NURSES AND MIDWIVES COUNCIL OF MALAWI

APPLICATION FOR REGISTRATION FOR NURSES/MIDWIVES TRAINED OUTSIDE MALAWI

INSTRUCTIONS TO THE APPLICANT

1. This form should be completed by the applicant
2. Use block letters when filling out the form
3. If the name inscribed on the certificate is different from the one above please provide supporting legal documents
4. A detailed curriculum vitae should be provided

Personal details

SURNAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

MAIDEN NAME (if married): _____

YEAR, DATE & PLACE OF BIRTH: _____

NATIONALITY: _____

HOME ADDRESS: _____

_____

CONTACT ADDRESS (in Malawi): _____

_____

LANGUAGES SPOKEN FLUENTLY: _____

Education Information

HIGHEST EDUCATIONAL QUALIFICATIONS: _____

NAME ADDRESS OF SECONDARY SCHOOL: _____

_____

MALAWI SCHOOL CERTIFICATE OF EDUCATION (MSCE) OR ITS EQIVALENT: _____

SUBJECT	GRADES OBTAINED
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Employment Information

Employment record for the past 5 years

Date of first appointment	Type of experience	Employer's address
1.		
2.		
3.		
4.		
5.		

	Name & address of training school	Date training commenced	Date training completed	Qualification obtained	Name of registering authority	Registration number	Date of Registration
General Nurse							
Midwife							
Community Health Nursing							
Psychiatric Nursing							
Paediatric Nursing							
Other (please specify)							

Declaration

I hereby make my application for my name to be entered on the register/roll maintained by the Nurses and Midwives Council of Malawi.

Indicate with a tick (√) the register/roll to which this application applies.

- ☐ General Nurses Register
- ☐ Midwives Register
- ☐ Community Health Nurses Register
- ☐ Psychiatric Nurses Register
- ☐ Enrolled Nurses Roll
- ☐ Enrolled Midwives Roll
- ☐ Enrolled Community Health Nurses Roll
- ☐ Enrolled Psychiatric Nurses Roll

Signature of Applicant: _____

Date: _____

Please return this form to:

The Registrar
Nurses and Midwives Council of Malawi
PO Box 30361
Lilongwe 3
MALAWI

Revised: November 2008

NURSES AND MIDWIVES COUNCIL OF MALAWI

APPLICATION PROCEDURE FOR REGISTRATION

It is a legal requirement in this country that nurses trained abroad should be registered with the Nurses and Midwives Council of Malawi. They must also simultaneously apply for a work permit before they start work in any institution in Malawi. This also applies to those nurses/midwives who wish to do voluntary work.

REGISTRATION PROCEDURE

1. Complete form 1A of the attached forms and send it to the Nurses and Midwives Council together with:

   a. An application fee of MK_____ for both registered and enrolled nurses/midwives and nursing midwifery technicians.
   b. Copies of professional certificates. If these certificates are not in English, official translations are required. (Assistance with translations is offered by the NMCM at a fee)
   c. Copies of transcripts
   d. 2 Passport sized photographs

   Forms 1B, 1C and 1D should be sent to the authorities concerned.

2. On arrival in Malawi, the applicant must report to the Nurses and Midwives Council office for a personal interview. The interviews are done on Wednesday mornings and there is need to make an appointment. Appointments can be made by phone on 01772044 or 01772730.

3. The applicant's name will only be entered on a temporary register upon satisfactory completion of the application forms and submission of required professional documents.

Northern Region

Mzuzu Central Hospital	Mzuzu
St John's Hospital	Mzuzu
Ekwendeni Hospital	Mzuzu

Central Region

Kamuzu Central Hospital	Lilongwe
Bwaila Maternity Hospital	Lilongwe
Nkhoma Mission Hospital	Lilongwe
Malawi College of Health Sciences	Lilongwe campus

Southern Region

Zomba Central Hospital	Zomba
Queen Elizabeth Central Hospital	Blantyre
Malamulo Hospital	Thyolo
Malawi College of Health Sciences	Zomba campus/Blantyre campus

In addition to these institutions, District Hospitals are eligible to be used for orientation.

5. The Registrar will be responsible for arranging the orientation programme for the applicant.

6. The head of the hospital/institution will be required to submit to the Council a detailed report of the orientation programme undergone by each applicant

7. Subject to a satisfactory orientation, the applicant will be passed by Council. The nurse/midwife will then be required to pay the prevailing registration fee for that particular cadre. The nurse/midwife's name will be entered on a permanent register and a certificate of registration/enrolment will be issued.

REGISTRAR

Revised: November, 2008

NMCM/REG/1D

NURSES AND MIDWIVES COUNCIL OF MALAWI

VERIFICATION FORM

INSTRUCTIONS TO THE APPLICANT

1. This form should be completed by the registering body or the professional regulatory body

2. The form must be sent directly to:

   The Registrar
   Nurses and Midwives Council of Malawi
   PO Box 30361
   Lilongwe 3
   Malawi

3. If the names appearing on this form are not the same as those appearing on the certificates please provide supporting documents.

This is to certify that:

_____ _____ _____
(first name) (middle name) (last name)

_____
(maiden name if married)

Was issued a certificate of: (tick which is applicable)

- ☐ Registration
- ☐ Enrolment
- ☐ As a General Nurse
- ☐ As a Midwife
- ☐ Other qualification (please specify)

Revised: November 2008

Date of registration: _____

Did the applicant qualify by completing a state prepared examination ?

Yes
No

Has the certificate ever been revoked?

Yes
No

If yes, please give reason(s)

_____
_____
_____
_____
_____

When was the registration last renewed?

