



“.....”(The hospital's name should be written here). Department of Physiotherapy and Rehabilitation have applied health insurance for work accident and diseases until the end of the training period. Students who are subject to compulsory internship are obliged to pay premiums by their institutions for their undergraduate education. Below is the information about our student who have been trained for 15 work days. Thank you for your interest, we wish you success in your work.

Paste Picture
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**STUDENT ADDRESS INFORMATION**

Name - Surname		District	
Student Nubmer		Avenue	
Mail Address		Street	
Mobile Phone		Number	
Postal Code		City / Province	

**INTERNSHIP INSTITUTION**

Name					
Address					
Service Area					
Phone Number		Fax Number			
E-mail Address		Web Address			
Start date of the internship		End Date		Duration(days)	15 WORK DAYS

**EMPLOYER OR AUTHORIZATION**

Name - Surname				
Job and Title		Signature / Stamp		
E-mail Address				
Date				

**STUDENT REGISTRATION INFORMATION**

Name - Surname		Registration Province	
Father Name		City	
Mother Name		District	
Place of Birth		Volume No	
Date of Birth		Family Row No	
Identification Number		Row No	
ID Serial Number		Issuing Register Office	
Insurance Number		Reason of Issue	
Does the Insurance Continue?	Yes ( ) No ( )	Date of Issue	

**SIGNATURE OF STUDENT**

**HEAD OF INTERNSHIP  
COMMITTEE/ HEAD OF  
DEPARTMENT**

**FACULTY /  
HIGH SCHOOL  
APPROVAL**

I declare that the information on the document is correct, and with my respect, I offer the preparation of the internship documents related to the company which I commit to undertake an internship		Registered for the Social Security Institution was made for the internship.
Date:	Date:	Date: