REPUBLIC OF TÜRKİYE
ONDOKUZ MAYIS UNIVERSITY
INTERNSHIP APPLICATION FORM

NAME- SURNAME		**T.R. ID Number**	
Faculty/ School/ Vocational School		**Department/ Program**	
Student Number		**Academic Year**	
E-Mail Address		**Phone Number**	
Are you currently working in any institution or organization? Or are Social Security premiums currently being paid on your behalf?		Yes ☐ No ☐	
Select Social Security Institution*: Social Insurance Institution, Pension Fund, Bağ-Kur, Green Card, OMU		**On Own Behalf** ☐	**Through Family** ☐

*****An official document obtained from SGK (from the Institution or via e-Government – SPAS Eligibility Certificate) must be submitted as an attachment.
The current social security status under my own name or through my family is stated for the above-mentioned institutions and organizations.
Those working under Article 4(C) of Law No. 5510 (Pension Fund) are required to bring a permission document from their workplace.

Residential Address					
Last Graduated School		**Department**		**Year of Graduation**	

I will complete my day internship between the dates specified below.
1- If the start date of my internship changes, I will inform the institution authority at least 1 week in advance. 2-If I discontinue the internship for any reason after actually starting it, I will inform the institution authority within 3 days. Otherwise, I hereby undertake to accept the penal liabilities that may arise in accordance with Law No. 5510.

Date
Student
(Full Name – Signature)

Department / Program Internship Officer (Full Name – Signature)		

It is mandatory for the student whose identity is given above to complete the internship for the specified number of working days. During the internship period, our University will provide work accident and occupational disease insurance for our student. We thank you for your interest in allowing the aforementioned student to complete their internship at your organization and kindly request that all internship documents be delivered to us in a sealed envelope. We wish you success in your work.

Faculty / School / Vocational School Authorized Officer
(Full Name – Title – Signature)

INFORMATION OF THE INTERNSHIP PLACE

Name		**Number of Employees**			
Address					
Production/ Service Area					
Phone Number			**Fax Number**		
E-mail Address			**Web Adresi**		
Internship Start Date		**End Date**		**Duration (days)**	

EMPLOYER OR AUTHORIZED PERSON INFORMATION

Full Name		**Duty and Title**	
E-mail Address		**Date** **Signature /Stamp**	

*****EXPLANATIONS:** The student is required to submit the **Compulsory Internship Form** in **three original copies**, together with a **photocopy of their ID card**, to the **relevant department secretariat** at least **30 days before the start date of the compulsory internship**.