



ANNEX:1

TURKISH REPUBLIC
ISTANBUL MEDİPOL UNIVERSITY
FACULTY OF COMMUNICATION

PROFESSIONAL INTERNSHIP FORM

TO WHOM IT MAY CONCERN,

Students who are subject to professional internships during their higher education are covered by workers' compensation and occupational disease insurance. Pursuant to Law No. 5510, Istanbul Medipol University is responsible for paying premiums for students undergoing vocational training during their higher education. We thank you for your cooperation in allowing our student, whose information is provided below, to complete their internship at your institution for a period of 20 working days, and we wish you success in your endeavours.

.....

Name Surname			
Faculty / Student Number		Academic Year	
Department		Phone Number	
E-mail Adress			
Residential Adress			

Dean's Office

INFORMATION ABOUT THE PLACE OF INTERNSHIP

Name / Title of the Institution				
Address				
Field of Activity (Production/Service)				
Phone Number		Fax Number		
E-mail Address:		Website		
Internship Start Date:		End Date		Duration (days)

EMPLOYER / AUTHORIZED PERSON

Name and Surname			
Position and Title:		The student's Professional Internship at our institution/company is approved.	
E-mail Adress:		Signature/Stamp	
Date			

STUDENT IDENTITY INFORMATION

Surname		Nüfusa Kayıtlı Olduğu İl	
Name		İlçe	
Father's Name		Mahalle/Köy	
Mother's Name		Cilt No	
Place of Birth		Aile Sıra No	
Date of Birth		Sıra No	
Passport Number		Verildiği Nüfus Dairesi	
Nüfus Cüzdanı Seri No		Veriliş Nedeni	
(Varsa) SSK No		Veriliş Tarihi	
Does the student benefit from parents' social security?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Student's Adress			
STUDENT'S SIGNATURE	INTERNSHIP COMMISSION APPROVAL	FACULTY APPROVAL	
I declare that the information provided is correct and respectfully request the preparation of my internship documents. Date::	Date :	Internship start registration has been completed at the Social Security Institution. Date :	

IMPORTANT NOTE: The student must submit this form to the faculty internship commission at least 20 days before the internship start date, together with 3 copies of ID and 3 passport photos. The form must be prepared in 3 original copies (not photocopies). According to Law No. 5510, Istanbul Medipol University is responsible for insurance premiums.

ANNEX:2

TURKISH REPUBLIC
ISTANBUL MEDİPOL UNIVERSITY
FACULTY OF COMMUNICATION

WORKPLACE INTERNSHIP EVALUATION FORM*

Surname, Name		Department	
Date of Birth		Class	
Place of Birth		Faculty Number	

DATES	Internship Start Date	
	Internship End Date	
DAYS OF	Worked	
	Not Worked	

Department Worked In	
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	Grade **	Notes
Attendance		
Teamwork Ability		
Completing Tasks on Time		
Compatibility with Supervisors		
Relations with Staff		
Sobriety and Reliability		
Ability to Apply Theoretical Knowledge		
General Evaluation		

Supervisor Name, Title and Signature	
Sonuç ve Onay	

* After the professional internship is completed, this evaluation form (along with the workplace attendance record) is returned to the student by the workplace in a sealed, stamped envelope.

** Grades are assigned on a scale of 100: 90–100 (Excellent), 75–89 (Good), 60–74 (Average), 50–59 (Poor), 0–49 (Fail)

ANNEX 3:

DAILY INTERNSHIP ATTENDANCE SHEET

WORKPLACE																									
Name:			Phone / Fax:						E-Mail:						Month:			Document Date:/...../20..							
STUDENT			DAYS																	Total Absences					
NAME SURNAME	NO	DEPARTMENT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Excused	Unexcused	
SUPERVISOR / / 20.. Signature/Stamp			REVIEWED BY / / 20.. Departmental Coordinator of Professional Internship, Faculty of Communication Name Surname: Signature:										Symbols Indicating Absence İ: On Leave H: Sick Leave D: Absent (Unexcused) T: Official Holiday												

This form must be completed by the workplace, with the student's absences marked using the appropriate symbol for each day, then stamped and signed, and placed in a sealed envelope along with the Workplace Evaluation Form. The total number of absences indicated by the symbols (I), (H), and (R) must be entered in the "Excused Absences" column.

