Fenerbahçe University
Faculty of Health Sciences Clinical Practice Commitment

Name Surname	
T.R. Identification number/Passport Number	
Date of Birth (Day/Month/Year)	
Department	
Year	
Practice Institution/Hospital	
Practice Start-End Date	

In the letter dated 17.02.2021 sent by the Higher Education Institution to the universities, it is stated that, as a result of the evaluations, applied trainings can be made face to face by dividing students into groups, on condition that "maximum attention is paid and strict measures are taken", and students who do not want to continue their education can benefit from the right to suspend study.

Firstly; I understood and evaluated the options presented to me by the Higher Education Institution and University Rectorate. I want to do my compulsory practice training voluntarily at the Hospital/Medical Center. This decision is one that I have taken with my **complete consent**, and I am fully responsible for the consequences.

I know what the coronavirus (Covid-19) disease is, its possible consequences, complications, risks and if I start practicing, I can get infected with this disease.

I have read and understood the above information and I agree that all of it is correct. In line with this information, I accept all material and moral responsibility if I get infected with the Coronavirus (Covid-19) disease and/or any complications related to this disease despite the fact that the healthcare institution I practice provides all the protective equipment during my practice, I do not have any legal or material rights that I can direct to any institution or organization related to the subject.

"I have read and understood the text and I accept that it is completely correct." Please write this sentence in your own handwriting on the bottom line and sign it.

…….....

Name Surname/Date/Signature

** Students under the age of 18 require parental consent.

Parent Name Surname/Date/Signature