MARCH 2023

FORM BSCN/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE 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 ☐

IF READMISSION INDICATE THE NUMBER OF ATTEMPT

SECOND ATTEMPT ☐ THIRD ATTEMPT ☐

FOURTH ATTEMPT ☐ OTHER (PLEASE SPECIFY)

11. 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

Return the form to:

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

MARCH 2023

FORM BSCN/B

APPLICATION FOR REGISTRATION

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

Return the form to:

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

MARCH 2023 **FORM BSCN/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 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	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	
Environmental Health	40	

CLINICAL SITE	PRESCRIBED HOURS	HOURS COMPLETED
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	
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			

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
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			

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

OFFICIAL STAMP

Return the form to:

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