

Številka primera: _____ / _____
Izpolni Odbor za podeljevanje TI (OTI)
To be filled in by TUE Committee



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OBRAZEC ZA VLOŽITEV PROŠNJE ZA PODELITEV TERAPEVTSKE IZJEME (TI) THERAPEUTIC USE EXEMPTION (TUE) APPLICATION FORM

Navodilo: Prosimo, da izpolnite vse oddelke z velikimi tiskanimi črkami ali tipkano. Športnik izpolni oddelke 1, 5, 6 in 7; zdravnik izpolni oddelke 2, 3 in 4. Nečitljive ali nepopolne vloge se zavrnejo in jih je potrebno ponovno vložiti v čitljivi in popolni obliki.
Please complete all sections in capital letters or typing. Athlete to complete sections 1, 5, 6 and 7; physician to complete sections 2, 3 and 4. Illegible or incomplete applications will be returned and will need to be re-submitted in legible and complete form.

1. Osebni podatki / Athlete Information

Priimek: _____

Last name

Ženski/Female

Moški/Male

Ime: _____

First name

Naslov (ulica): _____

Mailing Address

Mesto: _____ **Poštna št.:** _ _ _ _ **Država:** _____

City

Zip Code

Country

Rojstni datum (dd/mm/llll) / Date of birth (dd/mm/yy): ___ / ___ / ___

T-služba / T-work: _____

T-doma / T-home: _____

E-mail: _____

Fax: _____

Šport / Sport: _____

Disciplina / Discipline: _____

Nacionalna zveza: _____

National Sport Federation

Če ste športnik s posebnimi potrebami, prosim navedite potrebo (invalidnost –stopnja):

If athlete with disability, indicate disability

Ali ste vključeni v skupino za testiranje (obkrožiti)/Are you a member of a Registered Testing Pool

Da, sem vključen v Nacionalno skupino za testiranje / National Registered Testing Pool (NRTP)

Da, sem vključen v skupino za testiranje pri MZ / International Federation Registered Testing Pool (IF RTP)

Nisem v nobeni skupini za testiranje/ I'm not in any Registered Testing Pool

2. Podatki o zdravniku (specialistu) / Medical Practitioner Information

Priimek: _____

Family name

Ime: _____

First name

Specializacija zdravnika: _____

Medical Speciality

Naziv in naslov delovne organizacije: _____

Name and Address of working organization

Mesto: _____

City

Poštna št.: _ _ _ _

Zip Code

Država: _____

Country

Tel. služba/T-work: _____

E-mail: _____

3. Zdravstveni podatki (nadaljujte na dodatnem listu, če je potrebno) / Medical Information (continue on separate sheet if necessary)

Diagnoza (tiskano)/Diagnosis (printed):

Če je na voljo zdravilo za zdravljenje vaše zdravstvene težave, prosimo, da klinično utemeljite, zakaj zaprošate za uporabo prepovedanega zdravila. (If permitted medication can be used to treat the medical condition, please provide clinical justification for the requested use of the prohibited medication.)

Pregled in testiranja/Medical examination and test(s) performed:

3.a. Podrobnosti o zdravilih / Medication details

Ime zdravila z liste/Prohibited substance(s)	Doza/Doze of administration	Vrsta aplikacije/Route of application	Število aplikacij/Frequency of application
1			
2			
3			

Predvideno trajanje zdravljenja /Anticipated duration of treatment	Nujno /Emergency	Enkratno /One-Time only	Dolgotrajno /Long term
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4. Izjava zdravnika / Medical practitioner's

Podpisani _____

izjavljam, da so podatki navedeni v oddelkih 2 in 3, točni, ter da je zgoraj navedeno zdravljenje medicinsko utemeljeno. Nadalje izjavljam, da bi bila uporaba alternativnega zdravila, ki ni na Listi prepovedanih snovi in postopkov, za opisano medicinsko stanje neustrezno. **Obrazložite razlog!** I,____, certify the above-mentioned substance/s for the above named athlete has been/are to be administrated as the correct treatment for the above named medical condition. I further certify that the use of alternative medications not on the Prohibited List would be unsatisfactory for the treatment of the above named medical condition, Specify reasons!

Podpis zdravnika: _____

Datum/Date: _ / _ / ____

Signature of Medical Practitioner

5. Prošnja za veljavnost za nazaj/ Retroactive applications

<p>Ali gre za vlogo z veljavnostjo za nazaj? Is this a retroactive application?</p> <p>DA/yes NE/no</p> <p>Če da, kdaj (na kateri datum) se je začelo zdravljenje? If yes, on what date was treatment started?</p> <p>Datum/Date: _ / _ / ____</p>	<p>Prosimo, navedite razlog:</p> <p>Potrebno je bilo nujno zdravljenje ali zdravljenje akutne zdravstvene težave. <i>Emergency treatment or treatment of an acute medical condition was necessary.</i></p> <p>Zaradi drugih izjemnih okoliščin ni bilo časa ali priložnosti za vložitev prošnje za dodelitev TI pred odvzemom vzorca. <i>Due to other exceptional circumstances, there was insufficient time or opportunity to submit an application prior to sample collection.</i></p> <p>Predhodna vložitev po veljavnih pravilih ni bila potrebna. <i>Advance application not required under applicable rules.</i></p> <p>Drugo/Other <i>Prosimo pojasnite/Please explain:</i> _____ _____</p>
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6. Predhodne vloge / Previous applications

