

DISASTER VICTIM IDENTIFICATION (DVI)

HOW TO USE THE YELLOW ANTE-MORTEM (AM) FORM

Please write legibly.

I. GENERAL INSTRUCTIONS

The AM Form is designed for listing any information that may be obtained from relatives, friends and/or physicians of the possible victim or missing person and that may assist in an identification, in order to compare that information with the data obtained from the dead bodies on the disaster site.

IMPORTANT: Record all information obtainable on the form, since it is impossible to know what data will be obtained from disaster site.

NOTE: It is important to obtain and forward detailed information as rapidly as possible.

Where provided, use the appropriate figures for description.

EXAMPLE: Section C1: Fill in the figures "0203" in the "No." column at item 24 to designate a pullover and describe the material, etc. In the space provided for this information.

Wherever appropriate, boxes that can simply be marked with a cross are provided. Please use as many of them as possible, This will facilitate electronic processing of the information and also make it possible to handle reports compiled in a foreign language without translation (the Interpol Member States all use the same forms). For this reason, the layout is the same for the AM and PM Forms. Because of this identical layout, some numbered spaces are left blank (e.g. item 31 in section D1: This is the space provided for the description of the state of the body on the pink PM Forms).

II. SPECIFIC INSTRUCTIONS

Section A1 & A2 Personal data of the possible victim or missing person.

Section B Not applicable here (section B of the pink form is the report on the recovery of the body from the site).

Sections C1 to C3 Description of effects (clothing, jewellery, etc.).

Section D1 to D3	Physical description.
Section D4	Record any distinguishing marks (tattoos, etc.).
Section D5	Record any fingerprint information.
Section E1 to E4	List any medical information that may assist in identification.
Section F1 & F2	Dental information (cf. instructions on the back of Section F1).
Section G	Record any further information that may assist in identification, and/or continue your description from a previous section (C to F) if there was not enough space.

It should be born in mind that photographs of the clothing, jewellery, etc. described in various sections may be of valluable help for comparison with items found on the disaster site. Please attach such photographs, if available.

MISSING PERSON		No: _____
Family name	: _____	<small>Barcode</small>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	<input type="checkbox"/> Male <input type="checkbox"/> Female

Nature of disaster :

Place of disaster :

Date of disaster : Day Month Year

Police force handling identification:	<i>NCB (country)</i>
	<i>Police file No:</i>

Reasons for assuming that person concerned is victim of disaster:

Police officers evaluation	<i>Is above person a victim?</i> <input type="checkbox"/> <i>Possibly</i> <input type="checkbox"/> <i>Probably</i> <input type="checkbox"/> <i>Undoubtedly</i>
DNA	<input type="checkbox"/> <i>Reference samples collected</i> <input type="checkbox"/> <i>Profiles ordered</i>

CHECK LIST OF CONTENTS	<i>Enclosed complete</i>	<i>Enclosed in part</i>	<i>Issued to Name</i>	<i>Date</i>	<i>Returned Date</i>	<i>Remarks</i>
A1 Info. relating to M.P.						
A2 Info.rela.to M.P.cont.						
C1 Clothing and Foot wear						
C2 Personal effects						
C3 Jewellery						
D1 Physical description						
D2 Physical desc. cont.						
D3 Physical desc. cont.						
D4 Body sketch						
D5 Fingerprint information						
E1 Medical information						
E2 Medical inform. cont.						
E4 DNA						
F1 Dental information						
F2 Dental inform.cont.						
G Further information						

MISSING PERSON		No: _____
Family name	:	<small>Barcode</small>
Forename(s)	:	
Date of birth	:	<input type="checkbox"/> <small>Male</small> <input type="checkbox"/> <small>Female</small>
	:	<input type="text"/> <small>Day</small> <input type="text"/> <small>Month</small> <input type="text"/> <small>Year</small>

