MARCH 2023

FORM CMA/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE COMMUNTY MIDWIFERY ASSISTANT

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

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 CMA/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the roll of Community Midwifery Assistants 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

[ ] Community Midwifery Assistant

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……..

Surname……First Name……

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

Date of Birth……/……/……

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

Nationality……National ID number……..

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 CMA/C**

SUMMARY OF THE COMMUNITY MIDWIFERY ASSISTANT'S CLINICAL 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 Area	Prescribed Hours	Hours Completed
Medical-Surgical Nursing	280	
Antenatal Clinic	320	
Antenatal ward	40	
Labour Ward	800	
Postnatal Clinic	20	
Postnatal Ward (Normal)	200	
Family Planning	120	
Home Visit	20	
Health Centre	240	

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

MIDWIFERY REQUIREMENTS

	Procedure	No. Required	No. of cases Done
1	Complete Assessment of pregnant women at first antenatal visit	**50**	
2	Complete assessment of pregnant women on subsequent visit	**70**	
3	Vaginal examinations including pelvic assessment	**60**	
4	Conduct spontaneous deliveries under minimum supervision	**50**	
5	Examination of placenta and membranes for completeness and abnormalities	**20**	

	Procedure	No. Required	No. of cases Done
6	Performing and repairing episiotomies using local anaesthesia	**3**	
7	Repairing perineal tears/ lacerations using local anaesthesia	6	
8	Witness Breech delivery	3	
9	Witness multiple delivery	3	
10	Care of postnatal mothers and their babies	50	
11	Conducting postnatal assessments of mothers and infants at one week	10	
12	Conducting postnatal assessments of mothers and infants at 6th week	10	
13	Resuscitate babies with Asphyxia	5	
14	Observe Manual removal of placenta	1	
15	Conducting Bi-manual compression	1	
16	Observe vacuum Extractions	3	
17	Initiating clients on Family Planning	5	
18	IV Insertion and removal	10 each	
19	Bed Bath	10	
20	Tepid sponging	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