MARCH 2023

FORM DE-AHN/A

APPLICATION FOR ADMISSION OR RE-ADMISSION TO THE PROFESSIONAL NURSE-(ADULT HEALTH) EXAMINATION

INSTRUCTIONS:

Numbers 1 to 12 are 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 APPLYING

PAPER ONE ☐ 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 DE-AHN/B

APPLICATION FOR REGISTRATION

I hereby make application for my Name to be entered on the register of Adult Health 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 (Adult Health) (AHN)

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/Designate……

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 DE-AHN/C**

SUMMARY OF THE PROFESSIONAL ADULT HEALTH 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 CLINICAL EXPERIENCE ACQUIRED BY THE CANDIDATE

CLINICAL SITE	**TOTAL HOURS**	**HOURS COMPLETED**
Basic Nursing	240	
Human Nutrition	160	
STI, HIV and AIDS	160	
Medical Nursing	640	
Surgical Nursing	640	
Critical Care		
Theatre Nursing	240	
High Dependence Unit	200	
Intensive Care Unit	240	
Trauma and emergency	200	

CLINICAL SITE	TOTAL HOURS	HOURS COMPLETED
Dialysis	120	
Obstetrics and Gynaecology		
Antenatal clinic	80	
Gynaecology ward	320	
Family Planning	200	
Oncology Nursing		
In-patient	80	
Outpatient	120	
Home Visit	40	
Palliative care clinic	80	
Mental Health and Psychiatric Nursing	160	
Management	120	
Total Hours	**4040**	

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

RESULTS OF CLINICAL ASSESSMENTS

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
1	Basic Nursing Care			
2	Total Care for a critically ill patient			
3	Care of a pre and Post – operative patient			
4	Care of a medically ill patient			

	ASSESSMENT TITLE	NO. OF ENTRIES	RESULTS	COMMENT
5	Care of a surgically ill patient			

CLINICAL EXPERIENCE

	Procedure	No. Required	No. of cases Done
1	Physical assessments (3 male 3 female)	**6**	
2	Tepid sponging	**5**	
3	Bed bath	**10**	
4	Wound dressing	**10**	
5	Comprehensive care for bedridden patients	**8**	
6	Comprehensive care for geriatric patients	**3**	
7	Insertion and removal of urethral catheter	**10**	
8	Comprehensive care to critically ill patients	**3**	
9	Removal of sutures	**6**	
10	Manual Vacuum Aspiration	**5**	

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 3