a = Data not available b = Photo c = Further information on page G

INFORMATION RELATED to MISSING PERSON (cont.)			a	b	c
00	Information given by.. or: Name Address Phone/E-mail Relationship	Date: _____ 1 <input type="checkbox"/> See item 12			
01	Family name	Aliases ?			
02	Family name at birth	Mother's maiden name ?			
03	Forename(s)	Aliases ?			
04	Nationality	Birthplace Dual/Multiple nationality			
05	National ID number	<input type="text"/>			
	Country code	<input type="text"/>			
06	Name in Chinese Commercial Code	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
07	Date of birth	<input type="text"/> <small>Day</small> <input type="text"/> <small>Month</small> <input type="text"/> <small>Year</small> <input type="text"/> <small>Age at disappearance</small>			
08	Marital status	Single 1 <input type="checkbox"/> Engaged(date) 2 <input type="checkbox"/> _____ Cohabiting 3 <input type="checkbox"/> Married(date) 4 <input type="checkbox"/> _____ Separated 5 <input type="checkbox"/> Divorced 6 <input type="checkbox"/> Widowed 7 <input type="checkbox"/> Forename of partner: _____			
09	Occupation				
10	Full address	Street/No. Postcode/Town Country			
11	Religion	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes(name of religion): _____			
12	Next-of-kin	Name Address Phone/E-mail Relationship			
12 A	Blood relation (DNA)	Close relatives known or reference sample for DNA-comparison 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes - see page G			

Collected by	Duty Title : Name : Address : Phone/E-mail :	Signature / Date
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MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> <i>Day</i> <input type="text"/> <input type="text"/> <i>Month</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Year</i>	<input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>

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INFORMATION RELATED to MISSING PERSON (cont.)		a	b	c																																				
15	General practitioner	Name Address Phone/E-mail																																						
16	General dentist	Name Address Phone/E-mail																																						
17	Distinguishing features																																							
18	Photographs	1 <input type="checkbox"/> <i>Enclosed</i> 2 <input type="checkbox"/> <i>Obtainable from:</i> _____ 3 <input type="checkbox"/> <i>Photo suitable for dental overlay</i> <i>Record date:</i> _____																																						
19	Documents	<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">01 Official records</td> <td style="width: 15%;">1 <input type="checkbox"/> <i>Enclosed</i></td> <td style="width: 15%;">2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td style="width: 55%;">_____</td> </tr> <tr> <td>02 Police records</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>03 Practitioners records</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>04 Hospital records</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>05 Hospital X-rays</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>06 Dental records</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>07 Dental X-rays</td> <td>1 <input type="checkbox"/> <i>Enclosed</i></td> <td>2 <input type="checkbox"/> <i>Obtainable from:</i></td> <td>_____</td> </tr> <tr> <td>08 Dental plate ID-numbers</td> <td colspan="3"><i>(specify):</i> _____</td> </tr> <tr> <td>09 Other records</td> <td colspan="3"><i>(specify):</i> _____</td> </tr> </table>			01 Official records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	02 Police records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	03 Practitioners records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	04 Hospital records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	05 Hospital X-rays	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	06 Dental records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	07 Dental X-rays	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____	08 Dental plate ID-numbers	<i>(specify):</i> _____			09 Other records	<i>(specify):</i> _____		
01 Official records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
02 Police records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
03 Practitioners records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
04 Hospital records	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
05 Hospital X-rays	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
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07 Dental X-rays	1 <input type="checkbox"/> <i>Enclosed</i>	2 <input type="checkbox"/> <i>Obtainable from:</i>	_____																																					
08 Dental plate ID-numbers	<i>(specify):</i> _____																																							
09 Other records	<i>(specify):</i> _____																																							

Continued item no 24 (Item 20-23 in form PM only)

Collected by Duty Title : Name : Address : Phone/E-mail :	Signature / Date
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MISSING PERSON **No:** _____

Family name : _____ *Barcode*

Forename(s) : _____

Date of birth : Day Month Year Male Female

a = Data not available b = Photo c = Further information on page G

CLOTHING AND FOOT WEAR (carried on person or in luggage)						a	b	c		
24	Clothing Items	No:	1 Material	2 Colour	3 Type	4 Label	5 Size			
	01 Head and neck									
	0101 Hat									
	0102 Scarf									
	0103 Tie									
	0199 Other									
	02 Upper part of the body and arms									
	0201 Overcoat									
	0202 Coat									
	0203 Pullover									
	0204 Shirt									
	0205 Waistcoat									
	0206 Vest									
	0207 Dress									
	0208 Cardigan									
	0209 Blouse									
	0210 Petticoat									
	0211 Chemise									
	0212 Brassiere									
	0213 Braces									
	0214 Gloves									
	0215 Jacket									
	0299 Other									
	03 Lower part of the body and legs									
	0301 Trousers (men)									
	0302 Underpants									
	0303 Trousers (women)									
	0304 Skirt									
	0305 Panties									
	0306 Girdle									
	0307 Corset									
	0308 Stockings									
	0309 Tights									
	0310 Socks									
	0311 Belt									
	0312 Belt buckle									
	0313 Shorts									
	0314 Swimming attire									
	0399 Other									
	04 The whole of the body									
	0401 Flying suit									
	0402 Boiler suit									
	0403 Trouser suit									
	0499 Other									
	In case of using "xx99 Other" describe the kind of item in column "3 Type".									
25	Foot wear	No:	1 Material	2 Colour	3 Type	4 Label	5 Size			
	01 Shoes									
	1A Open footwear									
	03 Boots									
	99 Other									
	Describe the kind of Foot wear in column "3 Type", eg Sport shoes Sandals									

