



FORM RNM/D

SUMMARY OF COMPLETED CLINICAL EXPERIENCE FOR PART II

INSTRUCTIONS:

This form must be completed and signed by the Principal or his or her designated of the College of Nursing where the applicant pursued the course.

NAME OF COLLEGE:.....

ADDRESS:.....

I certify that:.....

SURNAME

FIRST NAMES

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:.....

District Midwifery:.....

Family Planning:.....

Night Duty:.....

Others (Specify):.....

.....

.....

PROCEDURE	NO. REQUIRED	NO. DONE
Complete assessment of pregnant woman at first antenatal visit.	_____	_____
Complete assessment of pregnant woman on subsequent antenatal visits.	_____	_____
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	_____	_____

TOTAL LEAVE GRANTED TO THE APPLICANT DURING COURSE:

Vocational leave:.....

Sick leave:.....

Other leave:.....

2

Signature of Principal:..... Date:.....

Official Stamp:

Please return to:

The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
Capital City
LILONGWE 3



FORM RNM/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE REGISTERED NURSE MIDWIVES EXAMINATION

INSTRUCTIONS:

Number 1 to 11 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 MK.....
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:.....
..... TEL/CELL:.....

9. NAME OF COLLEGE:.....

10. REGION AT WHICH EXAMINATION WILL BE TAKEN (**indicate North, Central or South**).....

11. PLEASE (TICK) EXAMINATION BEING APPLIED FOR:

PART I **FIRST ADMISSION**

PART II **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:.....

Please return to:

The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
Capital City
LILONGWE 3



FORM RNM/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 the part of register to which this
application applies:

Malawi Registered Nurse (RN)

Malawi Registered Midwife (RM)

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:.....

Please return to:

The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
Capital City
LILONGWE 3



FORM RNM/C

SUMMARY OF COMPLETED CLINICAL EXPERIENCE FOR (PART I)
OF THE REGISTERED NURSE MIDWIFE PROGRAMME

INSTRUCTIONS:

This form must be completed and signed by the Principal or his or her designated of the College of Nursing where the applicant pursued the course.

NAME OF COLLEGE:.....

ADDRESS:.....

I certify that:.....

SURNAME

FIRST NAMES

Was indexed with the Nurses and Midwives Council on:

.....
DATE MONTH YEAR

Date course commenced:.....

Date course completed:.....

DETAILS OF INSTRUCTION UNDERGONE BY APPLICANT:

Community Nursing:.....

Medical Nursing:.....

Surgical Nursing:.....

Paediatric Nursing:.....

Gynaecological Nursing:.....

Psychiatric Nursing:.....

Ophthalmic Nursing:.....

Operating Theatre:.....

Outpatient and Casualty:.....

Family Planning.....

Night Duty:.....

Others (Specify):.....

Total _____

Total leave granted to the applicant during _____

Vocational leave _____

Sick leave _____

Other leave _____

Submitted by:.....

Signature:.....

Date:.....

Official Stamp:

Please return to:

The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
Capital City
LILONGWE 3



FORM RNM/E

SUMMARY OF A CASE FOR REGISTERED NURSE MIDWIFE
(PART II) PROGRAMME

INSTRUCTIONS:

This form must be completed immediately after the student has completed a case.

NAME OF STUDENT:.....

TYPE OF CASE:.....DATE OF DELIVERY:.....

- I. Describe student's ability to assess the patient completely and accurately including:
 - a) Review of previous records
 - (i) Antenatal card
.....
.....
 - (ii) Labour and delivery record (for postpartum and newborn management)
 - b) Taking histories:.....
.....
.....
 - c) Performs Physical Examinations:.....
.....
.....
 - d) Ordering appropriate diagnostic studies:.....
.....
 - e) Analysing and synthesizing the information gathered:.....

.....
II. Describe student's ability to PLAN the patient care comprehensively by:

a) Prioritizing care planned:.....
.....
.....

b) Setting goals and objectives:.....
.....
.....

c) Planning interventions:.....
.....

III. Describe the student's ability to IMPLEMENT care safely and efficiently by:

a) Performing skills appropriately:.....
.....

b) Consulting and referring as necessary:.....
.....

c) Educating the patient and family:.....
.....

d) Giving drugs appropriately:.....
.....
.....

IV. Describe student's ability to EVALUATE care accurately:.....
.....
.....

V. Describe effectiveness of students follow-up care for 6 weeks postpartum (for NSVD Case only)

.....
.....
.....

Assessor's Comments:.....
.....

..... 2

Student's performance was SATISFACTORY / UNSATISFACTORY
(Circle one)

Signature of assessors: 1.
2.

Student's Comments:.....
.....
.....

Signature of Student:.....