.….. / …... / 20......

Below is the identity information of our student who will do his/her voluntary internship at your institution. If his/her acceptance is deemed appropriate, I kindly request you to fill in the relevant section of this form and deliver it to the student.

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Head of Department (Title, Name, Surname, Signature)

\*Work Accident and Occupational Diseases Insurance Premium between the dates of the student's internship will be covered by the University. The student is not doing an internship in a different institution simultaneously with his/her application to you.

**STUDENT INFORMATION** (To be filled in by the student)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Identity Number |  | | | Cell Phone | | | |  | |
| Name-Surname |  | | | Home Tel | | | |  | |
| Student Number |  | | | | | | | | |
| Faculty / Vocational School / Institute |  | | | | | | | | |
| Department/Program |  | | | | | | | | |
| Classroom |  | | | | | | | | |
| Disciplinary Certificate | YES ( ) NO ( )  You can request your document via OIS. Please send a photocopy in the attachment. | | | | | | | | |
| Occupational Health and Safety Training/Certificate | YES ( ) NO ( )  You can get it online from Yetenek TV affiliated to the Presidency. If you have a document, please send a photocopy attached | | | | | | | | |
| General Health Insurance | Those who receive health benefits through their mother or father, for those who work subject to the Social Insurance Institution (4-A) -(4-B) -(4-C) (YES)  Those who receive health benefits through our university, (I have a university health card. Any social  for those without insurance (NO) | | | | | | | | |
| Education Level | Associate Degree ( | ) | License ( | | ) | | Postgraduate ( ) | |  |
| Type and Duration of Internship | Online ( | ) | Face to face( )  To | | | | | Total Number of Internship Days ( ) |  |
| Internship / Practicum Dates | Start Date: | | | | | End Date: | | | |
| Internship Day(s) |  | | | | | | | | |

**INFORMATION OF THE INSTITUTION** (To be filled in by the institution.)

|  |  |
| --- | --- |
| Name of Institution: |  |
| Field of Activity: |  |
| Unit(s) for Internship |  |
| Address: |  |
| Telephone Number: |  |
| Authorized Person/Title: |  |

A copy of this approved form will remain with the student and the original form will be submitted to the University Career Center and Alumni Office no later than 10 working days before the start of the internship. (Do not forget to have a photocopy made before submitting your document).

Deemed Appropriate

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Head of Department (Title, Name, Surname, Signature)