<p>Collected by Duty Title :</p> <p> Name :</p> <p> Address :</p> <p> Phone/E-mail :</p>	<p>Signature / Date</p>
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MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	<input type="checkbox"/> Male <input type="checkbox"/> Female

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CLOTHING AND FOOT WEAR (carried on person or in luggage)		a	b	c	
26	Watch	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	00 Always wearing	No: 1 Material 2 Colour 3 Design 4 Brand 5 Inscription			
	01 Digital				
	02 Analog				
	03 Digital/Analog				
	04 If wrist watch worn on	Left 1 <input type="checkbox"/> Right 2 <input type="checkbox"/> Leather 1 <input type="checkbox"/> Metal 2 <input type="checkbox"/> Outside 3 <input type="checkbox"/> Inside 4 <input type="checkbox"/> Other (specify): 3 <input type="text"/>			
	05 Watch strap/chain	Where worn: _____			
	06 Watch, other type				
27	Glasses	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	00 Always wearing	1 Material 2 Colour 3 Design 4 Brand 5 Inscription			
	01 Frame				
	02 Lenses (glass)	Tinted 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes (specify): _____ Round 1 <input type="checkbox"/> Oval 2 <input type="checkbox"/> Square / Half 3 <input type="checkbox"/> 4 <input type="checkbox"/> Glass 1 <input type="checkbox"/> Polycarbonate 2 <input type="checkbox"/> Bi-focal 3 <input type="checkbox"/>	Strength - Left/Right 3 <input type="text"/> L 4 <input type="text"/> R Rimless 5 <input type="checkbox"/>		
	03 Lenses/Shape				
	3A Lens type	Strength - Left/Right 3 <input type="text"/> L 4 <input type="text"/> R Details page G: _____			
	04 Contact lenses	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes (colour?): _____			
	05 Optometrist				
28	Identity Papers	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	00 Always carrying	No: 1 Type 2 Photograph 3 Fingerprint 4 Blood type			
	01 Passport				
	02 Driving licence				
	03 Credit cards				
	04 Identity card				
	05 Donor card				
	06 Travellers cheques				
	07 Personal cheques				
	08 Health card				
	99 Other				
29	Effects	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes			
	00 Always carrying	No: 1 Material 2 Colour 3 Design 4 Brand 5 Markings			
	01 Wallet				
	02 Purse				
	03 Money belt				
	04 Badges/keys				
	05 Currency				
	06 Mobile phone				
	07 PDA				
	08 Sim card				
	09 Ticket				
	10 Camera/Video				
	99 Other				

Collected by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

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PHYSICAL DESCRIPTION		a	b	c
31				
31 A				
32	Height	Min/cm _____ / Max/cm _____	Source ?	
33	Weight	Min/kg _____ / Max/kg _____	Source ?	
34	Build	<i>Light</i> <i>Medium</i> <i>Heavy</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		
	01 Bodily constitution			
	02 Head form, front	<i>Oval</i> <i>Pointheaded</i> <i>Pyramidal</i> <i>Circular</i> <i>Rectangular</i> <i>Quadrangular</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>		
	(02-03 see Silhouette sketch)			
	03 Head form, profile	<i>Shallow</i> <i>Medium</i> <i>Deep</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		
35	Race	<i>Caucasoid</i> <i>Mongoloid</i> <i>Negroid</i> Type: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		
	01 Group			
	02 Complexion	<i>Light</i> <i>Medium</i> <i>Dark</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		
36	Hair of the head	<i>Natural</i> <i>Artificial</i> <i>Hair-piece</i> <i>Wig</i> <i>Braided</i> <i>Implanted</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>		
	01 Type			
	02 Length	<i>Short < 6cm</i> <i>Medium < 12cm</i> <i>Long > 12cm</i> <i>Shaved</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		
	03 Colour	<i>Blond</i> <i>Brown</i> <i>Black</i> <i>Red</i> <i>Grey</i> <i>White</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>		
	04 Shade of colour	<i>Light</i> <i>Medium</i> <i>Dark</i> <i>Turning grey</i> <i>Dyed</i> <i>Streaked</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>		
	05 Thickness	<i>Thin</i> <i>Medium</i> <i>Thick</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>		
	06 Style	<i>Straight</i> <i>Wavy</i> <i>Curly</i> <i>Parted</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> <i>Left</i> 5 <input type="checkbox"/> <i>Right</i> 6 <input type="checkbox"/> <i>Middle</i>		
	07 Baldness	<i>Beginning</i> <i>Advanced</i> <i>Total</i> <i>Forehead</i> <i>Sides</i> <i>Tonsure</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/>		
	08 Other	(specify):		

