FACULTY OF HEALTH SCIENCES
DEPARTMENT OF ……………………………………………..
INTERNSHIP/ PROFESSIONAL PRACTICE FILE

Dear Student,
This guide has been prepared for the smooth execution and completion of the practices within the scope of "Internship/Professional Practice" courses.

PLEASE FILL THIS FILE AND ITS ATTACHMENTS CAREFULLY READING THE FOLLOWING INFORMATION!

1. Fill in the **Internship/ Professional Practice Application and Acceptance Form** with a **blue** ballpoint/fountain pen, completely and without any incorrect information, and submit it by attaching a photograph.
2. After completing the relevant form, sign it and send it to the **responsible lecturer**, and to the Human Resources/education unit/directorate of the **institution** you will practice with.
3. Submit a copy of the document signed at the institution/hospital where the application will be made to your department.
4. Incomplete and/or incorrect information, signature, date etc. on the form. In the absence of information, the relevant units have the right not to accept the file.
5. The SGK entry of the student who does not submit his/her file is not made. In this case, it is not possible for the student to start the application.
6. SGK entry made by the University **does not cover general health insurance**, it is only made against **work accidents and occupational diseases** and ends at the end of the practice course.
7. The documents required by the institutions to be implemented vary. The test/document required for each institution will be learned from the relevant institution and will be prepared by the student. The "final checklist before submission" must be **fully filled** and **signed by you**, and the course must be submitted in a file **after receiving approval from your instructor.**

Name Surname:
Student number:
Class:

FENERBAHCE UNIVERSITY **FACULTY OF HEALTH SCIENCES** **DEPARTMENT OF ……………………………………………..** **CLINICAL PRACTICE APPLICATION AND ACCEPTANCE FORM**	PHOTO

Our student, who is studying at our faculty and whose identity information is written below, would like to do his/her internship/professional practice in your institution/organization on the dates specified. In accordance with the provisions of subparagraph (e) of Article 87 of the Social Security Law No. 5510, the **"Work Accident and Occupational Disease Insurance"** premium for the period in which our student will practice will be paid by our university.		
Name Surname:		
Class:		
Student number:		
Identification number:		
SGK Number:	**Bağ-Kur Number:**	**Emekli Sandığı Number:**
Address:		
Phone Number:		
Term:		
Name of the Course in which the Clinical Practice will be made:		
Institution for Clinical Practice:		
Clinical Practice Start and End Date:		**Days**:

TO THE DEPARTMENT OF ……………………………………..…………………….. (ENGLISH)

I want to do my clinical practice covering ……………… working days between the dates mentioned above. I undertake that I will inform to the head of the program within 2 (two) business days at the latest, in case I leave my professional practice for any excuse before the end of ………..…… business days, otherwise I accept the penal obligations that will arise in accordance with the Social Insurance and General Health Insurance Law No. 5510.
I submit it to your information.

Name surname:
Signature:

TO THE INTERNSHIP COORDINATOR

It is appropriate for the ……………………..……….. (English) Department student, whose identity and school information are given above, to practice the…………………….. for the specified working day in the institution.
I submit it to your information.

Responsible Instructor of the course
Name surname:
Date:
Signature:

THE AUTHORITY APPROVING ON BEHALF OF THE INSTITUTION

It is appropriate for the student whose name and information are written above to do an internship in our institution for ……… working days.

Institutional Manager
Name surname:
Date:
Signature:

DECLARATION AND COMMITMENT

I am a student …………………………….... Department/Programme at our University. I want to work as a trainee student in…………………………………in accordance with Article 5/b of the Social Insurance and General Health Insurance Law No. 5510.

☐ I **receive** health services from **my family under general health insurance through my mother / father**. For this reason**, I do not accept to be covered** by general health insurance during my part-time work or internship.

☐ I **do not receive** health services from **my family under general health insurance through my mother / father**. For this reason**, I accept to be covered** by general health insurance during my part-time work or internship.

I accept that my declaration is correct and that in case of a change in my situation, I will immediately notify the change, and I undertake that I will pay the premium, administrative fine, late fee, and delay interest arising from my erroneous or incomplete statement.

Name-Surname :

ID Card No. :

Department :

Student No. :

Signature :

Date :