Ali ste že kdaj prej vložili prošnjo(-e) za podelitev TI?		Da/yes	Ne/no
<i>Have you submitted any previous TUE application(s)?</i>			
Za katero snov ali postopek? /For which substance or method?			
Komu? /To whom? _____		Kdaj? /When? _ / _ / ____	
Odločitev /Decision:	Odobreno/Approved	Neodobreno/Not approved	

7. Izjava športnika/ Athlete's declaration

Podpisani _____

izjavljam, da so vsi podatki, navedeni v oddelkih 1, 5 in 6 točni in da prosim za izjemo pri uporabi v terapevtske namene za snovi oziroma postopke z WADA Liste prepovedanih snovi in postopkov. Soglašam, da je moja osebna medicinska dokumentacija posredovana Slovenski antidoping organizaciji vključno z njenim Odborom za podeljevanje terapevtskih izjem (OTI), kot tudi osebnemu WADA, WADA odboru za podeljevanje TI (TUEC) in pristojnim mednarodnim športnim zvezam ter njihovim TUEC po pravilih Svetovnega protidopinškega kodeksa (Kodeks) in Mednarodnih standardov.

Soglašam, da moj zdravnik, navedenim osebam razkrije moje zdravstvene podatke, za katere oceni, da so potrebni za preučitev moje vloge in odločitev v zvezi z njo.

Razumem, da bodo moji podatki uporabljeni samo za ocenjevanje moje prošnje za podelitev TI ter v okviru preiskav in postopkov v zvezi s potencialnimi kršitvami protidopinških pravil. Razumem, da moram, če želim (1) pridobiti več informacij o uporabi svojih zdravstvenih podatkov; (2) uporabiti svojo pravico do dostopa in popravljanja ali (3) umakniti soglasje, da te organizacije pridobivajo moje zdravstvene podatke, o tem pisno obvestiti svojega zdravnika in svojo protidopinško organizacijo. Razumem in se strinjam, da bo morda treba podatke v zvezi s TI, ki sem jih predložil pred umikom soglasja, zadržati za izključni namen dokazovanja morebitne kršitve protidopinških pravil, če to zahteva Kodeks.

Strinjam se, da je odločba v zvezi s to vlogo na voljo vsem protidopinškim organizacijam ali drugim organizacijam s pristojnostjo, da me testirane in/ali upravljajo moje rezultate.

Razumem in sprejemam, da so lahko prejemniki mojih podatkov in odločbe v zvezi s to vlogo izven države, kjer prebivam. V nekaterih izmed teh držav zakoni o varstvu podatkov in zasebnosti niso enakovredni tistim v državi, kjer prebivam.

Razumem, da lahko, če bom menil, da se moji osebni podatki ne uporabljajo v skladu s tem soglasjem in Mednarodnimi standardi za zaščito zasebnosti in osebnih podatkov, vložim pritožbo pri WADA ali CAS.

I, ____, certify that the information set out at sections 1, 5 and 6 is accurate. I authorize the release of personal medical information to the Anti-Doping Organization (ADO) as well as to WADA authorized staff, to the WADA TUEC (Therapeutic Use Exemption Committee) and to other ADO TUECs and authorized staff that may have a right 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 to the above persons any health information that they deem necessary in order to consider and determine my 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 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 and accept that the recipients of my information and of the decision on this application may be located outside the 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 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 to WADA or CAS.

Podpis športnika/ Athlete's Signature: _____ **Datum/Date:** __ / __ / ____

Podpis športnikovih staršev oziroma skrbnikov, če je oseba mladoletna, oziroma ima telesne okvare, ki mu onemogočajo podpis: Parent's / Guardian's signature – if the athlete is a minor or has a disability preventing him/her to sign the form, a parent or guardian shall sign together or on behalf of the athlete

Podpis starša oz. skrbnika/ Parent's/Guardian's Signature: _____

Datum/Date: __ / __ / ____

Opomba/Note:

Opomba 1/Note 1	Diagnoza/Diagnosis <i>Dokaz, ki potrjuje diagnozo mora biti priložen tej vlogi. Medicinski dokazi morajo vključevati podatke o zgodovini bolezni, rezultate vseh relevantnih diagnostičnih pregledov, laboratorijskih in slikovnih rezultatov. Če je le mogoče naj bodo v vlogi kopije originalnih dokumentov. Če gre za nedokazljive okoliščin, bo tej vlogi v pomoč neodvisno zdravniško mnenje, ki jo podpira.</i> <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>
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Nepopolne prošnje bodo vrnjene z zahtevo po dopolnitvi!

Incomplete Applications will be returned and need to be resubmitted!

Izpolnjeno prošnjo oddajte na Slovensko antidoping organizacijo (naslov v glavi dokumenta), pri sebi hranite kopijo prošnje.

Incomplete Applications will be returned and will need to be resubmitted. Please submit the completed form to the SLOADO and keep a copy of completed form for your records.