Collected by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

MISSING PERSON		No: _____
Family name :	_____	
Forename(s) :	_____	
Date of birth :	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

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PHYSICAL DESCRIPTION (cont.)		a	b	c						
37	Forehead	<i>Low</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>High</i> 3 <input type="checkbox"/>	<i>Narrow</i> 4 <input type="checkbox"/>	<i>Medium</i> 5 <input type="checkbox"/>	<i>Wide</i> 6 <input type="checkbox"/>			
	01 Height / Width <small>(01-02 see Silhouette sketch)</small> 02 Inclination	<i>Protruding</i> 1 <input type="checkbox"/>	<i>Vertical</i> 2 <input type="checkbox"/>	<i>Receding/slightly or clearly</i> 3 <input type="checkbox"/> S 4 <input type="checkbox"/> C						
38	Eyebrows	<i>Straight</i> 1 <input type="checkbox"/>	<i>Arched</i> 2 <input type="checkbox"/>	<i>Joining</i> 3 <input type="checkbox"/>	<i>Thin</i> 4 <input type="checkbox"/>	<i>Medium</i> 5 <input type="checkbox"/>	<i>Thick</i> 6 <input type="checkbox"/>			
	01 Shape / Thickness 02 Peculiarities	<i>Plucked</i> 1 <input type="checkbox"/>	<i>Tattooed</i> 2 <input type="checkbox"/>							
39	Eyes	<i>Blue</i> 1 <input type="checkbox"/>	<i>Grey</i> 2 <input type="checkbox"/>	<i>Green</i> 3 <input type="checkbox"/>	<i>Brown</i> 4 <input type="checkbox"/>	<i>Black</i> 5 <input type="checkbox"/>				
	01 Colour	<i>Light</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Dark</i> 3 <input type="checkbox"/>	<i>Mixed</i> 4 <input type="checkbox"/>					
	02 Shade	<i>Small</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Large</i> 3 <input type="checkbox"/>						
	03 Distance between eyes	<i>Cross-eyed</i> 1 <input type="checkbox"/>	<i>Squint-eyed</i> 2 <input type="checkbox"/>	<i>Artificial eye</i> 3 <input type="checkbox"/>	<i>Left</i> 4 <input type="checkbox"/>	<i>Right</i> 5 <input type="checkbox"/>				
40	Nose	<i>Small</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Large</i> 3 <input type="checkbox"/>	<i>Pointed</i> 4 <input type="checkbox"/>	<i>Roman</i> 5 <input type="checkbox"/>	<i>Alcoholics</i> 6 <input type="checkbox"/>			
	01 Size / Shape	<i>Marks of spectacles</i> 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes		<i>Missshapen</i> 3 <input type="checkbox"/>	<i>Other(specify):</i> 4 _____					
	02 Peculiarities	<i>Concave</i> 1 <input type="checkbox"/>	<i>Straight</i> 2 <input type="checkbox"/>	<i>Convex</i> 3 <input type="checkbox"/>	<i>Turned down</i> 4 <input type="checkbox"/>	<i>Horizontal</i> 5 <input type="checkbox"/>	<i>Turned up</i> 6 <input type="checkbox"/>			
41	Facial hair	<i>No beard</i> 1 <input type="checkbox"/>	<i>Moustache</i> 2 <input type="checkbox"/>	<i>Goatee</i> 3 <input type="checkbox"/>	<i>Whiskers</i> 4 <input type="checkbox"/>	<i>Full beard</i> 5 <input type="checkbox"/>				
	01 Type	<i>Blond</i> 1 <input type="checkbox"/>	<i>Brown</i> 2 <input type="checkbox"/>	<i>Black</i> 3 <input type="checkbox"/>	<i>Red</i> 4 <input type="checkbox"/>	<i>Grey</i> 5 <input type="checkbox"/>	<i>White</i> 6 <input type="checkbox"/>			
42	Ears	<i>Small</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Large</i> 3 <input type="checkbox"/>	<i>Close-set</i> 4 <input type="checkbox"/>	<i>Medium</i> 5 <input type="checkbox"/>	<i>Protruding</i> 6 <input type="checkbox"/>			
	01 Size / Angle	<i>Attached</i> 1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes /		<i>Pierced - specify number of piercings</i> 3 <input type="checkbox"/> Left _____	5 <input type="checkbox"/> Right _____					
43	Mouth	<i>Small</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Large</i> 3 <input type="checkbox"/>	<i>Other (specify):</i> 4 _____					
44	Lips	<i>Thin</i> 1 <input type="checkbox"/>	<i>Medium</i> 2 <input type="checkbox"/>	<i>Thick</i> 3 <input type="checkbox"/>	<i>Made up</i> 4 <input type="checkbox"/>	<i>Other (specify):</i> 5 _____				
45	Teeth (cf.page F1/F2)	<i>Natural</i> 1 <input type="checkbox"/>	<i>Untreated</i> 2 <input type="checkbox"/>	<i>Treated</i> 3 <input type="checkbox"/>	<i>Crowns</i> 4 <input type="checkbox"/>	<i>Bridges</i> 5 <input type="checkbox"/>	<i>Implants</i> 6 <input type="checkbox"/>			
	01 Conditions	<i>Gaps between front teeth</i> 1 <input type="checkbox"/> Upper 2 <input type="checkbox"/> Lower		<i>Missing teeth</i> 3 <input type="checkbox"/> Upper 4 <input type="checkbox"/> Lower	5 <input type="checkbox"/> Upper 6 <input type="checkbox"/> Lower	<i>Toothless</i>				
	02 Gaps/Missing teeth	<i>Part.upper</i> 1 <input type="checkbox"/>	<i>Part.lower</i> 2 <input type="checkbox"/>	<i>Full upper</i> 3 <input type="checkbox"/>	<i>Full lower</i> 4 <input type="checkbox"/>	<i>ID-number(specify):</i> 5 _____				
46	Smoking habits	<i>No</i> 1 <input type="checkbox"/>	<i>Yes</i> 2 <input type="checkbox"/>	<i>Cigarettes</i> 3 <input type="checkbox"/>	<i>Cigars</i> 4 <input type="checkbox"/>	<i>Pipe</i> 5 <input type="checkbox"/>	<i>Chewing tobacco</i> 6 <input type="checkbox"/>			

