MARCH 2023

FORM DE-COMHN/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE-(COMMUNITY HEALTH) 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-COMHN/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Community Health Nurses 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 (Community Health) (COMHN)

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:

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

SUMMARY OF THE PROFESSIONAL NURSE (COMMUNITY HEALTH) 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**
Fundamentals of Nursing	240	
Communicable and Non Communicable diseases	**760**	
Surgical Ward	240	
Medical Ward	240	
Eye ward/clinic	120	
Skin Clinic	80	
TB Ward	160	
Community Mental Health and Psychiatric	200	

CLINICAL SITE	Prescribed Hours	Total Hours Completed
STI, ART Clinic	160	
One Stop Centre Youth Friendly Services	160	
Oncology Nursing	**240**	
Medical Clinics (Palliative care clinic, diabetic, epilepsy, hypertension Paediatrics)	120	
Oncology Ward	120	
Fundamentals of Child Health Nursing	**320**	
Neonatal ward	80	
Paediatric Wards/ clinics Nutritional rehabilitation	240	
Obstetrics and gynaecology nursing	**800**	
Family Planning	320	
Gynaecology ward	120	
Antenatal Clinic	120	
Labour ward	120	
Postnatal	120	
Health Promotion	**680**	
School Health	200	
Under five care -	240	
Refugee Camp, Prisons, Orphanage	80	
Occupational Health	160	
Human Nutrition	160	
Home Health Care/	**160**	

CLINICAL SITE	Prescribed Hours	Total Hours Completed
Home Visiting, KMC follow-up care and Geriatrics	160	
Community Assessment	**160**	
Leadership and Management in Nursing	**120**	
District Community Health Nursing Management	120	
TOTAL	**4160**	

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

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
1	The medically ill patient (on palliative /Home Based Care)			
2	Care of the Under-five child			
3	Management of a client seeking family planning services			
4	Care of a Mentally ill client			
5	School Child			

OTHER EXPERIENCES

	Procedure	No. Required	No. of cases Done
1	Physical assessments (10 male 10 female)	20	

	Procedure	No. Required	No. of cases Done
2	Tepid Sponging	10	
3	IV insertion, care and removal	20	
4	Bed bath	5	
5	Wound dressing	10	
6	Suturing and Removal of sutures	5	
7	Screening under-five children	40	
8	Initiation of ART drugs	10	
9	Initiate family planning methods for clients	40	
10	Care patient on palliative /Home based care:	5	
11	Administering immunizations	10	
12	Insertion and removal of urethral catheter	5	
13	Insertion and removal of oro/nasogastric tube	10	
14	Assess and classify Malaria cases	5	
15	Giving and removal of bedpans	5	

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

OFFICIAL STAMP

Please Return to:

The Registrar

Nurses and Midwives Council

P.O. Box 30361

Capital City,

LILONGWE 3