JULY, 2014

FORM NMT/E

NURSES AND MIDWIVES COUNCIL OF MALAWI

APPLICATION FOR FINAL EXAMINATIONS FOR NURSING MIDWIFERY TECHNICIANS

This form must be completed and signed by the Principal or his or her designate of the College of Nursing six weeks before Council Examinations.

NAME OF TRAINING INSTITUTION:……
ADDRESS:…… ……

NAME OF STUDENT:…… ……
SURNAME FIRST NAME MIDDLE NAME

INDEX NUMBER:……

DATE OF COMMENCEMENT OF TRAINING:……

RESULTS OF ASSESSMENTS

NO.	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENTS
1	Total care of medically ill patient			
2	Care of the post operative patient (Adult or Child)			
3	Care of the under five child			

NO.	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENTS
4	Care of the patient with mental health problems			
5	Management of a client seeking family planning services			

NO.	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENTS
6	Care of an antenatal woman on booking visit			
7	Care of a woman in labour			
8	Care of a mother within the first 48 hours post partum			
9	Care of a neonate within the first 48 hours post partum			

GENERAL COMMENTS:……

I certify that the above information is a true reflection of the candidate's performance

NAME OF HEAD OF INSTITUTION:……

SIGNATURE:……. DATE:……

Official Stamp

Please Return to: The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
LILONGWE 3

MAY 2014

FORM NMT/D

SUMMARY OF THE MIDWIFERY TECHNICIANS' MIDWIFERY EXPERIENCE

INSTRUCTIONS:

This form must be completed and signed by the Principal Tutor or his/her designate of the College of Midwifery where the applicant pursed the course.

NAME OF COLLEGE:……..

ADDRESS:…….

I certify that:……. ……
SURNAME **FIRST NAME(S)**

Was indexed with the Nurses and Midwives Council on:

…… ……. ……..
DATE **MONTH** **YEAR**

Date course commenced:……

Date course completed:……

DETAILS OF INSTRUCTION UNDERGONE BY APPLICANT:

Antenatal Clinic:……..

Antenatal Ward:……..

Labour and Delivery:……..

Neonatal Care:…….

Postnatal Care:.....

District Midwifery:……..

Family Planning:……

Night Duty:……

Others (Specify):……

1

PROCEDURE	**NO. REQUIRED**	**NO. DONE**
Complete assessment of pregnant Woman at first antenatal visit.	_____	
Vaginal examinations including the pelvic assessment.	_____	_____
Spontaneous vertex delivery	_____	_____
Episiotomy with repair under local anaesthetic.	_____	_____
Delivery by vacuum extraction.	_____	_____
Repair of perineal laceration under local Anaesthetic.	_____	_____
Breech delivery.	_____	_____
Multiple delivery.	_____	_____
Management of postnatal mothers and their infants.	_____	_____
Postnatal assessment of mother (including Pelvic examination) and infant at 6 weeks.	_____	_____
CASE STUDIES:		
Normal delivery.	_____	_____
Abnormal deliveries	_____	_____

N.B. Please indicate clearly where clinical experiences were combined.

Signature of Principal Tutor:……..

Date:…….

OFFICIAL STAMP:

Please Return to: The Registrar
Nurses and Midwives Council
P.O. Box 30361
Capital City, **LILONGWE 3**

MAY 2014

FORM NMT/C

SUMMARY OF THE NURSING TECHNICIANS' CLINICAL EXPERIENCE

INSTRUCTIONS:

This form must be completed and signed by the Principal Tutor or his/her designate of the college of Nursing where the applicant pursed the course.

NAME OF COLLEGE……..

ADDRESS:……..

I certify that: …….. ……..
SURNAME **FIRST NAME(S)**

Was indexed with the Nurses and Midwives Council on:
…… ……. ……..
DATE **MONTH** **YEAR**

Date course commenced:……

Date course completed:……

DETAILS OF INSTRUCTION UNDERGONE BY APPLICANT:

Experience	**Number of Hours**
Community Nursing	……
Medical Nursing	……
Surgical Nursing	……..
Paediatric Nursing	……..
Casualty and O.P.D.	……..
Management	……..

Psychiatric Nursing ……..

Operating Theatre ……..

Night Duty ……..

Others (Specify) ……..

N.B. Please indicate clearly where clinical experiences were combined.

Total leave granted to the applicant during course:

Vactional leave:……..

Sick leave:……..

Other leave:……

Signature of Principal Tutor:……

Date:……

OFFICIAL STAMP:

Please Return to: The Registrar
Nurses and Midwives Council
P.O. Box 30361
Capital City,
LILONGWE 3

MAY 2014

FORM NMT/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Nurses maintained by the Nurses and Midwives Council of Malawi

OFFICE USE

K T
FEE PAID:……..
DATE.:……
RECEIPT NO:……

Indicate with a [√] register to which this application applies:

[ ] Nursing Midwifery Technician (NMT)

[ ] Nursing Technician (NT)

[ ] Midwifery Technician (MT)

STATE CLEARLY

TYPE OF TRAINING	NAME OF EDUCATIONAL INSTITUTION AND ADDRESS	DATE TRAINING		CERTIFICATE NUMBER (if applicable)
		COMMENCED	COMPLETED	

ENCLOSED INITIAL REGISTRATION FEE MK……..

STUDENT INDEX NUMBER:……..

LIST BELOW THE STUDENTS FUNDING SOURCE:

☐	Ministry of Health/CHAM
☐	Donor Partially Funded (Specify) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
☐	Donor Fully Funded (Specify) _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _
☐	Self-Funded

SURNAME MISS/MRS/MR:……

FIRST NAME:……

MAIDEN NAME (if married):…….....

DATE OF BIRTH:…….....
DATE MONTH YEAR

PLACE OF BIRTH:…….....
TOWN/VILLAGE T/A DISTRICT

……
COUNTRY

NATIONALITY:…….....

ADDRESS TO WHICH LICENCE TO PRACTICE SHOULD BE SENT:

……..

……..

SIGNATURE OF APPLICANT:…….....

SIGNATURE OF PERSON IN-CHARGE OF PROGRAMME:……..

DATE:…….

OFFICIAL STAMP:

Please return to: The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
LILONGWE 3