**MARCH 2023**

**FORM RNM DIP-UP/A**

## APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE DIPLOMA REGISTERED 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……

OFFICIAL STAMP

**MARCH 2023**

**FORM RNM/DIP-UP/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 Midwife (RNM)

**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……National ID number……..

Signature of applicant……Date……/……/……

Name of Head of Institution……..……..

Signature……Date……/……/……...

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**MARCH 2023** **FORM RNM/DIP-UP/C**

## SUMMARY OF THE REGISTERED NURSE MIDWIFE (DIPLOMA-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 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 NURSING CLINICAL EXPERIENCE ACQUIRED BY THE CANDIDATE**

| | **Experience** | **Prescribed Hours** | **Number of Hours Completed** |
|---|---|---|---|
| 1 | Medical Ward | 240 | |
| 2 | Surgical Ward/Gynaecology | 200 | |
| 3 | Paediatric Ward | 200 | |
| 4 | Mental Health Nursing | 160 | |
| 5 | Community Health Nursing | 440 | |
| 6 | Operating theatre | 120 | |
| 7 | Outpatient/Casualty | 80 | |
| 8 | Ward Management | 160 | |

| | Experience | Prescribed Hours | Number of Hours Completed |
|---|---|---|---|
| 9 | Antenatal Clinic | 120 | |
| 10 | Antenatal Ward | 40 | |
| 11 | Labour and Delivery | 440 | |
| 12 | Postnatal Ward | 120 | |
| 13 | Postnatal Clinic | 40 | |
| 14 | Neonatal Care | 120 | |
| 15 | District Experience | 160 | |

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 | Management of a client seeking family planning services | | | |
| 4 | Home visiting | | | |
| 5 | Care of a Mentally ill client | | | |
| 6 | Care of a Paediatric Patient with medical condition | | | |
| 7 | Care of the Antenatal mother on initial visit | | | |
| 8 | Care of a Woman in Labour | | | |

| | ASSESSMENT TITLE | NO. OF ENTRIES | RESULTS | COMMENT |
|---|---|---|---|---|
| 9 | Care of a Postnatal mother in the first 48 hours | | | |
| 10 | Care of a Neonate in the first 48 hours | | | |

**OTHER REQUIREMENTS**

| | 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 | **20** | |
| 3 | Vaginal examinations including pelvic assessment | **10** | |
| 4 | Conduct spontaneous deliveries | **20** | |
| 5 | Examine placenta and membranes for completeness and abnormalities | **10** | |
| 6 | Conduct deliveries by vacuum extraction | **5** | |
| 7 | Performing and repairing episiotomies using local anaesthesia | **3** | |
| 8 | Repairing perineal tears/ lacerations using local anaesthesia | **3** | |
| 9 | Conducting Breech delivery | **3** | |

| | Procedure | No. Required | No. of cases Done |
|---|---|---|---|
| 10 | Conducting multiple delivery | **2** | |
| 11 | Care of postnatal mothers and their babies | **20** | |
| 12 | Conducting postnatal assessments of mothers and infants at 1st week | **6** | |
| 13 | Conducting postnatal assessments of mothers and infants at 6th week | **6** | |

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