

Place of disaster: ..... PM No: \_\_\_\_\_

Nature of disaster: .....

Date of disaster:

Male  Female  Other  Unknown

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

ADMINISTRATIVE DATA (checklist of operations in the mortuary)				Date	a	b	c
150	Body part	No 1 <input type="checkbox"/>	Yes (specify): 2 <input type="checkbox"/> _____				
155	Photographs taken	No 1 <input type="checkbox"/>	Yes by: 2 <input type="checkbox"/> _____				
160	Exhibits	No 1 <input type="checkbox"/>	Yes by: 2 <input type="checkbox"/> _____				
165	Prints taken from	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
	01 Finger(s)	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
	02 Palm(s)	No 1 <input type="checkbox"/>	Not Possible 2 <input type="checkbox"/>	Yes by: 3 <input type="checkbox"/> _____			
170	Examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	01 External examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	02 Partial autopsy	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify): 3 <input type="checkbox"/> _____			
	03 Full autopsy	No 1 <input type="checkbox"/>	Yes - See separate report 2 <input type="checkbox"/>				
	04 Pathologist name						
	Street / No. Postcode / Town State / Country Phone / Email						
175	Dental examination	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify in field 615) 3 <input type="checkbox"/>			
	01 Completed	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	Images (specify in field 615) 3 <input type="checkbox"/>			
	02 Odontologist name						
	Street / No. Postcode / Town State / Country Phone / Email						
180	Samples taken	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		
	01 By pathologist Reference to 545	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		
	02 By odontologist Reference to 610	No 1 <input type="checkbox"/>	Yes 2 <input type="checkbox"/>	DNA 3 <input type="checkbox"/>	Tox (if required) 4 <input type="checkbox"/>		

CHECKLIST OF CONTENTS	Enclosed complete	Not available	Remarks
Administrative Data (fields 1xx)			
Effects (fields 3xx)			
Body description (fields 4xx)			
Pathology (fields 5xx)			
Odontology (fields 6xx)			
Supporting information (fields 7xx)			
Appendix (fields 8xx) (optional)			

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EFFECTS						a	b	c					
<b>300 Clothing Items</b>	<b>No:</b> 1	Type/style	2	Main colour	3	Brand/make	4	Material	5	Size			
	<b>Head and neck</b>												
	101 Headcover												
	102 Scarf												
	103 Tie												
	199 Other												
	<b>Upper part of the body and arms</b>												
	201 Blouse												
	202 Braces												
	203 Brassiere												
	204 Cardigan												
	205 Coat/Jacket												
	206 Gloves												
	207 Overcoat												
	208 Pullover												
	209 Shirt												
	210 T-shirt												
	211 Undershirt												
	212 Waistcoat												
	299 Other												
<b>Lower part of the body and legs</b>													
301 Belt													
302 Shorts													
303 Skirt													
304 Socks													
305 Stockings													
306 Swimming attire													
307 Tights													
308 Trousers													
309 Underpants													
399 Other													
<b>The whole of the body</b>													
401 Body suit													
402 Dress													
403 Religious/Cultural/Traditional													
404 Uniform													
499 Other													
In case of using "x99 Other" describe the kind of item in column "1 Type/style".													
<b>305 Footwear</b>	<b>No:</b> 1	Type/style	2	Main colour	3	Brand/make	4	Material	5	Size			
	01 Boots												
	02 Open footwear												
	03 Shoes												
	99 Other												
Describe the kind of footwear in column "1 Type/style", e.g. sports shoes, sandals													

Only use these colours: Black, Blue, Brown, Green, Grey, Orange, Pink, Purple, Red, White, Yellow, Unknown.

