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

ATT: Bob Bennett – Executive Director
Nevada State Athletic Commission
3300 W. Sahara Avenue, Suite 450
Las Vegas, Nevada 89102 Office: (702) 486-2575

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

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 <u>all</u> 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