



APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE COMMUNITY 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

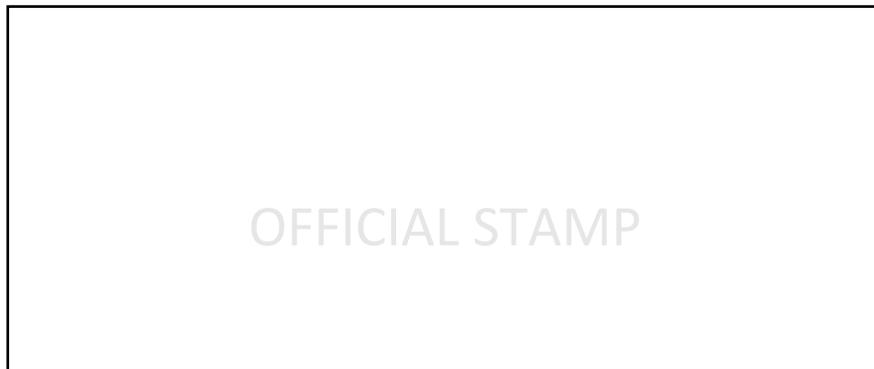
SIGNATURE OF STUDENT:.....DATE:.....

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.....



Return the form to:

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



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

| |
|--|
| <p>FOR OFFICIAL USE</p> <p>FEE PAID MK.....</p> <p>RECIPT NUMBER.....</p> |
|--|

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:

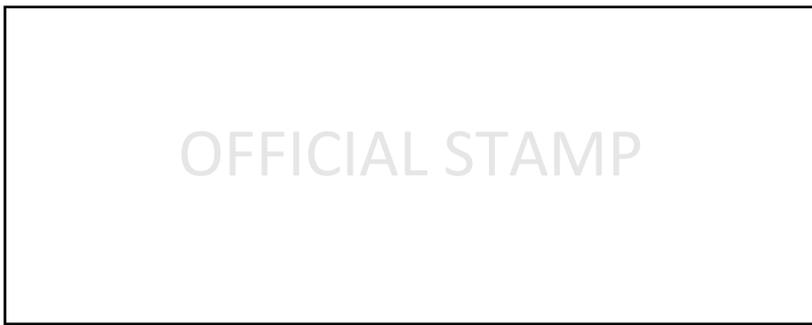
Village.....T/A.....District.....

Nationality.....National ID number.....

Signature of applicant.....Date...../...../.....

Name of Head of Institution.....

Signature.....Date...../...../.....



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LILONGWE 3



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 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 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 6 th 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