CMWFHC
CANADIAN MASTERS WEIGHTLIFTING FEDERATION
HALTEROPHILIE CANADIENNE
MASTERS
MAÎTRES

# Medical Review APPLICATION FORM

***(Request for Review of Medical Records)***

Please complete all sections in capital letters or typing. Athlete to complete sections 1, and 5; 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. Athlete Information

Surname: _____ Given Names: _____

Female ☐ Male ☐ Date of Birth (d/m/y): _____

Address: _____

City:_____ Country:_____ Postcode:_____

Tel.: _____ E-mail:_____
(*with International code*)

Sport: _____ Discipline/Position: _____

International or National Sport Organization:

_____

If you are an Athlete with an impairment, please indicate the impairment:

_____

_____

_____

## 2. Medical information *(continue on separate sheet if necessary)*

Diagnosis:

_____

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

_____

_____

## MEDICAL REPORT:

Evidence confirming the diagnosis shall be attached and forwarded with this application. The medical information must 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. In the case of non-demonstrable conditions, independent supporting medical opinion will assist this application.

WADA maintains a series of guidelines to assist physicians in the preparation of complete and thorough TUE applications. These TUE Physician Guidelines can be accessed by entering the search term "Medical Information" on the WADA website: https://www.wada-ama.org. The guidelines address the diagnosis and treatment of a number of medical conditions commonly affecting athletes, and requiring treatment with prohibited substances.

## 3. Medication details

| Prohibited Substance(s): Generic name | Dose | Route of Administration | Frequency | Duration of Treatment |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

## 4. Medical practitioner's declaration

**I certify that the information at sections 2 and 3 above is accurate, and that the above-mentioned treatment is medically appropriate.**

Name:

_____

Medical specialty:

_____

Address: _____

Tel.: _____

Fax: _____

E-mail: _____

Signature of Medical Practitioner: _____ Date:_____

## 5. Athlete's declaration

I, _____, certify that the information set out at section 1 is accurate. I authorize the release of personal medical information to the CMWFHC Anti-Doping Disciplinary Committee (ADC) as well as to CMWFHC authorized staff that may have a right to this information under the CMWFHC Anti-doping Policy.

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 Medical Review 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 the CMWFHC in writing of that fact. I understand and agree that it may be necessary for Medical Review-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 CMWFHC .

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 will notify the CMWFHC of my concern.

**Athlete's signature:** _____ **Date:** _____

**According to the CMWFHC Anti-doping Policy, Article 3.04.1:**
**A Medical Review application will be requested by the CMWFHC-ADC and considered retroactively should an athlete's sample produce an Adverse Analytical Finding for a prohibited substance or method.**

However, it is recommended that you bring the completed form and the Medical Review Report to any CMWHFC Competition that is subject to doping control. If you are selected for doping control you are encouraged to present these documents to the Doping Control Officer at the time of the sample collection.