



**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

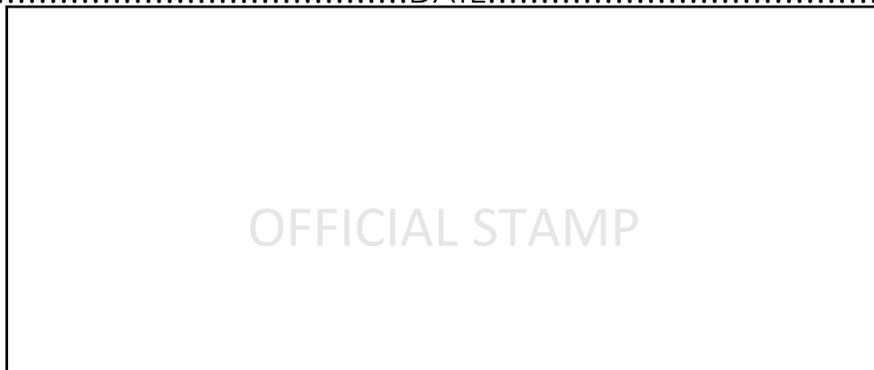
SIGNATURE OF STUDENT:.....DATE:.....

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.....



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.....

RECIPT 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...../...../.....





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 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	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			

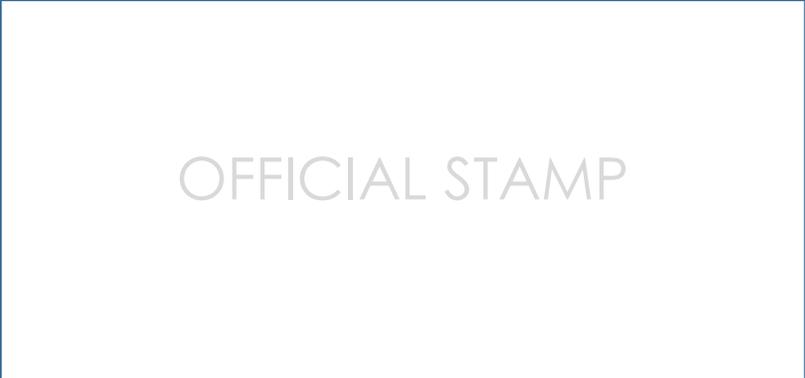
	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
9	Care of a Postnatal mother in the first 48 hours			
10	Care of a Neonate in the first 48 hours			

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 1 st week	6	
13	Conducting postnatal assessments of mothers and infants at 6 th week	6	

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



Please Return to: The Registrar
 Nurses and Midwives Council of
 Malawi
 P.O. Box 30361
 Capital City, Lilongwe