Collected by	Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date : _____
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MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

a = Data not available b = Photo c = Further information on page G

PHYSICAL DESCRIPTION (cont.)		a	b	c							
47	Chin	<i>Small</i>	<i>Medium</i>	<i>Large</i>	<i>Receding</i>	<i>Medium</i>	<i>Protruding</i>				
	01 Size / Inclination	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
	02 Shape	<i>Pointed</i>	<i>Round</i>	<i>Angular</i>	<i>Cleft chin</i>	<i>Groove</i>					
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>					
48	Neck	<i>Short</i>	<i>Medium</i>	<i>Long</i>	<i>Thin</i>	<i>Medium</i>	<i>Thick</i>				
	01 Length / Shape	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
	02 Peculiarities	<i>Goitre</i>	<i>Prominent Adams apple</i>		<i>Collar / Shirt No</i>		<i>Circumference</i>				
		1 <input type="checkbox"/>	2 <input type="checkbox"/>		4 <input type="text"/>		6 <input type="text"/> in cm				
49	Hands	<i>Slender</i>	<i>Medium</i>	<i>Broad</i>	<i>Small</i>	<i>Medium</i>	<i>Large</i>				
	01 Shape / Size	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
	02 Nail length	<i>Short</i>	<i>Medium</i>	<i>Long</i>							
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>							
	03 Peculiarities	<i>Bitten short</i>	<i>Manicured</i>	<i>Painted</i>	<i>Artificial</i>	<i>Nicotine</i>					
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/> Left	6 <input type="checkbox"/> Right				
50	Feet	<i>Slender</i>	<i>Medium</i>	<i>Broad</i>	<i>Flatfooted</i>	<i>Arched</i>					
	01 Shape	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>					
	02 Condition / Nail	<i>Bunion</i>	<i>Corn</i>	<i>Painted</i>	<i>Defective</i>						
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
	03 Peculiarities	<i>(Specify):</i> _____									
51	Body hair	<i>None</i>	<i>Slight</i>	<i>Medium</i>	<i>Pronounced</i>						
	01 Extent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
	02 Colour	<i>Blond</i>	<i>Brown</i>	<i>Black</i>	<i>Red</i>	<i>Grey</i>	<i>White</i>				
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
52	Pubic hair	<i>None</i>	<i>Slight</i>	<i>Medium</i>	<i>Pronounced</i>	<i>Shaved</i>					
	01 Extent	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>					
	02 Colour	<i>Blond</i>	<i>Brown</i>	<i>Black</i>	<i>Red</i>	<i>Grey</i>	<i>White</i>				
		1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
53	Specific details	No:	1 Scars/Piercing	2 Skin marks	3 Tattoo marks	4 Malformations	5 Amputations				
		01 Head									
		1A Neck / Throat									
		02 Right arm									
		03 Left arm									
		04 Right hand									
		05 Left hand									
		06 Body - front									
		07 Body - back									
		08 Right leg									
		09 Left leg									
		10 Right foot									
11 Left foot											
Indicate specific details on body sketch, page D4.											
54	Circumcision	1 <input type="checkbox"/> No	2 <input type="checkbox"/> Yes	3 <input type="checkbox"/> Unknown							
55	Other peculiarities										

