Abbreviated Therapeutic Use Exemptions ATUE

Please complete all sections in capital letters or typing

beta-2 agonists by inhalation	glucocorticosteroids by
	non-systemic routes *

1. Athlete Information

Surname:	Given Names:
Female Male	Date of Birth (d/m/y):
Address:	
City:	Postcode:
Tel.:	E-mail :
(with international co	de)
Sport:	Discipline/Position:
International or Nat	ional Sporting Organization:
2. Medical info	ormation

N.B. Any ATUE may be reviewed at any time, by the ADO and/or WADA

^{*} All routes other than orally, rectally, intravenously and intramuscularly. Dermatological glucocorticosteroids do not require any TUE

Prohibited substance(s): <u>Generic name</u>	Dose	Route	Frequency
1.			
2.			
3.			
Intended duration of treatment: (Please tick appropriate box)	once only or duration (week/month	emergency):	

3. Medical practitioner's and athlete's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative
medications not on the Prohibited List would be unsatisfactory for this condition.
Name:
Medical Speciality:
Address:
Tel.: Fax:
E-mail:
Signature of Medical Practitioner: Date:
I,
Athlete's signature: Date:
Parent's/Guardian's signature:

Incomplete Applications will be returned and need to be resubmitted.

Please submit completed form to the South African Institute for Drug-Free Sport

Fax 021 683 7274 / email $\frac{drugfree@iafrica.com}{drugfree@iafrica.com}$ / PO Box 2553 Clareinch 7740 / Tel 021 683 7129 and keep a copy for your records.