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	Name	:	
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EFFECTS							a	b	c						
310	<b>Watch</b>	<b>No:</b> 1	Brand/make	2	Model	3	Main colour	4	Material	5	Inscription				
	01 Digital wristwatch														
	02 Analog wristwatch														
	03 Digital/analog w.														
	04 Smartwatch														
	05 If wristwatch, worn on	Left 1 <input type="checkbox"/>	Right 2 <input type="checkbox"/>	Outside 3 <input type="checkbox"/>	Inside 4 <input type="checkbox"/>										
	06 Watch strap/chain	Leather 1 <input type="checkbox"/>	Metal 2 <input type="checkbox"/>	Rubber 3 <input type="checkbox"/>	Other (specify): 4 <input type="checkbox"/>										
07 Watch, other type	Where worn: _____														
315	<b>Glasses</b>	1	Brand/make	2	Model	3	Main colour	4	Material	5	Inscription				
	01 Frame														
	02 Lenses (glass)	Self tinting 1 <input type="checkbox"/>	Tinted 2 <input type="checkbox"/> No	3 <input type="checkbox"/> Yes (specify): _____											
	03 Shape of lenses	Round 1 <input type="checkbox"/>	Oval 2 <input type="checkbox"/>	Square 3 <input type="checkbox"/>	Half 4 <input type="checkbox"/>	Rimless 5 <input type="checkbox"/>	Full rim 6 <input type="checkbox"/>								
	04 Lenses material/type	Glass 1 <input type="checkbox"/>	Polycarbonate 2 <input type="checkbox"/>	Bi-focal 3 <input type="checkbox"/>	Progressive 4 <input type="checkbox"/>										
320	<b>Contact lenses</b>	No 1 <input type="checkbox"/>	Yes (if coloured specify): 2 _____												
325	<b>Hearing aids</b>	No 1 <input type="checkbox"/>	Yes (specify): 2 _____							Serial No: _____					
	01 Left	No 1 <input type="checkbox"/>	Yes (specify): 2 _____							Serial No: _____					
325	02 Right	No 1 <input type="checkbox"/>	Yes (specify): 2 _____							Serial No: _____					
	330	<b>External prostheses</b>	No 1 <input type="checkbox"/>	Yes (specify): 2 _____							Serial No: _____				
335	<b>Jewellery</b>	<b>No:</b> 1	Type/style	2	Main colour	3	Material	4	Inscription	5	Where worn				
	01 Anklet														
	02 Bracelets														
	03 Earclips														
	04 Earrings														
	05 Neck chains														
	06 Necklace														
	07 Nose ring														
	08 Pendant on chain														
	09 Wedding ring														
	10 Other rings														
	99 Other														
	In case of using "99 Other" describe the kind of item in column "1 Type/style".														

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EFFECTS							a	b	c
<b>340 Identity documents</b>  01 Bank cards 02 Driving licence 03 Identity card 04 Passport 99 Other  In case of using "99 Other" describe the kind of item in column "3 Details".	<b>No:</b>	<b>1 Nationality</b>	<b>2 Number</b>	<b>3 Details</b>	<b>4 Biometrics</b>	<b>5 Chip</b>			
<b>345 Effects</b>  01 Badges/keys 02 Bum bag 03 Currency 04 Diary/agenda 05 Purse 06 Ticket 07 Wallet 99 Other  In case of using "99 Other" describe the kind of item in column "2 Model".	<b>No:</b>	<b>1 Brand/make</b>	<b>2 Model</b>	<b>3 Main colour</b>	<b>4 Material</b>	<b>5 Serial No.</b>	<b>6 Markings</b>		
<b>350 Electronic devices</b>  01 Camera 02 Mobile phone 03 Music player 04 SIM 05 Tablet/handheld 06 Video 99 Other  In case of using "99 Other" describe the kind of item in column "2 Model".	<b>No:</b>	<b>1 Brand/make</b>	<b>2 Model</b>	<b>3 Main colour</b>	<b>4 Material</b>	<b>5 Serial No.</b>	<b>6 Markings</b>		

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BODY DESCRIPTION (external)		a	b	c
402	State of the body	Complete 1 <input type="checkbox"/>	Incomplete 2 <input type="checkbox"/>	
404	Specific details	No: 1	2	3
	Head and neck	Scars	Piercings	Tattoos
	01 Head			
	02 Neck			
	Torso			
	03 Torso front			
	04 Torso back			
	05 Genitalia			
	06 Buttocks			
	Upper limbs			
	07 Right upper arm			
	08 Left upper arm			
	09 Right forearm			
	10 Left forearm			
	11 Right hand	No: 4	5	6
	12 Left hand	Skin marks	Malformations	Amputations
	Lower limbs			
	13 Right thigh			
	14 Left thigh			
	15 Right knee			
	16 Left knee			
	17 Right lower leg			
	18 Left lower leg			
	19 Right foot			
	20 Left foot			
408	Height	Min _____ cm / Max _____ cm	Min _____ ft _____ in / Max _____ ft _____ in	
412	Weight	Min _____ kg / Max _____ kg	Min _____ lb / Max _____ lb	
416	Build	Slight 1 <input type="checkbox"/>	Medium 2 <input type="checkbox"/>	Large 3 <input type="checkbox"/>
420	Hair of the head	Natural 1 <input type="checkbox"/>	Extensions 2 <input type="checkbox"/>	Hairpiece 3 <input type="checkbox"/>
	01 Type	Wig 4 <input type="checkbox"/>	Implanted 5 <input type="checkbox"/>	
	02 Length	Short <6 cm / 2.4 in 1 <input type="checkbox"/>	Medium <12 cm / 4.7 in 2 <input type="checkbox"/>	Long >12 cm / 4.7 in 3 <input type="checkbox"/>
	03 Dyed colour	Shaved 4 <input type="checkbox"/>	None/unknown 1 <input type="checkbox"/>	Streaked 2 <input type="checkbox"/>
	04 Natural colour	Blond 3 <input type="checkbox"/>	Brown 4 <input type="checkbox"/>	Black 5 <input type="checkbox"/>
	05 Baldness	Red 6 <input type="checkbox"/>	Grey 7 <input type="checkbox"/>	White 8 <input type="checkbox"/>
	06 Distinctive feature(s)	Mixed grey 9 <input type="checkbox"/>	Other (specify): 10 _____	
		Blond 1 <input type="checkbox"/>	Brown 2 <input type="checkbox"/>	Black 3 <input type="checkbox"/>
		Red 4 <input type="checkbox"/>	Grey 5 <input type="checkbox"/>	White 6 <input type="checkbox"/>
		Mixed grey 7 <input type="checkbox"/>	Other (specify): 8 _____	
		Partial 1 <input type="checkbox"/>	Total 2 <input type="checkbox"/>	Forehead 3 <input type="checkbox"/>
		Sides 4 <input type="checkbox"/>	Tonsure 5 <input type="checkbox"/>	
		Describe (and use page Sup. Info. (700's) for details): _____		

