MARCH 2023

FORM BSCNM/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE MIDWIFE EXAMINATION

INSTRUCTIONS:

Number 1 to 12 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/S APPLYING

NURSING PAPER ONE ☐ NURSING PAPER TWO ☐

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

MARCH 2023

FORM BSCNM/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Professional Nurses and 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 Nurse (PNM)

[ ] Malawi Professional Nurse (PN)

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

MARCH 2023 **FORM BSCNM/C**

SUMMARY OF THE PROFESSIONAL NURSE MIDWIFE EXPERIENCE

INSTRUCTIONS:

This form must be completed and signed by the Principal or his/her designate of the training institution where the candidate pursed 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**	**HOURS COMPLETED**
Surgical Ward	280	
Medical Ward	280	
Family planning, including youth friendly reproductive health services, and VIA	160	
Under five clinic / IMCI	160	
Community Diagnosis and Home Visits	80	
School Health	80	
Occupational health	80	
Palliative care	40	

CLINICAL SITE	PRESCRIBED HOURS	HOURS COMPLETED
Environmental Health	40	
STI Clinic	80	
ART Clinic	80	
Mental Health and Psychiatric Nursing	240	
Ophthalmology (1 week - Clinic, 1 week - Ward)	80	
Skin clinic	40	
Accident and Emergency /ENT	120	
Intensive Care Unit /HDU	160	
Theatre	160	
Gynaecology	120	
Paediatric medical ward (including HDU,NRU)	160	
Paediatric surgical ward including Neuro and Musculo - Skeletal	160	
Administration (DNO's office / Health Centre Supervision/ Night Supervision or Call)	80	
Ward Management - (Maternity unit)	80	
Ante-natal Clinic	160	
Ante-natal Ward	120	
Labour ward	520	
Post-natal Ward	240	
Postnatal Clinic	40	
Neonatal Ward	160	
Kangaroo mother care (Kangaroo ward)	40	
TOTAL HOURS	**4200**	

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

RESULTS OF CLINICAL ASSESSMENTS

	ASSESSMENT TITLE	**NO. OF ENTRIES**	**RESULTS**	**COMMENT**
1	Care of a patient with a medical condition			
2	Care of a pre and post operative patient			
3	Care of the Under-five child			
4	Management of a client seeking family planning services			
5	Care of a patient with a Mental illness			
6	Home visiting			
7	Care of critically ill Paediatric Patient			
8	Care of the Antenatal woman at initial visit			
9	Care of a woman in Labour			
10	Care of a Postnatal Mother within 48 hours			
11	Care of a Neonate within the first 48 hours			

OTHER MIDWIFERY REQUIREMENTS

	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 subsequent visit	**50**	
3	Vaginal examinations including pelvic assessment	**20**	
4	Conduct spontaneous deliveries under minimum supervision	**40**	
5	Conduct deliveries by vacuum extraction	**6**	
6	Performing and repairing episiotomies using local anaesthesia	**5**	
7	Repairing perineal tears/ lacerations using local anaesthesia	**3**	
8	Conducting Breech delivery	**2**	
9	Conducting multiple delivery	**2**	
10	Care of postnatal mothers and their infants during the hospital stay	**40**	
11	Conducting postnatal assessments of mothers and infants at one week	**6**	
12	Conducting postnatal assessments of mothers and infants at 6th week	**6**	

	Procedure	No. Required	No. of cases Done
13	Provide PMTCT prophylactic drugs to infants	**5**	
14	Management of a neonate on CPAP	**5**	
15	Commencing a neonate on CPAP	**2**	
16	Conduct bimanual compression	**1**	

Signature of Principal/ Designate:.....Date:...../...../.....

OFFICIAL STAMP

Return the form to:

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