TURKISH REPUBLIC
ISTANBUL MEDİPOL UNIVERSITY
FACULTY OF COMMUNICATION

ANNEX: 5

INTERNSHIP COMPLETION CERTIFICATE

Department of.....

Date: /..... / 20

TO WHOM IT MAY CONCERN,

The student named has successfully completed their Professional Internship as evaluated by the department internship commission.

Department Professional Internship Coordinator

Head of Department

Signature

Signature

Internship Place Name & Address :

Department / Unit :

Start & End Dates :

INTERNSHIP FILE

Department Of.....

Student

Name Surname :

Student Number :

Semester :

Intership

Start Date :

End Date :

Intership Institution

Name :

Adress :

Supervisor :

ANNEX: 7.	
ISTANBUL MEDİPOL UNIVERSITY STUDENT INTERSHIP FILE	
Date:	Department Where the Internship is Conducted:
Work Days	The Work Performed
1. Workday	
2. Workday	
3. Workday	
4. Workday	
5. Workday	
Views and Recommendations of the Unit Head:	
Name Surname and Title of the Unit Head:	Signature of tht Unit Head:

ISTANBUL MEDİPOL UNIVERSITY STUDENT INTERSHIP FILE	
Date:	Department Where the Internship is Conducted:
Workdays	The Work Performed
6. Workday	
7. Workday	
8. Workday	
9. Workday	
10. Workday	
Views and Recommendations of the Unit Head:	
Name Surname and Title of the Unit Head:	Signature of the Unit Head:

ANNEX 7.2.	
ISTANBUL MEDİPOL UNIVERSITY STUDENT INTERSHIP FILE	
Date:	Department Where the Internship is Conducted:
Workdays	The Work Performed
11. Workday	
12. Workday	
13. Workday	
14. Workday	
15. Workday	
Views and Recommendations of the Unit Head:	
Name Surname and Title of the Unit Head:	Signature of the Unit Head:

ANNEX: 7.3.	
ISTANBUL MEDİPOL UNIVERSITY STUDENT INTERSHIP FILE	
Date:	Department Where the Internship is Conducted:
Workdays	The Work Performed
16.Workday	
17. Workday	
18. Workday	
19. Workday	
20. Workday	
Views and Recommendations of the Unit Head:	
Name Surname and Title of the Unit Head:	Signature of the Unit Head:

ANNEX

8

ISTANBUL MEDİPOL UNIVERSITY

**TO THE DEANSHIP OF THE SCHOOL OF
COMMUNICATION**

..... / / 20..... and / / 20..... as part of the professional internship course, I hereby confirm that I will participate in the occupational safety training to be conducted by the Occupational Health and Safety Unit of the Rectorate of Istanbul Medipol University prior to the practical training; I acknowledge that if I commence the practical training without participating in the occupational health and safety training, I will be solely responsible for any workplace accidents that may occur during the practical training.

Signature

Student's

Name :.....

Surname :.....

Department :.....

Number :.....

The student, whose name and department are listed above has completed the training courses offered by the Occupational Health and Safety Unit at Istanbul Medipol University

Occupational Health and Safety Unit

Name Surname:

Signature :

Stamp:

..... / / 20...

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X:9

TURKISH REPUBLIC
ISTANBUL MEDİPOL UNIVERSITY
FACULTY OF COMMUNICATION

BUSINESS & STUDENT INFORMATION FORM*

Type of Institution: Public Private Foundation

To benefit from the state contribution under Law No. 6764 Yes No

Company Name:

Address :

Phone : GSM:

Tax Number :

Tax Office :

Bank Name :

Account Number: IBAN No: TR.....

Number of Employees (Except Intern) :

Number of Interns :

Facility Manager :

Contact person(s) at the company:

ID Number	Name Surname	Title	Telephone
.....
.....

Students participating in the workplace internship program

Passport Number	Name Surname	Department	Class
.....
.....
.....
.....
.....

I acknowledge my liability and agree to any penalties that may apply should I improperly benefit from the state subsidy due to the inaccuracy of the information provided.

.... / .../ 20...

Company Stamp and

Signature

.....
* This form must be completed by the company where the internship will take place.