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BODY DESCRIPTION (external)			a	b	c
424	<b>Eyebrows</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
428	<b>Eyes</b> 01 Colour (Left and Right) 02 Distinctive feature(s)	Blue 1 <input type="checkbox"/> <input type="checkbox"/> L R Grey 2 <input type="checkbox"/> <input type="checkbox"/> L R Green 3 <input type="checkbox"/> <input type="checkbox"/> L R Brown 4 <input type="checkbox"/> <input type="checkbox"/> L R Black 5 <input type="checkbox"/> <input type="checkbox"/> L R Hazel 6 <input type="checkbox"/> <input type="checkbox"/> L R Maroon 7 <input type="checkbox"/> <input type="checkbox"/> L R Pink 8 <input type="checkbox"/> <input type="checkbox"/> L R Cross-eyed 1 <input type="checkbox"/> <input type="checkbox"/> L R Squint-eyed 2 <input type="checkbox"/> <input type="checkbox"/> L R Artificial eye 3 <input type="checkbox"/> <input type="checkbox"/> L R Other (specify): 4 <input type="checkbox"/>			
432	<b>Nose</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
436	<b>Facial hair</b> 01 Type 02 Colour	Shaved 1 <input type="checkbox"/> Moustache 2 <input type="checkbox"/> Goatee 3 <input type="checkbox"/> Whiskers 4 <input type="checkbox"/> Full beard 5 <input type="checkbox"/> Other (specify on page 700's) 6 <input type="checkbox"/> Blond 1 <input type="checkbox"/> Brown 2 <input type="checkbox"/> Black 3 <input type="checkbox"/> Red 4 <input type="checkbox"/> Grey 5 <input type="checkbox"/> White 6 <input type="checkbox"/> Mixed grey 7 <input type="checkbox"/> Other (specify): 8 <input type="checkbox"/>			
440	<b>Ears</b> 01 Ear lobes/pierced 02 Distinctive feature(s)	Attached 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes Pierced - specify number of piercings 3 <input type="checkbox"/> Left 4 <input type="checkbox"/> Right No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
444	<b>Mouth/teeth</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
448	<b>Lips</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
452	<b>Chin</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
456	<b>Neck</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
460	<b>Hands/nails</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
464	<b>Feet/nails</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
468	<b>Body/pubic hair</b> 01 Distinctive feature(s)	No 1 <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/>			
472	<b>Circumcision</b>	No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/>			
476	<b>Ancestry</b>	European 1 <input type="checkbox"/> White African 2 <input type="checkbox"/> Black Asian 3 <input type="checkbox"/> Other 4 <input type="checkbox"/> Mixed (specify): 5 <input type="checkbox"/>			

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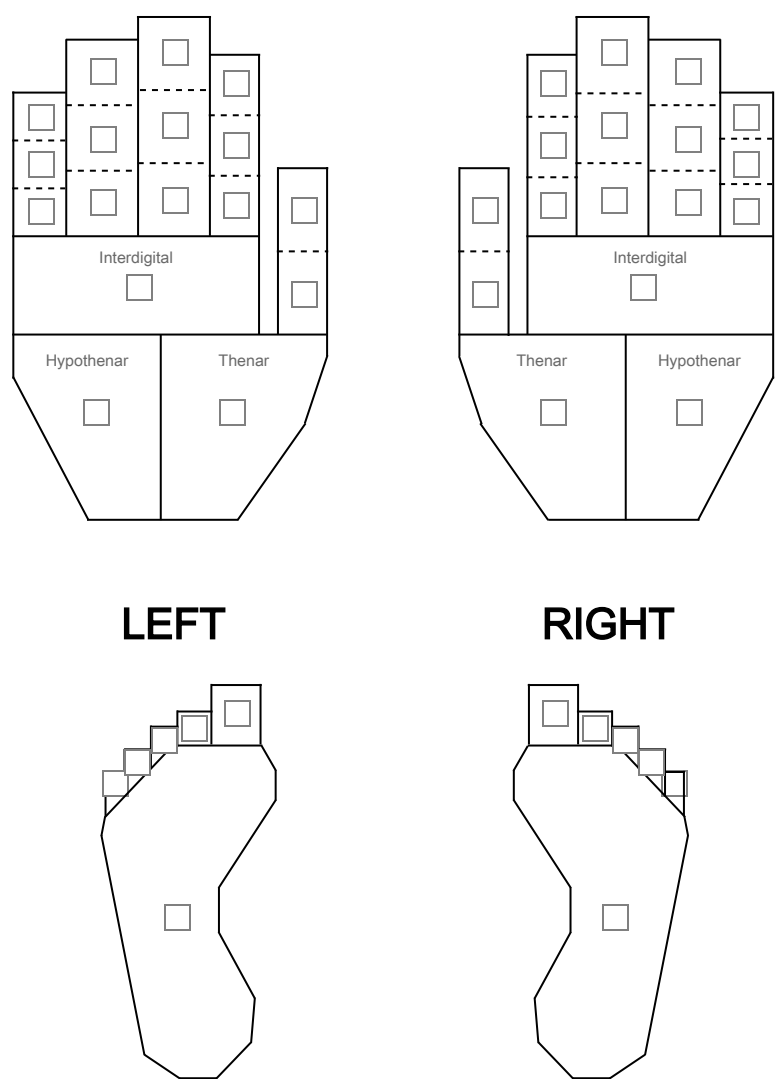
Date of disaster:

