



**365 STRONG World Powerlifting Federation (365-SWPF)**  
Powerlifting Exemption Application Form

## Therapeutic Use Exemptions

Please complete all sections in capital letters or typing

### 1. Athlete Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Gender: Female \_\_\_\_\_ Male \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State/Prov: \_\_\_\_\_

Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_

International Tel Code: \_\_\_\_\_ Phone #: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

International or National Sport Organization: \_\_\_\_\_

If athlete with disability, indicate disability: \_\_\_\_\_

### 2. Medical Information

**Diagnosis with sufficient medical information** (see note 1):

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

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### 3. Medication Details

Prohibited Substance(s): <u>Generic name</u>	Dose	Route	Frequency
1.			
2.			
3.			

<b>Intended Duration of this treatment</b> (please tick appropriate box)	one time use only    emergency or duration (week/month): _____
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<b>Have you submitted any previous TUE application:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For what substance(s)? _____		
To whom: _____ When? _____		
Decision:	<input type="checkbox"/> Approved	<input type="checkbox"/> Not approved

### 4. Medical Examiner's Declaration

<b>I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medication not on the prohibited list would be unsatisfactory for this condition.</b>	
Name: _____	
Medical specialty: _____	
Address: _____	
Tel: _____	Fax: _____
E-mail Address: _____	
Signature of Medical Examiner: _____	Date: _____



## 5. Athlete's Declaration

I, \_\_\_\_\_ certify that all above information is accurate and that I am requesting approval to use a Substance or Method from the 365-SWPF Prohibited List (mentioned in the Federation Rulebook). I authorize the release of personal medical information to the Anti-Doping Organization (ADO) as well as to 365-SWPF staff, to the 365-SWPF Therapeutic Use Exemption Committee and to other ADO under the provisions of the Code. I understand that if I ever wish to revoke the right of these organizations to obtain my health information on my behalf, I must notify my medical practitioner and my ADO in writing of that fact.

**Athlete's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent's/Guardian's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(If the athlete is a minor, or has a disability preventing him/her to sign this form, a parent or guardian shall sign together with or on behalf of the athlete)

## 6. Note:

Note 1	Diagnosis
	<p><i>Evidence confirming the diagnosis must be attached and forwarded with this application. The medical evidence should include a comprehensive medical history and the results of all relevant examinations, laboratory investigations and imaging studies. Copies of the original reports 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.</i></p>

**Incomplete Applications will be returned and will need to be resubmitted.**

**Please submit the completed form to the ADO** (Chairman of the 365 Strong World Powerlifting Federation Medical Committee) **and keep a copy of the completed form for your records.**