MARCH 2023

FORM RN/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE REGISTERED NURSE (DIPLOMA) EXAMINATION

INSTRUCTIONS:

Numbers 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 ☐

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:

OFFICIAL STAMP

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

MARCH 2023

FORM RN/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Nurses/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 Registered Nurse (RN)

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……Email address……

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 RN/C**

SUMMARY OF THE REGISTERED NURSE 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 NURSING CLINICAL EXPERIENCE ACQUIRED BY THE CANDIDATE

	Experience	**Prescribed Hours**	**Number of Hours Completed**
1	Medical Ward	400	
2	Surgical Ward	400	
3	Paediatric Ward	320	
4	Gynaecology Ward	200	
4	Mental Health	240	
5	**Community Health Nursing**	**880**	
	Under five	240	
	Nutrition Clinics	80	
	Community assessment and intervention	160	

	Home Visiting	80	
	Family Planning	40	
	Visits to special Groups	40	
	School Health	240	
	Occupational Health	80	
6	Operating theatre	160	
7	Outpatient/Casualty	320	
8	District Hospital Experience	160	
	Others		
10			
11			

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

	ASSESSMENT TITLE	**NO. OF ENTRIES**	**RESULTS**	**COMMENT**
1	Total Care for a critically ill patient			
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	Home visiting			
6	Care of a Mentally ill client			

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
7	Care of a Paediatric Patient with medical condition			

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

OFFICIAL STAMP

Please Return to:

The Registrar

Nurses and Midwives Council

P.O. Box 30361

Capital City,

LILONGWE 3