INTERNATIONAL GOLF FEDERATION

STRICTLY CONFIDENTIAL
Application No_____

APPLICATION FORM FOR THERAPEUTIC USE EXEMPTION

Please complete all sections **in English**, in CAPITAL LETTERS or typing.
Incomplete applications will be returned and will have to be resubmitted.

1, PLAYER INFORMATION

Family Name		**Given Name(s)**	
Date of Birth		**Gender**	**MALE** ☐ **FEMALE** ☐
Nationality			
Address			
City			
Zip/Postcode		**Country**	
Telephone No (with international code)		**Cell/ Mobile** (with international code)	
Email			
Reply to be sent by:	**Email** ☐ **SMS** ☒ **Tel** ☐		

2. RELEVANT MEDICAL CONDITION & MEDICATION DETAILS - Use one form per Medical Condition

MEDICAL CONDITION
DIAGNOSIS with sufficient medical information. **Evidence confirming the diagnosis** must be attached and forwarded with this application. The medical evidence should include: **a comprehensive medical history and results of all relevant examinations, laboratory investigations and imaging studies**. Copies of the original report or letters should be included when possible. Evidence should be as objective as possible in the clinical circumstances and, in the case of non-demonstrable conditions, independent supporting medical opinion will assist this application.
If a non prohibited medication can be used to treat the medical condition, provide **clinical justification** for the requested use of the prohibited medication and **confirmation** as to why a permitted alternative is not appropriate:
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 a TUE application could not be submitted in advance.

Have you submitted a previous TUE application for the medical condition above?			No ☐ Yes ☐
If Yes, for which substance(s)			
To Whom?		**When?**	
Decision:	Not Approved ☐ Approved* ☐		
*if approved what duration does the approval have		**Date approval ends**	

Contact Dr. Thomas Hospel at (614) 537-3000 or at thospel@yahoo.com with any questions.
Complete on-line, save and submit form as an email attachment to thospel@yahoo.com
You may also print and submit by fax to 614-467-2292 or via post to:
Thomas G. Hospel, M.D. 87 South High St. Dublin, OH 43017
You are advised to keep a copy of this application for your own records.

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FULL GENERIC NAME OF MEDICATION	DOSE & FREQUENCY	ROUTE OF ADMINISTRATION	TREATMENT DATES start/finish
1.			
2.			
3.			

3. PHYSICIAN'S INFORMATION & DECLARATION

Full Name		**Professional Registration No**	
Address			
Telephone		**Email**	
Fax		**Mobile/Cell**	
Qualifications			
Medical Speciality			
I certify that the above mentioned treatment is medically appropriate and that the use of alternative medication not on the IGF prohibited list would be unsatisfactory for the treatment of the medical condition (state condition) below			
I have attached additional information	Yes ☐ No ☐ (note no of pages here) ____		
Signature of Medical Practitioner:		**Date:**	

4. PLAYER'S DECLARATION

I,_____ , certify that the information above is accurate and that I request approval to use the medication(s) listed above for therapeutic purposes only. I authorise release of my personal medical information to the USGA, IGF and its TUE Committee, as well as WADA authorised staff/TUE Committee and to other Anti-Doping Organisations with a right to this information under the provisions of the WADA Code. I understand that my information will only be used for evaluating my TUE request and in the context of possible anti-doping rule 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 organisations to obtain my health information, I must notify my medical practitioner and the IGF 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 understand and agree that I should obtain medical advice from a qualified medical practitioner before starting or stopping any medication and/or treatment in relation to this application.

Player's signature: _____ Date

If applicant is under 18 years of age or has a disability preventing him signing this form, a parent or guardian shall sign together with or on behalf of the applicant:

Parent's/Guardian's Signature: _____ Date

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