Collected by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

MISSING PERSON

Family name : _____ **No:** _____
Barcode

Forename(s) : _____

Date of birth : Day Month Year Male Female

BODY SKETCH (described in item 53)

Mark on charts

Scars/Piercing	<input type="text" value="Please draw"/>	
Skin marks	<input type="text" value="Please draw"/>	
Tattoo marks	<input type="text" value="Please draw"/>	
Malformations	<input type="text" value="Please draw"/>	
Amputations		

RIGHT

LEFT

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

a = Data not available b = Photo c = Further information on page G

FINGERPRINT INFORMATION		a	b	c
01	Fingerprinted 01 Reason	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes <i>Where:</i> _____ <i>Criminal</i> <i>Civil</i> <i>Other:</i> _____ <i>Date:</i> _____ 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> _____		
02	If not, are fingerprints obtainable from residence/workplace/other 01 Address 02 Attending member	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes		
03	Number of fingerprints retrieved 01 Format	<i>No:</i> _____ <i>Lifts</i> <i>Digital Photo</i> <i>35mm Photo</i> <i>Other (specify):</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> _____		
04	Development technique	<i>Powder</i> <i>Chemicals</i> <i>Other (specify):</i> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> _____		
05	Exhibits forwarded 01 Description	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes		
06	Other information			

Collected by Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
---	------------------

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> <i>Day</i> <input type="text"/> <input type="text"/> <i>Month</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Year</i>	Male <input type="checkbox"/> Female <input type="checkbox"/>

MEDICAL CONDITIONS (as known to relatives or others)

56	General state of health (Describe past and present diseases and/or treatment)	
	<small>General practitioner see A2-15</small>	
57	Medication (What drugs are kept at residence ?)	

MEDICAL INFORMATION (If not given by the general practitioner 'A2-15', then please specify from whom)

58	01 Regular/occasional patient ? MEDICAL RECORD lists: 02 Symptoms 03 Findings 04 Diagnose 05 Treatment 06 Prescriptions 07 Ref. to specialist 08 Operation scars 09 Other scars 10 Fractures 11 Organs missing 12 Hospitalization 13 Other ADDICTED to: 14 Tobacco 15 Alcohol 16 Drugs 17 Narcotics INFECTIOUS DISEASE: 18 Hepatitis 19 AIDS / HIV 19A Tuberculosis 20 Other IN WOMEN: 21 Pregnancy 22 Births 23 Hysterectomy	No:	
	IMPLANT: 24 Intrauterine contraceptive devices 25 Other implants	Metal <input type="checkbox"/> Plastic <input type="checkbox"/> Describe: _____ Metal <input type="checkbox"/> Plastic <input type="checkbox"/> Describe: _____	

59	Blood type	
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Continued item no 66 (Item 60 - 65 in form PM only)

Collected by	Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
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MISSING PERSON		No: _____
Family name	: _____	<small>Barcode</small>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> <i>Day</i> <input type="text"/> <input type="text"/> <i>Month</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Year</i>	Male <input type="checkbox"/> Female <input type="checkbox"/>