Day     Month     Year     Male     Female     Other     Unknown

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BODY DESCRIPTION (fingerprint information)		a	b	c			
484	Skin type prints retrieved from	<i>Epidermis</i> 1 <input type="checkbox"/>	<i>Dermis</i> 2 <input type="checkbox"/>				
488	Print development technique	<i>Washed and printed</i> 1 <input type="checkbox"/> <i>Epidermal glove</i> 3 <input type="checkbox"/> <i>Other (specify):</i> 5 <input type="checkbox"/> _____	<i>Boiling water technique</i> 2 <input type="checkbox"/> <i>Silicon based casting agent</i> 4 <input type="checkbox"/>				
492	Print development technique	<i>Black powder &amp; adhesive label</i> 1 <input type="checkbox"/> <i>Digital scanner</i> 3 <input type="checkbox"/> <i>Other (specify):</i> 5 <input type="checkbox"/> _____	<i>Ink</i> 2 <input type="checkbox"/> <i>Photograph</i> 4 <input type="checkbox"/>				
496	Prints retrieved from	 <p style="font-size: 24px; font-weight: bold; margin: 10px 0;">LEFT                      RIGHT</p> <p style="text-align: center; margin: 10px 0;">SHADE AREAS PRINTS RETRIEVED FROM</p>					

<b>Registered by</b> Duty Title    : Name                    : Address                : Phone / Email        :	Signature / Date
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PATHOLOGY				a	b	c				
510	<b>Internal examination</b>  <b>Head</b> 01 Brain 02 Neck 03 Skull 04 Other  <b>Chest</b> 10 Heart/vessels 11 Lungs 12 Thorax/ribs/sternum 13 Other  <b>Abdomen</b> 20 Appendix 21 Intestines 22 Stomach 23 Other  <b>Other internal organs</b> 30 Adrenals/pancreas/ Spleen 31 Genitalia 32 Kidneys/ureters/ Bladder 33 Liver/gall bladder  <b>Skeleton/soft tissue</b> 40 Left lower limb 41 Left upper limb 42 Pelvis 43 Right lower limb 44 Right upper limb 45 Other bones 46 Soft tissue, other locations  <b>Various</b> 50 Demonstrable pathological condition (e.g. heart disease, cancer etc.) 51 Healed fractures 52 Operations  <b>In women</b> 60 Births 61 Hysterectomy 62 Intrauterine contra- ceptive devices 63 Pregnancy	No: 1	<i>Specify</i>							
		515	<b>Implants</b>  01 Breast 02 Pacemaker 03 Insulin pump 04 Other surgical implants	No: 1	<i>Specify</i>	2	<i>Serial No.</i>			

