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| http://www.subu.edu.tr/timthumb.php?src=http://www.subu.edu.tr/sites/subu.edu.tr/image/SUBU_LOGO_3.png&w=800 | **SAKARYA UNIVERSITY OF APPLIED SCIENCES**  **FACULTY OF SPORT SCIENCES**  **DEPARTMENT OF COACHING EDUCATION** | | | | | | |
| **INTERNSHIP ACCEPTANCE FORM** | | | | | | | |
| **STUDENT** | |  | |  | | | |
| **Name and Surname** | | **:** | |  | | | |
| **Student ID Number** | | **:** | |  | | | |
| **ID Number** | | **:** | |  | | | |
| **Telephone Number** | | **:** | |  | | | |
| **E-mail** | | **:** | |  | | | |
| **INTERNSHIP** | |  | |  | | | |
| **Type** | | **:** | |  | | | |
| **Duration** | | **:** | |  | | | |
| **Starting and End Date of Internship** | | **:** | | . ......./…..../…..... - .….../….../.......... | | | |
| - Between the dates mentioned above I will do my .………….-day internship. | | | | | | | |
| - I hereby undertake that I will notify the secretary of the department by submitting the original documents (e.g. sick-leave report etc.) taken during the internship, and I will inform the school at least (7) days in advance in case the start and end dates of my internship change or I give up the internship. Otherwise, I undertake to accept the criminal obligations that will arise in accordance with the law numbered 5510.  ……/……/ ……  Student Signature  It is obligatory for the student of our department, whose ID is given above, to do an internship for the specified working day. During the internship period, the student's work accident and occupational diseases insurance will be made by our University.    Stamp and Signature  Department Internship Officer | | | | | | | |
|  | | | | | | |  |
| **INTERNSHIP ORGANISATION** | | | | | | | |
| **Title** | | | **:** | | **IBAN number:** | | |
| **Adress** | | | **:** | |  | | |
| **Telephone Number** | | | **:** | |  | | |
| **Fax Number** | | | **:** | |  | | |
| **Workplace Registration Number** | | | **:** | |  | | |
| **Workplace’s Tax Number** | | | **:** | |  | | |
| **Chamber of commerce number** | | | **:** | |  | | |
| **E-mail adress** | | | **:** | |  | | |
| **Activity area (Sector)** | | | **:** | | **Total Number of Personnel of the Workplace:** | | |
| - It is obligatory to state whether the intern student will be paid or not; and to submit payroll or bank receipt.  - Requested State Contribution Amount:  - The student whose Name and Surname and Identification Number are written above, has been deemed appropriate to do an internship at our workplace on the dates mentioned above.  Employer or Officer | | | | | | | |
|  | | | | | | Name-Surname  (Title)  Seal and signature | |
|  | | | | | | | |
| **APPROVED** | | | | | | | |
| .….. / ….. / ……. | | | | | | | |
| **Head of Department Internship Committee**  **Important Note: It should be stated if more than 20 people work in the workplace.** | | | | | | | |
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