T.C
KARABÜK UNIVERSITY
FACULTY OF HEALTH SCIENCES

INTERNSHIP APPLICATION FORM

Number: Date:
Subject: Summer Internship

AUTHORITY OF INTEREST

Our student, who has given the information in below, wants to apply for a compulsory summer internship for total 20 working days at your institution.

We kindly request you to inform us whether it is appropriate for our student to do an internship at your institution.

Department of Midwifery Vice-Dean

INSTITUTION

Name	Karabük University Faculty of Health Sciences Department of Midwifery		
Address	Karabük University Faculty of Health Sciences Demir Çelik Kampüsü 78050 Karabük		
Tel No	0370 418 91 71	Fax No	0370 418 93 53

STUDENT INFORMATION

Name Surname		ID Number	
Student Number		Year	
E-mail		Tel No	
Residence Address			

INSTITUTION

Name			
Address			
Tel No		Fax Number	
E-mail		Web Address	
Internship starting date		Ending date	

STUDENT SIGNATURE I declare that the information on the document is correct.	**INSTITUTION APPROVAL FOR INTERNSHIP** **Signature** **Stamp/Seal**