STRICTLY CONFIDENTIAL

#DrivingGolfFurther

THERAPEUTIC USE EXEMPTION APPLICATION FORM

For Attention Deficit Hyperactivity Disorder (ADHD)

Guidance for completion of this form on page 4. Complete all sections **in English**, (capital letters or typing).
Prescribing Physician information required to complete sections 2, 3, 4, 5
This form may be completed online, saved as a document & emailed as an attachment, marked as confidential.

USE ONE FORM PER MEDICAL CONDITION.

1. PLAYER PERSONAL INFORMATION

Family Name		**First Name(s)**	
Date of Birth	**dd/mm/yy**	**Unique ID/ Membership No**	
Nationality			
Address			
City			
Country		**Zip/ Postcode**	
Tel (with international code)		**Cell/ Mobile** (with international code)	
Email			
Preferred method of communication:		**Email** ☐ **SMS** ☐ **Tel** ☐	

2. RELEVANT MEDICAL CONDITION & MEDICATION DETAILS

Please tick relevant boxes below to indicate the types of medication you are declaring or applying for exemption

RELEVANT MEDICAL CONDITION	**ADHD** ☐

Full name of Medication (include generic names & ingredients)	Dose / units of administration	Route of Administration	Frequency/Duration of Treatment
1.			
2.			
3.			

Intended Duration of Treatment
Date treatment commenced: dd/mm/yy
Once Only ☐ **Emergency** ☐ **or Duration (Day/ Week/ Month)**

Status of medications may be checked through drug information websites listed in ET Anti-Doping Information Handbook (N.B. Full list at all times)
or by calling Michele Verroken ET Anti-Doping Administrator on +44 (0) 7785 326 569 or by email mverroken@consultant.etghq.com or michele@sportingintegrity.com or Dr Andrew Murray +44 7791303980, or by email amurray@etghq.com

Complete online, save and send as an attachment, or print and fax.
Submit the completed form by email to antidoping@europeantourgroup.com
Incomplete applications will be returned and should be resubmitted. Keep a copy of this application for your own records

3 DIAGNOSIS

Diagnosis with sufficient medical information: *see page 4 for details of medical evidence required*
Evidence *confirming the diagnosis* must be attached and forwarded with this application.
If a permitted medication can be used to treat the medical condition, provide **clinical justification** for the requested use of the prohibited medication and rationale, with any supporting evidence as to why a permitted alternative is not appropriate:
Indicate the informants used during the diagnosis of ADHD: **Past informant:** Parent ☐ Partner ☐ Other ☐ Please state: **Present informant:** Parent ☐ Partner ☐ Other ☐ Please state:

4. PHYSICIAN'S DECLARATION

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.
I note that the European Tour may contact me to review information further.

Name		**Professional Registration No**	
Medical Speciality			
Address			
Telephone		**Fax**	
Email			
I have attached additional information	Yes ☐ No ☐ (note no of pages here)		
Signature of Medical Practitioner:		**Date:**	dd/mm/yy

5. RETROACTIVE APPLICATION

Is this a retroactive application?	No ☐ Yes ☐	**If Yes, date treatment started**	dd/mm/yy
Duration of treatment			

Please indicate reason for retroactive application:

☐ Emergency treatment or treatment of an acute medical condition was necessary
☐ Advance application not required under applicable rules (e.g. EMERGENCY use, temporary member registration).
☐ Due to other exceptional circumstances, insufficient time or opportunity to submit application prior to sample collection (explain)….

6. CONFIRMATION OF PREVIOUS APPLICATION FOR TUE/APPROVED TUE IN PLACE

Have you submitted a previous TUE application for the medical condition above?	**No** ☐ **Yes** ☐
If Yes, for which substance(s)	

Complete online, save and send as an attachment, or print and fax.
Submit the completed form by email to antidoping@europeantourgroup.com
Incomplete applications will be returned and should be resubmitted. Keep a copy of this application for your own records

To Whom?		When?		Decision:	☐ Not Approved	☐ Approved*

*if approved what duration does the approval have **Date approval ends** dd/mm/yy

Attach copy of TUE Certificate of Approval for same Prohibited Substance.

7. PLAYER'S DECLARATION and DATA PRIVACY CONSENT

I, , certify that the information set out above is accurate.
I request approval to use the medication for therapeutic purposes only. I authorise release of my personal medical information to the independent Therapeutic Use Exemption Committee and authorised officials (who are subject to professional or contractual confidentiality obligations), appointed by the European Tour.

I consent to my physician(s) releasing to the above person(s) any relevant health information deemed necessary to consider and determine my application.