Date: _____
Country: _____

Signature: _____
Date: _____

Stamp or Seal of Nursing Board/Council granting original registration

Please return this form to:

The Registrar
Nurses and Midwives Council of Malawi
PO Box 30361
Lilongwe 3
MALAWI

Revised: November 2008

NURSES AND MIDWIVES COUNCIL OF MALAWI

TRANSCRIPTS FROM NURSING TRAINING SCHOOLS

INSTRUCTIONS TO THE APPLICANT

1. This form must be filled in and signed by the head of the training institution where the applicant pursued his/her professional course.
2. When completed the form must be sent directly to the Nurses and Midwives Council of Malawi.

This is to certify that:

SURNAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

MAIDEN NAME (if married): _____

Was admitted at: _____
(Name of School of Nursing)

_____
(Address)

PERIOD OF TRAINING

Date training commenced: _____
Date training completed: _____
Language of instruction: _____

RECORD OF LEAVE

Holiday: _____
Sick Leave: _____

RECORD OF THEORETICAL INSTRUCTION AND GRADES OBTAINED

Subject	Hours	Grades obtained
Anatomy and Physiology		
Microbiology		
Trends and issues in Nursing		
Health Education		
Nursing Principles and Practice		
Fundamentals		
Pharmacology		
Ethico-legal aspects of nursing		
Nutrition		
Medical Nursing		
Surgical Nursing		
Paediatric Nursing		
Ear, Nose and Throat		
Ophthalmic Nursing		
First Aid		
Emergency Nursing		
Community Health Nursing		
Communicable diseases		
Psychology		
Psychiatric Nursing		
Gynaecology		
Other Specialties (please specify)		
_____		
_____		

RECORD OF CLINICAL PRACTICE AND GRADES OBTAINED

Department	No.of weeks	Grades Obtained
Medical Nursing		
Surgical Nursing		
Paediatric Nursing		
Operating Theatre Nursing		
Outpatients		
Community Health Nursing		
Gynaecological Nursing		
Psychiatric Nursing		
Other (please specify)		
_____		
_____		

FACILITIES USED DURING CLINICAL PLACEMENT BY THE APPLICANT

Total number of Hospital beds _____

Surgical beds _____
Medical beds _____
Paediatric beds _____
Gynaecology beds _____
Psychiatric beds _____
Other specialties (please specify)

_____ _____
_____ _____
_____ _____

Average number of qualified tutors/clinical instructors during the entire period of training _____

Signature of Head of Institution _____

Date: _____ _____ _____
(day) (month) (year)

Stamp or Seal of Institution

Please return this form to:

The Registrar
Nurses and Midwives Council of Malawi
PO Box 30361
Lilongwe 3
MALAWI

NURSES AND MIDWIVES COUNCIL OF MALAWI

TRANSCRIPTS FROM MIDWIFERY TRAINING SCHOOLS

INSTRUCTIONS

1. This form must be filled in and signed by the head of the midwifery training institution where the applicant pursued his/her professional course.
2. When completed the form must be sent directly to the Nurses and Midwives Council of Malawi.

This is to certify that:

SURNAME: _____

FIRST NAME: _____

MIDDLE NAME: _____

MAIDEN NAME (if married): _____

Was admitted at: _____
(Name of School of Midwifery)

_____
(Address)

PERIOD OF TRAINING

Date training commenced: _____
Date training completed: _____
Language of instruction: _____

RECORD OF LEAVE

Holiday: _____
Sick Leave: _____

RECORD OF THEORETICAL INSTRUCTION AND GRADES OBTAINED

Subject	Hours	Grades obtained
Anatomy and Physiology of Obstetrics	_____	_____
Normal Pregnancy	_____	_____
High risk/abnormal pregnancy	_____	_____
Neonatology	_____	_____
Health education	_____	_____
Family Planning	_____	_____
Other Specialties (please specify)		
_____	_____	_____
_____	_____	_____

RECORD OF CLINICAL PRACTICE AND GRADES OBTAINED

Department	No.of weeks	Grades Obtained
Antenatal clinic	_____	_____
Antenatal Inpatients ward	_____	_____
Labour ward & Delivery Suite	_____	_____
Postnatal ward (low risk)	_____	_____
Postnatal ward (high risk)	_____	_____
Neonatal nursery	_____	_____
Isolation	_____	_____
Postnatal clinic	_____	_____
Obstetric Theatres	_____	_____
Other (please specify)		
_____	_____	_____
_____	_____	_____

RECORD OF PRACTICAL ASSESSMENTS AND CASE STUDIES DONE

1. Number of antenatal history takings recorded by the student
   _____
2. Number of antenatal examinations (first booking)performed by the student
   _____
3. Number of antenatal examinations (subsequent) performed by the student
   _____
4. Number of vaginal examinations of woman in labour performed by the student
   _____
5. Number of deliveries conducted by the student midwife
   _____
6. Number of neonatal examinations conducted by the student
   _____
7. Any other (please specify) _____ _____
   _____ _____
   _____ _____

FACILITIES USED DURING CLINICAL PLACEMENT BY THE APPLICANT

Antenatal Inpatient _____
Labour ward/Delivery Suite _____
Postnatal wards (low risk/high risk) _____
Neonatal Nursery _____
Obstetric theatre _____
Other specialties (please specify)
_____ _____
_____ _____
_____ _____

Average number of qualified midwifery tutors/clinical instructors during the entire period of training _____

Average number of normal confinements per year _____

Average number of high risk/abnormal confinements per year _____

Signature of Head of Institution _____

Date: _____ _____ _____
(day) (month) (year)

Stamp or Seal of Institution

Please return this form to:

The Registrar
Nurses and Midwives Council of Malawi
PO Box 30361
Lilongwe 3
MALAWI