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 your physician confirming that your medical condition was evaluated within the last year, including the date of the appointment (See Annex 1 for sample);
- A complete summary regarding your diagnosis and plan of management from the treating physician, with copies of any assessments performed by consultants or other professionals;
- Information regarding trials of non-prohibited alternative medications;
- Independent supporting medical opinion in the case of non-demonstrable conditions;
- Relevant correspondence between physicians regarding the diagnosis and prescription; and
- A copy of your Medical Document for the *Marihuana for Medical Purposes Regulations* as outlined by Health Canada, or other proof of permission to possess marijuana.

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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (dd/mm/yyyy):	dd / mm / yyyy
Preferred method of communication:		<input type="checkbox"/> Email <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 application(s)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For which substance(s) or method(s)?		
To which organization?		
When was it submitted?		
Decision:	<input type="checkbox"/> Approved	<input type="checkbox"/> Not approved

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

Diagnosis - please attach sufficient medical information (see Step 3 of checklist):

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

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 above-mentioned 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, on what date was treatment started?	Date (dd/mm/yyyy):	dd / mm / yyyy
Please indicate the reason : <input type="checkbox"/> Emergency treatment or treatment of an acute medical condition was necessary. <input type="checkbox"/> Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection. <input type="checkbox"/> Advance application not required under applicable rules. <input type="checkbox"/> 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 other 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. 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 to the above persons any personal information or personal health information that they deem necessary in order for my application to be considered and determined by the CCES or ADOs.

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 and 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
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(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