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PATHOLOGY			a	b	c
520	Prostheses	No 1 <input type="checkbox"/>	Yes (specify): _____		Serial No: _____
525	Other artificial aids	No 1 <input type="checkbox"/>	Yes (specify): _____		
535	Sex	Male 1 <input type="checkbox"/>	Female 2 <input type="checkbox"/>	Undetermined 3 <input type="checkbox"/>	Reason: _____
540	Estimated age 01 Age (Fill either year or month) 02 Method used	Min _____ year	Max _____ year	Min _____ month	Max _____ month
		Specify: _____			
545	DNA specimens taken				
		Specimen No. _____			
		Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>	Blood 4 <input type="checkbox"/>
		Other (specify): _____			
		Swab-card spotted with: _____			
		Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Tissue 8 <input type="checkbox"/>	
		Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.	Advanced 4 <input type="checkbox"/> decomp.
		Skeletonized 5 <input type="checkbox"/>	Burnt 6 <input type="checkbox"/>		
		-----			
		Specimen No. _____			
		Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>	Blood 4 <input type="checkbox"/>
		Other (specify): _____			
		Swab-card spotted with: _____			
		Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Tissue 8 <input type="checkbox"/>	
		Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.	Advanced 4 <input type="checkbox"/> decomp.
		Skeletonized 5 <input type="checkbox"/>	Burnt 6 <input type="checkbox"/>		
		-----			
		Specimen No. _____			
		Bone 1 <input type="checkbox"/>	Teeth 2 <input type="checkbox"/>	Muscle 3 <input type="checkbox"/>	Blood 4 <input type="checkbox"/>
		Other (specify): _____			
		Swab-card spotted with: _____			
		Buccal cells 6 <input type="checkbox"/>	Blood 7 <input type="checkbox"/>	Tissue 8 <input type="checkbox"/>	
		Fresh 1 <input type="checkbox"/>	Slight 2 <input type="checkbox"/> decomp.	Moderate 3 <input type="checkbox"/> decomp.	Advanced 4 <input type="checkbox"/> decomp.
		Skeletonized 5 <input type="checkbox"/>	Burnt 6 <input type="checkbox"/>		
550	Further ID information				

<p><b>Registered by</b>    Duty Title    :</p> <p>                         Name                :</p> <p>                         Address            :</p> <p>                         Phone / Email    :</p>	<p>Signature / Date</p>
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Place of disaster: .....	PM No: _____														
Nature of disaster: .....															
Date of disaster: <table style="display: inline-table; border: none; vertical-align: middle;"> <tr> <td style="padding: 0 5px;">Day</td> <td style="padding: 0 5px;">Month</td> <td style="padding: 0 5px;">Year</td> <td style="padding: 0 5px;">Male</td> <td style="padding: 0 5px;">Female</td> <td style="padding: 0 5px;">Other</td> <td style="padding: 0 5px;">Unknown</td> </tr> <tr> <td style="text-align: center;">□ □</td> <td style="text-align: center;">□ □</td> <td style="text-align: center;">□ □ □ □</td> <td style="text-align: center;">□</td> <td style="text-align: center;">□</td> <td style="text-align: center;">□</td> <td style="text-align: center;">□</td> </tr> </table>	Day	Month	Year	Male	Female	Other	Unknown	□ □	□ □	□ □ □ □	□	□	□	□	
Day	Month	Year	Male	Female	Other	Unknown									
□ □	□ □	□ □ □ □	□	□	□	□									

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ODONTOLOGY					a	b	c	
<b>610</b>	<b>Material present for examination</b>	<i>Check</i>	<i>Specimen taken</i>					
	01 Jaws with teeth	<input type="checkbox"/> Upper <input type="checkbox"/> Lower						
	02 Jaws without teeth	<input type="checkbox"/> Upper <input type="checkbox"/> Lower						
	03 Teeth only	FDI No's:						
	04 Fragments							
	05 Other							
<b>615</b>	<b>Dental images available</b>	<b>1</b> Digital	<b>2</b> State number of	<b>3</b> Non digital	<b>4</b> State number of			
	01 PA	□		□				
	02 BW	□		□				
	03 OPG	□		□				
	04 CT	□		□				
	05 Other radiographs	□		□				
	06 Photographs	□		□				
<b>625</b>	<b>Supplementary details</b>	01 Condition of the body  02 Other details						

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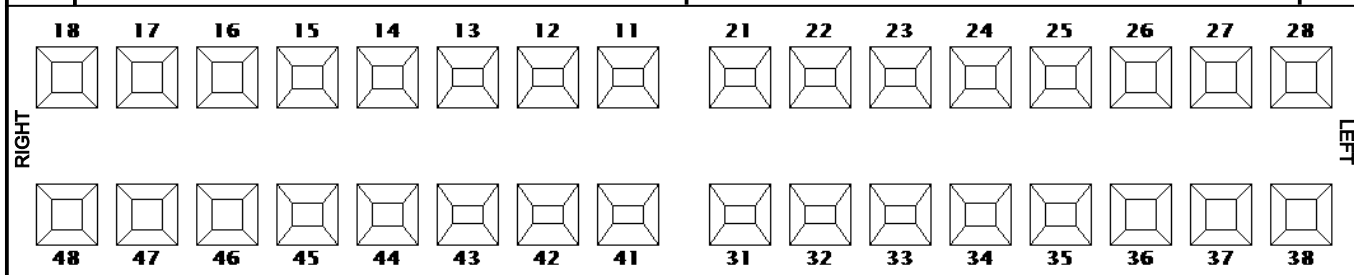
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**ODONTOLOGY**

