ANKARA MEDIPOL UNIVERSITY
DIRECTORATE OF THE VOCATIONAL SCHOOL

INFORMATION FORM FOR STUDENTS UNDERTAKING INTERNSHIP WITHIN THE SCOPE OF LAW NO. 5510 ON SOCIAL INSURANCE AND GENERAL HEALTH INSURANCE

STUDENT INFORMATION:

TR Identity No		Student ID No	
Full Name		Program	
Father's Name		Mother's Name	
Place of Birth		Date of Birth	
E-mail		Mobile Phone	
Address			

HOST INSTITUTION / WORKPLACE INFORMATION:

Title / Company Name		
Address		
Phone No	Fax No	
Internship Start Date	Internship End Date	
Working Days Per Week Insurance premium days to be paid by month during internship	Total Working Days	

STUDENT DECLARATION AND UNDERTAKING:

I wish to work as a student intern pursuant to Article 5/b of Law No. 5510. WITHIN THE SCOPE OF GENERAL HEALTH INSURANCE, through myself or my parents, I ( ) receive, ( ) do not receive healthcare benefits.

I hereby certify the accuracy of my declaration. I accept and undertake that in case of any change in my status or if I suffer an accident at the workplace, I will notify the Vocational School Directorate within one (1) working day; and that any insurance premium, administrative fine, late fee, or delay interest arising from erroneous, incomplete, and/or untimely notification on my part shall be paid in full by myself.

Student's Full Name and Signature

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