

**NEVADA STATE ATHLETIC COMMISSION  
REQUEST FOR PROFESSIONAL BOXING, KICKBOXING, OR MIXED MARTIAL ARTS  
THERAPUTIC USE EXEMPTION (TUE)**

Fighter should complete Part A of this form.  
Fighter's physician should complete Part B and send to the Nevada State Athletic Commission ("Commission").

**PART A: FIGHTER INFORMATION:**

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_

FEDERAL ID #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ [ ] MALE [ ] FEMALE  
M D Y

REQUEST IS FOR: \_\_\_ NEW TUE \_\_\_ RENEWAL OF TUE IF A RENEWAL, YEAR OF LAST TUE: \_\_\_\_\_

**Mailing Address:**

Street: \_\_\_\_\_ Apartment Number: \_\_\_\_\_

City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Physician/Prescriber Information:**

Physician's Name: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State/Country: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**TUE INFORMATION:**

For which medication(s) on the Prohibited Substance list are you requesting a TUE?

1. \_\_\_\_\_
2. \_\_\_\_\_

Medical Condition/Diagnosis: \_\_\_\_\_  
\_\_\_\_\_

**Important Notice:** If you use any prohibited substance before receiving a TUE Approval from the Commission, you run the risk of being found to have committed a doping violation should the Commission subsequently deny the request for a TUE. Fighters should refrain from using a Prohibited Substance of which they have requested a TUE until such request has been granted in writing by the Commission. Also, by signing below, you authorize the release of this personal medical information, including the identification of the Prohibited Substance listed above ("Personal Medical Information") to the Commission and/or authorize staff designated by the Commission to be used by the Commission in the performance of their duties. By signing below you hereby release the Commission from any claims, damages, or liabilities arising out of the permitted use of your Personal Medical Information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PART B:      PHYSICIAN INFORMATION: (\*Must be and MD or DO)**

Medication Prescribed:    Name: \_\_\_\_\_ Dose: \_\_\_\_\_

Frequency: \_\_\_\_\_ Date Initiated: \_\_\_\_\_

Clinical Indication: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Diagnosis Based Upon: \_\_\_\_\_

**\*Medical evidence confirming the diagnosis (including blood work) must be attached and forwarded with this application. Office notes documenting the medical condition and treatment should be forwarded to the Nevada State Athletic Commission.**

Do you believe that this fighter needs to be on this medication while competing      [ ] Yes    [ ] No

**I CERTIFY THAT THE ABOVE TREATMENT IS MEDICALLY NECESSARY AND ALTERNATIVE MEDICATIONS (NOT ON THE RESTRICTED LIST) WOULD BE UNSATISFACTORY TO TREAT THIS INDIVIDUAL'S MEDICAL CONDITION:**

**Mailing Address:**

Physician's Name: \_\_\_\_\_ Degree: \_\_\_\_\_

Physician's Medical Specialty: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_

PLEASE FAX OR SCAN COMPLETED FORM AND ALL RELEVANT DOCUMENTATION:

**FAX TO: (702) 486-2577 -OR- SCAN TO: bobbennett@boxing.nv.gov**

ATT:    Bob Bennett – Executive Director  
Nevada State Athletic Commission  
555 E. Washington Avenue, Suite 3200  
Las Vegas, Nevada 89101      Office: (702) 486-2575

**DO NOT WRITE BELOW THIS LINE. FOR COMMISSION USE ONLY:**

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**TUE DECISION:      APPROVED [ ]      DENIED [ ]**

**Executive Director:      Name: \_\_\_\_\_**

**Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**Physician:      Name: \_\_\_\_\_**

**Signature: \_\_\_\_\_**

**Date: \_\_\_\_\_**

**COMMENTS:**

**Nevada State Athletic Commission**  
**Application for**  
**Therapeutic Use Exemption (TUE)**

Name: \_\_\_\_\_

- A. Have you had any previous and/or do you have any current TUE requests? If yes, please list the regulatory body to which the request was made, the decision of that regulatory body concerning the TUE request, and the decisions of any other regulatory body on review or appeal.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- B. Have you had any previous test results that indicated the presence of any prohibited substance or prohibited method and the regulatory body, if any, to whom those test results were reported?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- C. Have you previously used and/or do you currently use any substances or methods contained in or listed within the World Anti-Doping Agency (WADA) list of prohibited substances or methods?

Yes \_\_\_\_\_ No \_\_\_\_\_

- D. If you answered "Yes" to the question above, please list below all such substances or methods and the dates of such use:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby swear, under penalty of perjury, that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Date