



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):.....

.....

.....

<b>PROCEDURE</b>	<b>NO. REQUIRED</b>	<b>NO. DONE</b>
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.	_____	_____
	_____	_____
<b>CASE STUDIES:</b>		
Normal delivery.	_____	_____
Abnormal deliveries	_____	_____

**TOTAL LEAVE GRANTED TO THE APPLICANT DURING COURSE:**

Vacational leave:.....

Sick leave:.....

Other leave:.....

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/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:..... K T  
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:.....

Official Stamp:

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:.....  
.....  
.....

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

Signature of assessors: 1. ....  
2. ....

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

Signature of Student:.....