ACIBADEM MEHMET ALİ AYDINLAR UNIVERSITY FACULTY OF PHARMACY PHARMACY INTERNSHIP/ PROFESSIONAL EDUCATION IN BUSINESS APPLICATION/ACCEPTANCE FORM

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To Faculty of Pharmacy Internship Committee;

I hereby kindly submit the informations for my internship at the pharmacy / institution and dates I have specified below.

STUDENT INFORMATION	
Name-Surname	
Citizen ID	
Student ID	
Class/Semester	
Address	
Phone Number (mobile)	
E-mail Address (university)	@live.acibadem.edu.tr
E-mail Address (other)	
Internship/ Professional Education in	
Business Code and Name	
Internship/ Professional Education in	
Business Start Date	
Internship/ Professional Education in	
Business Completion Date	
Internship/ Professional Education in	
Business Duration (Total Working Days**)	777
Saturday working status of the Pharmacy	YES [] NO []
Health related special cases (please specify	
if any)	
INTERNSHIP / PROFESSIONAL EDUC	ATION IN BUSINESS INFORMATION
Name of the Internship Place	
Internship Supervisor	
Internship Organization Address	
Phone Number	
	tion submitted as indicated above are correct and I
	nternship programme, I will perform all the duties
	with my professional development. In case I fail to p programme or have made any changes to my
	Faculty Internship Commission' at least 2 days in
	sate for pecuniary (including insurance payments),
non-pecuniary and administrative damages that n	
	Surname s Signature
Student	o Dignature

 $^{\ ^{*}}$ Internship: Refers to all summer internships.

^{**} The first page of ANNEX-2a will be filled by the student and the second page by the pharmacist and delivered to the relevant internship sub-board with signature.

^{**} Saturdays can be counted as working days for pharmacies working full time.

To the Acıbadem Mehmet Ali Aydınlar University Dean of Faculty of Pharmacy; Info: Internship Commission;

I accepted internship / professional education in business application of your student, whose name is, in my pharmacy between dates of		
inform you that I will spend at least generations by taking care of her	As a necessity of our profession, I would like to st one hour every day with the awareness of raising the next him and trying to answer her/his professional questions. I operation with your faculty to monitor the attendance and dates.	
Sincerely,	(Seal and Signature)	
Name-Surname: (Responsible Pharmacist)		
Phone Number: (Responsible Pharmacist)		
E-mail Address:		
Chamber of Pharmacy Registration:		
Registration Number:		
Name of the Pharmacy:		
Address of the Pharmacy:		
Phone Number of the Pharmacy:		
Working Field of the Pharmacy: [Locality of Pharmacy, Pharmacy Profile, Product Profile (OTC, Prescription, Cosmetics) etc. Please specify]		
Professional Civil Society Organization Membership and Duties:		
Expectations from the Faculty and/or the Student:		

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