**630 Dental findings (for primary teeth change specific FDI code)**

11			21
12			22
13			23
14			24
15			25
16			26
17			27
18			28



48			38
47			37
46			36
45			35
44			34
43			33
42			32
41			31

635	Specific data 01 Specify	1 <input type="checkbox"/> Crowns	2 <input type="checkbox"/> Pontics	3 <input type="checkbox"/> Implants	a	b	c
		4 <input type="checkbox"/> Dentures	5 <input type="checkbox"/> Other				
640	Other findings 01 Specify	1 <input type="checkbox"/> Occlusion	2 <input type="checkbox"/> Tooth wear	3 <input type="checkbox"/> Periodontal status			
		4 <input type="checkbox"/> Supernumeraries	5 <input type="checkbox"/> Stains	6 <input type="checkbox"/> Other			
645	Type of dentition 01 Dentition	1 <input type="checkbox"/> Primary dentition	2 <input type="checkbox"/> Mixed dentition	3 <input type="checkbox"/> Permanent dentition			
647	Estimated age 01 Age (Fill either year or month)	Min _____ year / Max _____ year	Min _____ month / Max _____ month				
650	Quality check FOd 1	Date: _____	Signature: _____				
		FOd 2 (If available)	Date: _____	Signature: _____			

Registered by	Duty Title	:	Signature / Date
	Name	:	
	Address	:	
	Phone / Email	:	









Place of disaster: .....	PM No: _____
Nature of disaster: .....	
Date of disaster: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

**805 APPENDIX DNA** a   b   c

810	Typing Laboratory	Name: _____ Email: _____				
		Address: _____				
		City: _____ Date of sample: _____				
815	Laboratory Standards	Accredited according to: _____		Not accredited 1 <input type="checkbox"/>		
820	STR kit(s) used	Name(s) of kit(s) used: _____				
825	DNA	Human Remains	Human Remains			
	VWA					
	TH01					
	D21S11					
	FGA					
	D8S1179					
	D3S1358					
	D18S51					
	Amelogenin					
	TPOX					
	CSF1PO					
	D13S317					
	D7S820					
	D5S818					
	D16S539					
	D2S1338					
	D19S433					
	Penta D					
	Penta E					
	D1S1656					
	D2S441					
	D10S1248					
	D22S1045					
	D12S391					
	SE33					
	D6S1043					
<i>Add any information not represented of the markers above, using c-column/page 700's Supporting information.</i>						
830				Additional DNA profile page (805-825)    1 <input type="checkbox"/> No    2 <input type="checkbox"/> Yes		

<b>Registered by</b> Duty Title : _____ Name : _____ Address : _____ Phone / Email : _____	Signature / Date _____
--	---------------------------



Place of disaster: .....

PM No: .....

Nature of disaster: .....

Date of disaster:

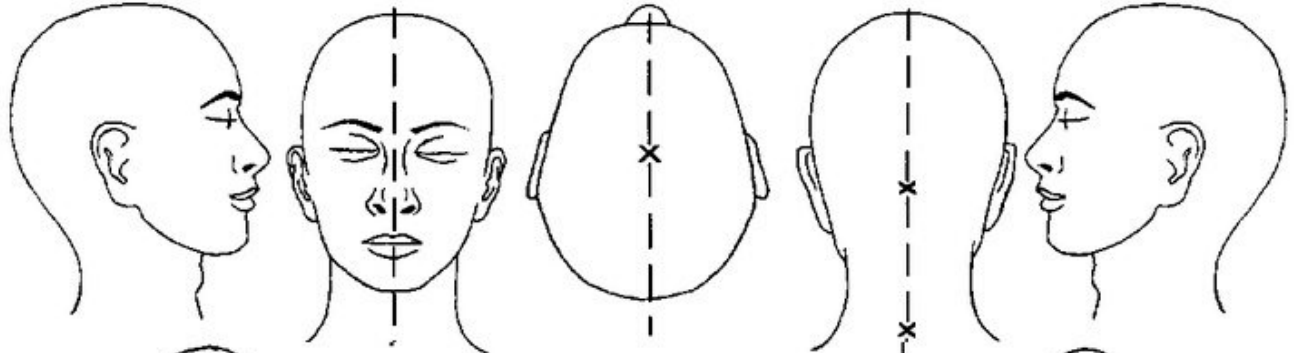
Male  Female  Other  Unknown

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

835 APPENDIX BODY SKETCH (for optional use)

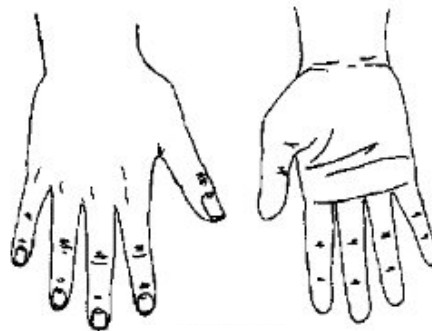
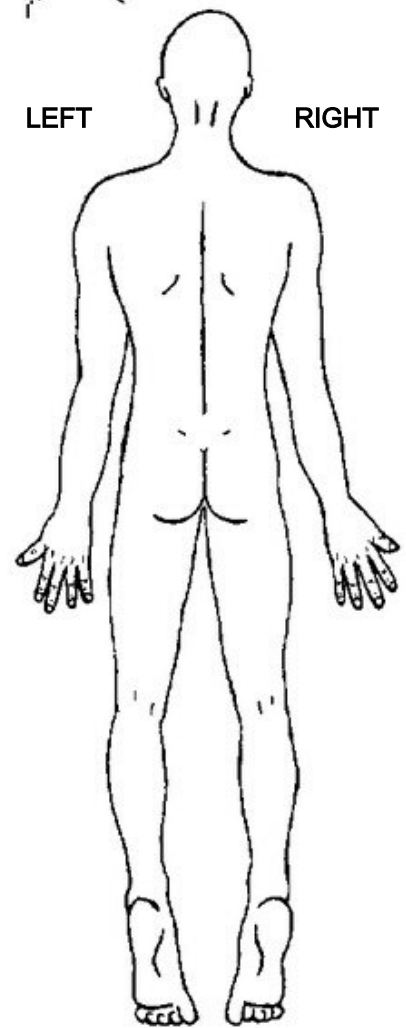
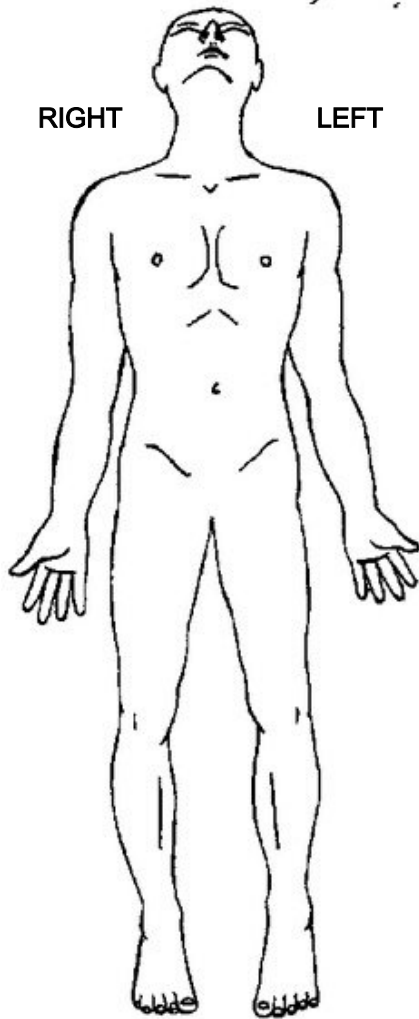


RIGHT

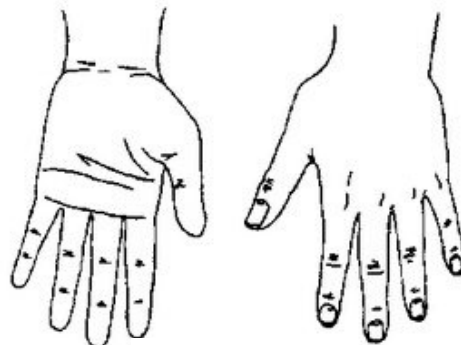
LEFT

LEFT

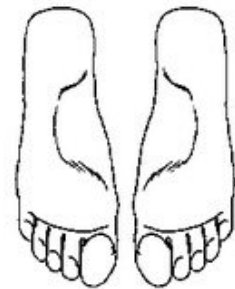
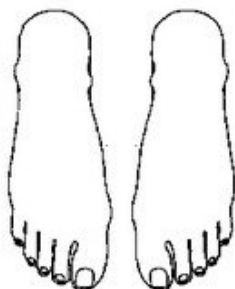
RIGHT



RIGHT



LEFT



Place of disaster: .....

PM No: .....

Nature of disaster: .....

Date of disaster: Day [ ] [ ] Month [ ] [ ] Year [ ] [ ] [ ] [ ]

