MARCH 2023

FORM DE-MID/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL MIDWIFE-DIRECT ENTRY LICENSURE EXAMINATION

INSTRUCTIONS:

Numbers 1 to 12 are to be completed by candidates

Numbers A to C are 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

MIDWIFERY PAPER ONE ☐ MIDWIFERY 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-MID/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Midwives 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 Midwife (PM)

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……

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-MID/C**

SUMMARY OF THE PROFESSIONAL MIDWIFE 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	HOURS	TOTAL HOURS	HOURS COMPLETED
Basic Nursing		**240**	
Medical Ward	120		
Surgical	120		
Women's Health		**880**	
Gynaecology ward	240		
Medical Ward	240		
Gynaecology Clinic	80		
Family Planning (Youth friendly services, VIA)	240		
Mental Health Clinic	80		

CLINICAL SITE	HOURS	TOTAL HOURS	HOURS COMPLETED
STI and ART Clinic		**160**	
STI Clinic	80		
ART clinic	80		
Management and Leadership	**160**	**160**	
Midwifery Science I		**720**	
Ante-natal Clinic	240		
Labour ward	320		
Post-natal Ward	160		
Midwifery Science II		**1200**	
Theatre	160		
ICU /HDU	160		
Antenatal Clinic	160		
Ante-natal Ward	160		
Labour ward	400		
Post-natal Ward	160		
Neonatal Science		**320**	
Neonatal Care ward	240		
Kangaroo Mother Care	80		
Community Midwifery		**360**	
Environmental Health	**80**		
Home visit/ Community Mobilization/ Health Centre	**160**		
One- and Six-weeks postnatal care /under five Clinic	**120**		
TOTAL HOURS	**4040**	**4040**	

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

RESULTS OF CLINICAL ASSESSMENTS

	ASSESSMENT TITLE	**NO. OF ENTRIES**	**RESULTS**	**COMMENT**
1	Basic Nursing Care			
2	Total Care for a critically ill woman			
3	Care of a Post–Caesarean Section Mother			
4	Home visiting			
5	Care of an Antenatal Mother on initial visit			
6	Care of a woman in Labour			
7	Care of a Postnatal mother in the first 48 hours			
8	Care of a Neonate in the first 48 hours			

MIDWIFERY CLINICAL EXPERIENCE

	Procedure	**No. Required**	**No. of cases Done**
1	Complete Assessment of pregnant women at first antenatal visit	**20**	
2	Complete assessment of pregnant women on a subsequent visit	**50**	
3	Vaginal examinations including pelvic assessment	**20**	

	Procedure	No. Required	No. of cases Done
4	Conduct spontaneous Vertex deliveries	**40**	
5	Performing and repairing episiotomies using local anaesthesia	**5**	
6	Repairing perineal tears/ lacerations using local anaesthesia	**3**	
7	Conduct deliveries by vacuum extraction	**6**	
8	Conducting Breech delivery	**2**	
9	Conducting multiple delivery	**2**	
10	Manage postnatal mothers and their babies during the hospital stay	**40**	
11	Providing PMTCT prophylactic drugs to infants	**5**	
14	Conducting postnatal assessments of mothers and infants at one week	**10**	
15	Conducting postnatal assessments of mothers and infants at 6th week	**12**	

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