CHNT/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE COMMUNITY HEALTH NURSING TECHNICIANS EXAMINATION

INSTRUCTIONS:

Number 1 to 10 to be completed by candidate

Numbers A to C to be completed by the person in-charge of the programme

OFFICE USE
FEE.:……………………………………...
ELIGIBLE.:………………………………
EXAM. NO.:…………………………...
EXAM. RESULTS.:……………………..
MK.…………………………………….

1. ENCLOSED EXAMINATION FEE:……………………………………………………

2. DATES OF EXAMINATION:…………………………………………………………..

3. SURNAME:…………………………………… FIRST NAMES:……………………….

4. MAIDEN NAME (IF MARRIED):……………………………………………………..

5. INDEX NUMBER:……………………………………………………………………...

6. DATE PROGRAMME COMMENCED:………………………………………………..

7. PERMANENT HOME ADDRESS: VILLAGE:……………………………………..
   T/A:…………………………………………...
   DISTRICT:……………………………………

8. CONTACT ADDRESS:……………………………………………………………….

9. NAME OF SCHOOL:…………………………………………………………………..

10. PLEASE TICK EXAMINATION BEING APPLIED FOR:

COMMUNITY HEALTH NURSING TECHNICIAN ☐

FIRST ADMISSION ☐

RE-ADMISSION:

- 2ND ATTEMPT ☐

- 3RD ATTEMPT ☐

OTHER (SPECIFY) ☐

SIGNATURE OF STUDENT:……………………………………DATE:………………………

I certify that this form is being submitted subject to the following conditions:

a) The candidate has completed the required theoretical instructions and clinical experiences.

b) Candidate has passed the theoretical examination conducted by the school.

c) The candidate has attained satisfactory performance in clinical nursing.

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
<u>LILONGWE 3</u>

PNT/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PSYCHITRIC NURSING TECHNICIANS EXAMINATION

INSTRUCTIONS

Number 1 to 10 to be completed by candidate

Numbers A to C to be completed by the person in-charge of the programme

OFFICE USE
FEE:...
ELIGIBLE:......................................
EXAM. NO.:..................................

1. ENCLOSED EXAMINATION FEE:..

2. DATES OF EXAMINATION:..

3. SURNAME:.. FIRST NAMES:............................

4. MAIDEN NAME (IF MARRIED):...

5. INDEX NUMBER:..

6. DATE PROGRAMME COMMENCED:...

7. PERMANENT HOME ADDRESS: VILLAGE:...

   T/A:..

   DISTRICT:...

8. CONTACT ADDRESS:...

9. NAME OF SCHOOL:…………………………………………………………………..

10. PLEASE TICK EXAMINATION BEING APPLIED FOR:

COMMUNITY HEALTH NURSING TECHNICIAN	☐	**FIRST ADMISSION**	☐
		RE-ADMISSION:	
		- 2ND ATTEMPT	☐
		- 3RD ATTEMPT	☐
		OTHER (SPECIFY)	☐

SIGNATURE OF STUDENT:……………………………………DATE:………………………

I certify that this form is being submitted subject to the following

conditions:

a) The candidate has completed the required theoretical instructions and clinical experiences.

b) Candidate has passed the theoretical examination conducted by the school.

c) The candidate has attained satisfactory performance in clinical nursing.

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

CHNT/PNT/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

FEE PAID:………………………..

DATE………………………………

RECEIPT NO:……………………

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

[ ] Nursing Midwifery Technician (NMT)

[ ] Psychiatric Nursing Technician (PNT)

[ ] Community Health Nursing Technician (CHNT)

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:………………………………………………………

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

NURSES MIDWIVES COUNCIL OF MALAWI

FORM CHNT/C

COMMUNITY HEALTH NURSING TECHNICIAN PROGRAMME

Statement of completed THEORETICAL experience requirements for the One Year Programme of the Community Health Nursing Technician.

College/School of Nursing:………………………………………………………………

Address:……………………………………………………………………..……………………..

This Statement covers the period from:…………………………………………………..

Subject/Course	**Hours**
Introduction to Community Health Nursing	……………….
Introduction to Sociology	……………….
Introduction to Psychology	……………….
Communication	……………….
Introduction to Epidemiology	……………….
Control of Specific Communicable and non communicable Diseases	……………….
Community Health Nursing	……………….
Community Health Nursing Skills	……………….
Child Spacing	……………….
Mental Health and Psychiatric Nursing	……………….
Teaching and Management	……………….
Others (Please Specify):	
………………..………………..………………..………………	……………….
………………………………………………………………………	……………….
………………..………………..………………..……………..	……………….
Total	……………….

Name………………………………………………………… Date………………………

Title……………………………………………………………………………………………

School Stamp

NURSES MIDWIVES COUNCIL OF MALAWI

FORM PNT/C

RECORD OF TRAINING AND NOTIFICATION OF COMPLETION OF TRAINING FOR THE COURSE OF PSYCHIATRIC NURSING TECHNICIAN PROGRAMME

NAME OF TRAINING SCHOOL:……………………………………………………………………

INDEX NUMBER OF NURSES AND MIDWIVES COUNCIL:…………………………………..

SURNAME OF STUDENT:…………………………………………………………………………

FIRST NAMES IN FULL:……………………………………………………………………………

DATE OF COMPLETION OF TRAINING:……………………………………………………..

LEAVE TAKEN DURING THE TRAINING PERIOD (SICK LEAVE, VACATION LEAVE OR ANY OTHER LEAVE TAKEN).

TYPE OF LEAVE	FROM	TO	NUMBER OF DAYS
……………………………	………………….	……………	……………………...
……………………………	………………….	……………	………………………
……………………………	………………….	……………	………………………
……………………………	………………….	……………	………………………
……………………………	………………….	……………	………………………

TOTAL NUMBER OF DAYS OF ATTENDING THEORETICAL TRAINING AT THE LECTURE ROOMS:……………………………………………………………………………………

CLINICAL TRAINING IN THE WARDS/DEPARTMENTS

	DAY : DAYS	NIGHT : DAYS	TOTAL : DAYS
Ward for the Mentally Subnormal: …………………………………………………………			
Admission Units and Units for Neuroses: …………………………………………………………			
Long-Term and Security Units: ……………………			
Child and Adolescent Units:………………………			
Psychogeriatric Units:………………………………			
Community and Rehabilitation Units: …………………………………………………………			

NB: CHILD – ADOLESCENT UNIT NOT READY. EXPERIENCE DONE ON WARDS WHERE THEY HAD CHILDREN

THEORETICAL TRAINING: TOTAL NUMBER OF LECTURES/DEMONSTRATIONS GIVEN

SUBJECTS	**NUMBER OF LECTURE/ DEMONSTRATION**
Introduction to Psychiatric Nursing:	....
Psychology:	....
Psychiatry:	....
First Aid:	....
Nutrition and Dietetics:	....
Anatomy and Physiology:	....
Psychiatric Nursing Science:	....
Psychiatry:	....
Ward Management and Clinical Teaching:	....
Other Lectures (Specify):	....
	....
	....
	....

....

SIGNATURE OF PERSON INCHARGE OF TRAINING   **DATE**