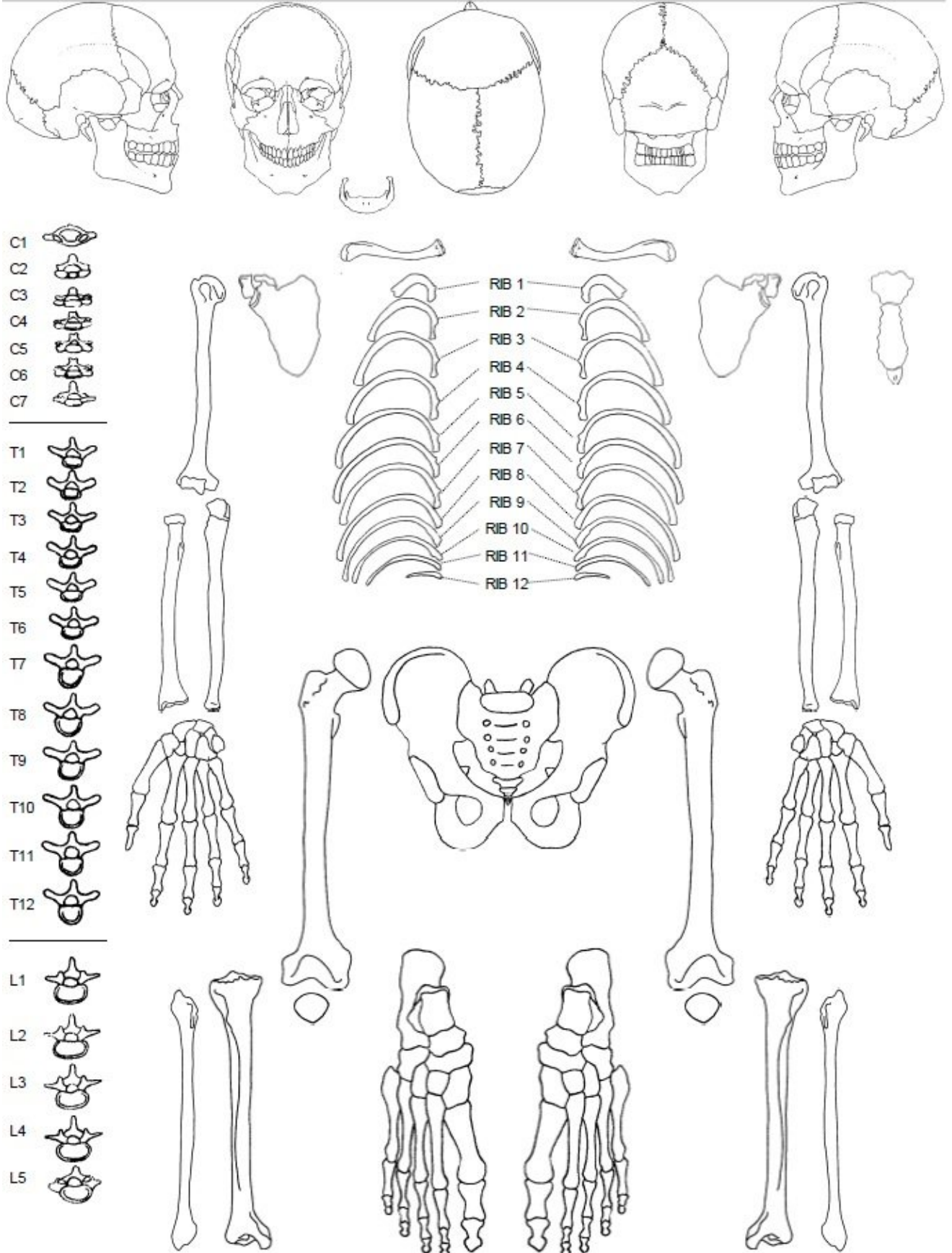
Sex: Male [ ] Female [ ] Other [ ] Unknown [ ]

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

840 APPENDIX SKELETON SKETCH (for optional use)



Place of disaster: ..... PM No: .....

Nature of disaster: .....

Date of disaster:

a = Data not available

b = Attachment

c = Further info on page Sup. Info. (700's)

850 APPENDIX RADIOLOGICAL EXAMINATION RECORD (for optional use)					a	b	c		
852	Modality	X-ray 1 <input type="checkbox"/>	CT 2 <input type="checkbox"/>	Fluoroscopy 3 <input type="checkbox"/>	Other (specify) 4 <input type="checkbox"/>				
854	Technical issues	No 1 <input type="checkbox"/>	Yes (specify): 2 <input type="checkbox"/>						
856	Type of remains	Human 1 <input type="checkbox"/>	Non-human 2 <input type="checkbox"/>	Comingled 3 <input type="checkbox"/>	Unsure 4 <input type="checkbox"/>				
858	State of remains	Intact 1 <input type="checkbox"/>	Incomplete 2 <input type="checkbox"/>	Individual body parts (specify): 3 <input type="checkbox"/>					
860	Disease processes	No 1 <input type="checkbox"/>	Yes (specify below) 2 <input type="checkbox"/>						
862	Dental work	No 1 <input type="checkbox"/>	Yes (specify below) 2 <input type="checkbox"/>						
864	Implants	No 1 <input type="checkbox"/>	Yes (specify below) 2 <input type="checkbox"/>						
866	Forensically significant findings	No 1 <input type="checkbox"/>	Yes (specify below) 2 <input type="checkbox"/>						
868	Hazards	No 1 <input type="checkbox"/>	Yes (specify below) 2 <input type="checkbox"/>						
870	Supplementary details								
872	Accompanying images	No 1 <input type="checkbox"/>	Yes (specify) 2 <input type="checkbox"/>						

Registered by	Duty Title	:	Signature / Date
	Name	:	
	Address	:	
	Phone / Email	:	