I understand and agree that my TUE data (or part of it) will only be:
• used to evaluate my TUE request and in the context of potential anti-doping rule violation investigations and procedures;

• collected by the European Tour Anti-Doping and core Medical Team who shall be principally responsible for ensuring the protection of this data. The Anti-Doping and core Medical Team shall store, process and manage my data, including its disclosure to authorised recipients in accordance with current data protection legislation;

• shared with other independent medical and/or scientific experts (including the appointed TUE Committee, World Sports Med who administer TUE information processing) and all necessary staff involved in the management, review or appeal of TUE decisions if applicable, in accordance with current data protection legislation and where relevant in redacted, protected format;

I understand and accept that recipients of my information and of the decision on this application may be located outside the country where I reside. In some countries data protection and privacy laws may not be equivalent to those of my country of residence.

Information will be stored securely and retained for the duration of international anti-doping standards. If I believe my information is not used in conformity with my consent, I can file a complaint with my national data protection regulator. I may have certain rights under applicable laws in relation to my TUE data, including rights to access and/or correct in accurate data.

I understand if I ever wish to obtain more information about the use of my health information, to access, rectify, restrict, oppose, delete or revoke this authorisation, I must notify the European Tour Anti-Doping Adviser (michele@sportingintegrity.com) and my medical practitioner, in writing of that fact. I understand that information submitted prior to consent revocation may be retained for the purpose of investigations or procedures under the Anti-Doping policy.

By signing this form, I expressly consent to the use of my TUE data as set out above.

Player's Signature **Date** dd/mm/yy

Parent's/Guardian's Name **Signature** ..... **Date** dd/mm/yy

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

GUIDELINES FOR THE COMPLETION OF THE ADHD TUE FORM

Please complete all sections in English, in capital letters or typing. Please note that information submitted in other languages may take longer to process due to the need for accurate translation**. You may complete this form online, save the document and send by email as an attachment with password protection. Original signatures may be requested later.**
Failure to submit personal information with sufficient safeguards on data transfer shall be at the Player's own risk.

In addition to the TUE/ADHD Application Form, supporting medical evidence confirming the diagnosis of ADHD in accordance with DSM-5 criteria MUST be submitted. Where an application is incomplete or ambiguous, European Tour may request the player seeks a second opinion from an experienced psychiatrist recognised by the Tour Chief Medical Officer. The following checklist indicates required evidence:

1. **Psychiatric Assessment Report from a paediatrician, psychiatrist, or other physician who specialises in assessment and treatment of ADHD. The report MUST contain:** ☐

- *Indication of number of years of experience supporting specialist has in assessing and treating ADHD; typical annual ADHD case load.*
- *Summary of the diagnostic schedule and rating scale findings*
- *A thorough clinical history that includes age when symptoms first presented and any family related history*
- *An outline of the areas where impairment is due to ADHD and not related to other co-occurring mental health or physical disorders*
- *A description of the current presentation and treatment plan*
- *Details of any behavioural modifying techniques trialled, and drug holidays considered and trialled.*

2. **Diagnostic Schedule:**
   a copy of the diagnostic schedule conducted to support the diagnosis (DIVA 2.0, CAADID or ACE+) ☐

3. **Rating Scales: a copy of the rating scale performed to assess severity of the disorder (ADHD-RS, AISRS, ASRS, Barkley or CAARS)** ☐

FIRST TIME APPLICATIONS

First time applications must include all the above, where the condition is not newly diagnosed, a copy of the most recent specialist review letter must be enclosed to demonstrate that clinical monitoring and evaluation is in place.

RENEWAL APPLICATIONS

Renewal applications: a new **TUE/ADHD form** should be completed and submitted to support the renewal request. In addition, a **Psychiatric Annual Review Letter** from a paediatrician, psychiatrist, or other physician who specialises in the treatment of ADHD. The review letter MUST include:

- Assessment findings from the clinical review meeting including a summary of current symptoms
- Up to date rating scale results as evidence that ongoing monitoring of symptom severity is occurring
- Description of the treatment effect over the last 12 months, including a report of benefits attributed to the medication and any side effects reported or observed. If there have been periods without medication, a statement should also be provided as to the symptoms experienced during those periods
- Treatment plan for the next 12 months
-

Rating Scales: a copy of the rating scale performed at the annual clinic review meeting. For consistency, the same rating scale used in the previous year should continue to be used. Only DSM-based rating scales such as ADHD-RS, AISRS, ASRS, Barkley or CAARS

Previous applications made prior to the release of this policy shall require all evidence outlined as if it is a first-time application.

For assistance with completion of this form, please contact

Michele Verroken (ET Anti-Doping Administrator) +44(0)7785 326569:
or by e-mail: mverroken@consultant.etghq.com or michele@sportingintegrity.com
or Dr Andrew Murray ET Chief Medical Officer +44 7791303980 or by email: amurray@etghq.com

Physician Guidelines