MARCH 2023

FORM DE-MHPN/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE-(MENTAL HEALTH & PSYCHIATRY) EXAMINATION

INSTRUCTIONS:

Numbers 1 to 12 are to be completed by candidates

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

OFFICE USE
FEE……
ELIGIBLE……
EXAM NUMBER……
EXAM RESULTS……
MK……

1. ENCLOSED EXAMINATION FEE……..
2. DATES OF EXAMINATION……
3. SURNAME……FIRST NAME……..
   MAIDEN NAME (If Married)……
4. INDEX NUMBER……NATIONAL ID NUMBER……
5. DATE PROGRAMME COMMENCED……
6. PERMANENT HOME ADDRESS:
   VILLAGE……..
   T/A……..
   DISTRICT……
7. CONTACT ADDRESS……
   ……
   PHONE NUMBER……EMAIL ADDRESS……
8. NAME OF UNIVERSITY/COLLEGE……
9. REGION AT WHICH EXAMINATION WILL BE TAKEN: **NORTH** ☐
   CENTRAL ☐ **SOUTH** ☐

10. PLEASE TICK EXAMINATION BEING APPLIED FOR:

FIRST ADMISSION ☐ RE-ADMISSION ☐

11. IF READMISSION INDICATE THE NUMBER OF ATTEMPT

SECOND ATTEMPT ☐ THIRD ATTEMPT ☐

FOURTH ATTEMPT ☐ OTHER (PLEASE SPECIFY)

12. IF IT IS NOT THE FIRST ATTEMPT INDICATE THE SPECIFIC EXAMINATION PAPER APPLYING

PAPER ONE ☐ PAPER TWO ☐

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. The candidate has passed the theoretical examination conducted by the school.
c. The candidate has attained satisfactory performance in clinical nursing.

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

SIGNATURE……DATE……

OFFICIAL STAMP

Return the form to:

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

MARCH 2023

FORM DE-MHPN/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Professional Nurses (Mental Health and Psychiatry) maintained by the Nurses and Midwives Council of Malawi

FOR OFFICIAL USE

FEE PAID MK……

RECIEPT NUMBER……

Indicate with a [√] the register which this application is made

[ ] Malawi Professional Nurse (Child Health) (AHN)

STATE CLEARLY

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

Enclosed initial Registration fee MK……Receipt No……

Student Index Number……National ID Number……

Surname……First Name……

Other Names…….....Maiden Name (if Married)……

Date of Birth……/……/……

Permanent Home address:
Village……T/A……District……

Nationality……

Signature of applicant……Date……/……/……

Name of Head of Institution/Designate……

Signature……Date……/……/……

OFFICIAL STAMP

Return the form to:

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

MARCH 2023 **FORM DE-MHPN/C**

SUMMARY OF THE PROFESSIONAL NURSE (MENTAL HEALTH &PSYCHIATRY) CLINICAL EXPERIENCE

INSTRUCTIONS:

This form must be completed and signed by the Principal or his/her designate of the training institution where the candidate pursued the course.

Name of Institution……....

Address……

I certify that …… ……..

SURNAME FIRST NAME

Was indexed by the Nurses and Midwives Council on……/……./……

Date Course Commenced…../……./……Date course completed……/…../…..

SUMMARY OF CLINICAL EXPERIENCE ACQUIRED BY THE CANDIDATE

Clinical Site	**Prescribed Hours**	**Total Hours Completed**
Basic Nursing	240	
Human Nutrition	160	
Medical-Surgical Nursing		
i. Medical ward	240	
ii. Surgical ward	240	
iii. OPD/Casualty	120	
STI, ART Clinic	160	
Counselling	240	
Psychiatry		

Clinical Site	Prescribed Hours	Total Hours Completed
i. Psychiatric OPD Clinic/Outreach clinic	160	
ii. PHC	200	
Psychiatric Nursing	960	
i. Acute Care Unit	720	
ii. Rehabilitation	240	
Child and Adolescent Psychiatry		
i. Child Development Centre (Hospital &Community)	120	
ii. Orphanage care centre	120	
iii. Children's Village	80	
iv. Youth Friendly Services	80	
Maternity Mental Health	**320**	
i. Antenatal Clinic	160	
ii. Postnatal Clinic	160	
Community Mental Health Nursing	**560**	
I. Psychogeriatric Nursing	80	
II. Community Diagnosis	80	
III. Community Rehabilitation	80	
IV. Home Visiting	80	
V. School Health	120	
VI. Occupational Health	40	
VII. Victim support unit	80	
Ward Management	120	

Clinical Site	Prescribed Hours	Total Hours Completed
TOTAL HOURS	**4120**	

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

RESULTS OF CLINICAL ASSESSMENTS

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
1	Child Psychiatry			
2	Adult Psychiatry			
3	Drug abuse patient			
4	Alcohol abuse patient			
5	Epileptic patient			

OTHER CLINICAL EXPERIENCE

	Procedure	No. Required	No. of cases Done
1	Physical assessments (10 male 10 female)	20	
2	Physical assessment of a neonate	20	
3	Tepid Sponging	10	
	IV insertion, care and removal	20	
3	Bed bath	20	
4	Wound dressing	10	
5	Suturing and Removal of sutures	5	

	Procedure	No. Required	No. of cases Done
6	Screening under-five children	20	
7	Initiating children on CPAP	10	
8	Collecting blood samples for Dry Blood Sample (DBS)	10	
9	Care of bedridden children	10	
10	Care of children with burns	10	
11	Insertion and removal of urethral catheter	5	
12	Insertion and removal of oro/nasogastric tube	10	
13	Commence and care for children on blood transfusion	10	
14	Initiate children on ART	5	
15	Provide infant feeding counselling to women	5	
16	Conduct assessments of infants at one week	2	
17	Conduct assessments of infants at 6th week	10	

Signature of Principal/ Designate:……Date:……/……/……

OFFICIAL STAMP

Please Return to:

The Registrar

Nurses and Midwives Council of Malawi

P.O. Box 30361

Capital City,

LILONGWE 3