



**APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE
MIDWIFE (UPGRADING) 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

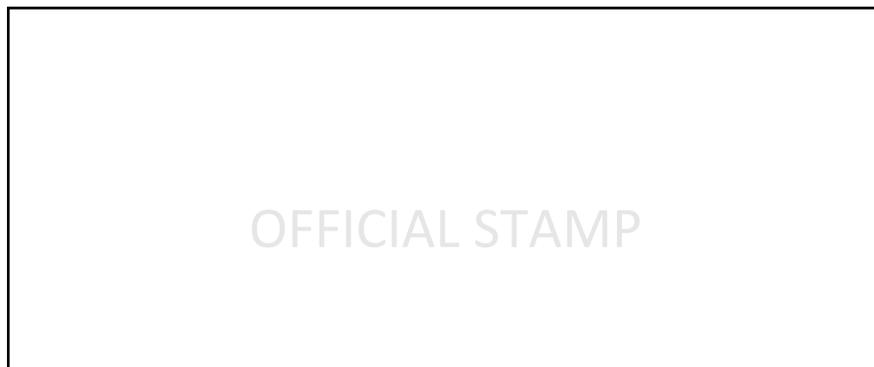
SIGNATURE OF STUDENT:.....DATE:.....

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.....



MARCH 2023



FORM NMT-BSCNM/UP/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.....
RECIPT NUMBER.....

Indicate with a the register which this application is made

Malawi Professional Nurse Midwife (PNM)

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...../...../.....



Return the form to The Registrar
Nurses and Midwives Council of Malawi
P.O. Box 30361
LILONGWE 3



SUMMARY OF THE PROFESSIONAL NURSE MIDWIFE (NMT-UPGRADING) 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	PRESCRIBED HOURS	HOURS COMPLETED
Surgical Ward	160	
Medical Ward	160	
Ophthalmology (1 week - Clinic, 1 week - Ward)	80	
Skin clinic	40	
Accident and Emergency /ENT	120	
Intensive Care Unit /HDU	160	
Mental Health and Psychiatric Nursing	160	
Oncology Ward	80	
Paediatric Ward/ Nutrition rehabilitation unit	160	

CLINICAL SITE	PRESCRIBED HOURS	HOURS COMPLETED
Paediatric clinics and OPD	80	
STI, ART Clinic	120	
Sexual Reproductive Health		
Gynaecology ward	120	
Family Planning	160	
Community health Nursing	520	
School Health	120	
Under five care / Nutritional Rehabilitation	160	
Occupational Health	120	
Home Visiting / Community Assessment/community midwifery	120	
Leadership and Management	160	
ICU/ dialysis	120	
Theatre	120	
Ante-natal Clinic	80	
Ante-natal Ward	80	
Labour ward	480	
Post-natal Ward	120	
Neonatal Ward	120	
TOTAL HOURS	3080	

N.B. clinical experiences were combined.

Please indicate clearly where

RESULTS OF CLINICAL ASSESSMENTS

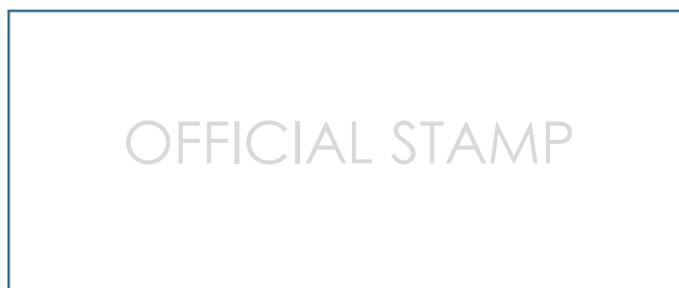
	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
1	Total Care for a Medically ill patient			
2	Care of a Critically ill paediatric patient			
3	Care of a patient with a mental illness			
4	Care of a Patient requiring pre and post-operative care			
5	Home visiting			
6	Care of antenatal woman at first visit			
7	Care of a woman in labour			
8	Care of a postnatal mother within 48 hours			
9	Care of a neonate within 48 hours			

OTHER MIDWIFERY EXPERIENCES

	Procedure	No. Required	No. of cases Done
1	Complete Assessment of pregnant women at first antenatal visit	10	
2	Complete assessment of pregnant women on subsequent visit	15	

	Procedure	No. Required	No. of cases Done
3	Vaginal examinations including pelvic assessment	20	
4	Conduct spontaneous deliveries	20	
5	Conduct deliveries by vacuum extraction	6	
6	Performing and repairing episiotomies using local anaesthesia	3	
7	Repairing perineal tears/ lacerations using local anaesthesia	2	
8	Conducting Breech delivery	2	
9	Conducting multiple delivery	2	
10	Care of postnatal mothers and their infants during the hospital stay	25	
11	Conducting postnatal assessments of mothers and infants at 6 th week	9	
12	Resuscitation of a neonate	5	
13	Conduct bimanual compression	3	

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



Return the form to

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P.O. Box 30361
LILONGWE 3