|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STUDENT IDENTITY INFORMATION** | | | | | | | | |
| **NAME & FAMILY NAME** |  | | | | | | | |
| **FACULTY DEPARTMENT** |  | | | | | | | |
| **T.R. IDENTITY NUMBER** |  | | | | | | | |
| **STUDENT NUMBER & CLASS** |  | | | | | | | |
| **MOBILE PHONE NUMBER** |  | | | | | | | |
| **E-MAIL ADDRESS** | @ | | | | | | | |
| **SSI\* REGISTER** (Health Services in the content of General Health Insurance of myself, my family, my mother/my father) | | | | I RECEIVE |  | I DON’T RECEIVE | |  |
| **WORKPLACE INFORMATION** | | | | | | | | |
| **NAME/TITLE** |  | | | | | | | |
| **ADDRESS** |  | | | | | | | |
| **IBAN NUMBER** |  | | | | | | | |
| **TAX ID NUMBER** |  | | | | | | | |
| **PHONE # and WEB SITE** |  | | | | | | | |
| **NUMBER OF EMPLOYEES** |  | | | | | | | |
| **FULL DAY WORK ON SATURDAYS** | | YES | | |  | NO | |  |
| **I declare and commit that;**  - The accuracy of information I specified here,  - I am going to fulfill the internship in the period of time given below,  - If the start and end days of the internship are change or completely waived, I will inform the Office of Student Affairs at least three days in advance, otherwise, I will pay the loss that can occur due to the SSI\* premium payments,  -I do not share the cases, persons, names and other information about workplace with third parties, otherwise I undertake the whole responsibility.  Date: …./…./…..  Student Name and Family Name:…………………………………..  Student Signature :………………………………….. | | | | | | | | |
| A ……… days mandatory internship of the student, whose identity information is given above, in our workplace is  ( ) authorized ( ) not authorized | | | **Workplace Authority/Representative;**  Name and Family Name:………………………………………  Signature :………………………………………  Date :………………………………………… | | | | | |
| **THE STUDENT’S** | | | | | | | | |
| **INTERNSHIP APPLIED** |  | | | | | | | |
| **INTERNSHIP START DATE** | …../……/…… | | | | Number of workdays in a week: ………………… | | Internship period:  ..….. days | |
| **INTERNSHIP END DATE** | …../……/…… | | | |
| **PREMIUM PAYMENT DAYS IN THE INTERNSHIP PERIOD MONTHS** (Number of internship days per month) | | |  | | | | | |
| **Department Internship Commission Head:** Name and Family Name: ……………………………….. Signature:………………… | | | | | | | | |
| **IMPORTANT NOTE:** **Before the internship starts**, it is mandatory for student to deliver this form to Department Internship Commission until the date indicted in Faculty Internship Instructions. This form should be prepared as 3 true copies (One of the copies will be left to the workplace, and the other will be delivered to Department Internship Commission). **After the internship ends**, the third copy, which is carrying the “✓workplace stamp, ✓workplace authority or representative signature, ✓the information about to whom the payment was made for which service, and ✓the information on the internship period” should be prepared, the bank account statement/ pay roll of the payment made to the student by the corresponding workplace should be attached and these two documents should be delivered to the Faculty Student Affairs Office by the student. | | | | | | | | |

\*SSI: Social Security Institution (“SGK: Sosyal Güvenlik Kurumu” in Turkish)