FURTHER MEDICAL INFORMATION

66	Forensic pathologist/ medical examiner's extract from medical records	
	Medical records provided by:	
	Name Address Phone/E-mail	

MEDICAL DATA OF SPECIFIC INTEREST

67	X-rays showing specific conditions	
68	Organs removed	
69	Prostheses	
70	Other artificial aids	

Continued item no 76 (Item 71 - 75 in form PM only)

Collected by	Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date
---------------------	---	------------------

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

c = Further information on page G

DNA		C																																																																																																				
93	Reference Missing person 1. Reference 2. Reference 3. Reference	<i>Type of sample:</i> _____ <i>Laboratory reference:</i> _____ <i>Name/Address:</i> _____ <i>National ID-number:</i> <input type="text"/> <i>Biological relationship:</i> _____ <i>Laboratory reference:</i> _____ <i>Contact person at the lab:</i> _____ <i>Laboratory quality standard:</i> _____ <i>Name/Address:</i> _____ <i>National ID-number:</i> <input type="text"/> <i>Biological relationship:</i> _____ <i>Laboratory reference:</i> _____ <i>Contact person at the lab:</i> _____ <i>Laboratory quality standard:</i> _____ <i>Name/Address:</i> _____ <i>National ID-number:</i> <input type="text"/> <i>Biological relationship:</i> _____ <i>Laboratory reference:</i> _____ <i>Contact person at the lab:</i> _____ <i>Laboratory quality standard:</i> _____																																																																																																				
94	DNA profiles	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 25%;">Missing person</th> <th style="width: 25%;">1. Reference</th> <th style="width: 25%;">2. Reference</th> <th style="width: 25%;">3. Reference</th> </tr> </thead> <tbody> <tr><td>D3S1358</td><td></td><td></td><td></td></tr> <tr><td>VWA</td><td></td><td></td><td></td></tr> <tr><td>D16S539</td><td></td><td></td><td></td></tr> <tr><td>D2S1338</td><td></td><td></td><td></td></tr> <tr><td>Amelogenin</td><td></td><td></td><td></td></tr> <tr><td>D8S1179</td><td></td><td></td><td></td></tr> <tr><td>D21S11</td><td></td><td></td><td></td></tr> <tr><td>D18S51</td><td></td><td></td><td></td></tr> <tr><td>D19S433</td><td></td><td></td><td></td></tr> <tr><td>TH01</td><td></td><td></td><td></td></tr> <tr><td>FGA</td><td></td><td></td><td></td></tr> <tr><td>TPOX</td><td></td><td></td><td></td></tr> <tr><td>CSF1PO</td><td></td><td></td><td></td></tr> <tr><td>D13S317</td><td></td><td></td><td></td></tr> <tr><td>D7S820</td><td></td><td></td><td></td></tr> <tr><td>D5S818</td><td></td><td></td><td></td></tr> <tr><td>Penta D</td><td></td><td></td><td></td></tr> <tr><td>Penta E</td><td></td><td></td><td></td></tr> <tr><td>FES</td><td></td><td></td><td></td></tr> <tr><td>F13A1</td><td></td><td></td><td></td></tr> <tr><td>F13B</td><td></td><td></td><td></td></tr> <tr><td>SE33</td><td></td><td></td><td></td></tr> <tr><td>CD4</td><td></td><td></td><td></td></tr> <tr><td>GABA</td><td></td><td></td><td></td></tr> </tbody> </table>	Missing person	1. Reference	2. Reference	3. Reference	D3S1358				VWA				D16S539				D2S1338				Amelogenin				D8S1179				D21S11				D18S51				D19S433				TH01				FGA				TPOX				CSF1PO				D13S317				D7S820				D5S818				Penta D				Penta E				FES				F13A1				F13B				SE33				CD4				GABA			
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CD4																																																																																																						
GABA																																																																																																						
95	Checked by	<i>Date:</i> _____ <i>Signature:</i> _____																																																																																																				

Collected by	Signature / Date
Duty Title : _____	
Name : _____	
Address : _____	
Phone/E-mail : _____	

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year	Male <input type="checkbox"/> Female <input type="checkbox"/>

DENTAL INFORMATION

76	Missing Persons address	
	(see A1 in item 10)	
77	Missing since	<input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Year
78	Circumstances of the disappearance	
79	Dental information Obtained from family members and/or others	
	01 Data in D2 item 45	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes

DENTAL DATA PROVIDED BY

80	Dentist / Institution	
	Address	
	Phone/E-mail	
	Period covered	From _____ To _____ <input type="checkbox"/> Records <input type="checkbox"/> X-rays <input type="checkbox"/> Models <input type="checkbox"/> Photos
	DOCUMENTS filed with	
81	Dentist / Institution	
	Address	
	Phone/E-mail	
	Period covered	From _____ To _____ <input type="checkbox"/> Records <input type="checkbox"/> X-rays <input type="checkbox"/> Models <input type="checkbox"/> Photos
	DOCUMENTS filed with	
82	Dentist / Institution	
	Address	
	Phone/E-mail	
	Period covered	From _____ To _____ <input type="checkbox"/> Records <input type="checkbox"/> X-rays <input type="checkbox"/> Models <input type="checkbox"/> Photos
	DOCUMENTS filed with	

Continued item no 86 (Item 83 - 85 in form PM only)

Collected by	Duty Title : _____	Signature / Date
	Name : _____	
	Address : _____	
	Phone/E-mail : _____	

The INTERPOL Victim Identification Form, Sections F1 and F2

GENERAL INFORMATION

The INTERPOL Victim Identification Form consists of several sections - divided into two groups:

- 1) YELLOW FORMS for listing latest known data concerning a missing person;
- 2) PINK FORMS for listing all findings concerning a dead body.

Identification of a dead body may become possible if data listed on the pink forms concerning this body can be compared with, and shown to match, data listed on the yellow forms concerning one particular missing person. If an identification is made, the experts involved will complete an Identification-Report - as a prerequisite to issuing a death certificate and releasing the body for burial.

The identification of a dead body may be accomplished in several ways, depending upon the type of data used. The INTERPOL Victim Identification Form has been set up in such a way, that sections listing the same type of data are marked with the same capital letter in the upper right-hand corner. For dental identification, the forms to use are Sections F1 and F2 (yellow), and Sections F1 and F2 (pink); because of the specialised vocabulary, they must be filled in by a forensically trained dentist.

INSTRUCTIONS FOR USE - SECTION F1 AND F2 AM (yellow)

These forms are designed for listing all dental information collected from dental practitioners records or other sources.

In Section F1, make sure that the reference number is clearly shown - and that the sex is clearly indicated (boxes at the top). Fill in all the details requested further down. Under "Circumstances of the Disappearance", give the shortest possible extract of the police report. Under "Dental information", list any supplementary information obtained by the police from family members and/or others. Request from the police - and list - exact name, address and telephone number of the dentists/institutions from which records etc. have been obtained; also list the respective periods covered (whole years). Written records should be originals or good photostat copies. Ensure that all record X-rays, models, and photographs are clearly marked with patient's name, dentist's name, and date of exposure or production; if they are not, you must do it yourself.

In Section F2, the missing person's latest known dental status is to be listed. The status can only be established by extraction from - and re-arrangement of - the data listed in one or more dental records - or apparent from X-ray, models, photographs, or other material produced. Start with the latest entry in the written record and work your way backwards; in this way, all previous treatment now covered by later treatment can be left out. Indicate surfaces by using Capital-Letter System: M = mesial, O = occlusal, D = distal, V = vestibular, L = lingual; if other abbreviations are used, please explain them in one of the boxes further down. (NOTE: there will be a notation only for treatment/conditions actually described or seen in the material) - Next, sketch on the dental chart the location and extent of all fillings and other conditions listed as present according to your re-arrangement of data. For colour distinction, use black for amalgam, red for gold, and green for tooth-coloured material. For teeth extracted or not formed, put large cross (X) over the appropriate tooth square. If the practitioner's record includes a dental chart, compare it with your own and make sure they tally. Do not hesitate to contact practitioner for clarification of dubious points. If X-rays and/or other material are available, indicate - in the appropriate boxes - type, year of exposure or production, and teeth concerned. Finally, record age at time of disappearance.

Once Section F2 has been completed, type your name, address and telephone number (or use your professional stamp) in the box at the bottom of Section F1. Finally, enter the date of completion above your personal signature. Remember - this is a legal document, so keep a full copy for your own file. Likewise, make copies of all original record material, before returning it to the practitioner.

MISSING PERSON		No: _____
Family name	: _____	<small>Barcode</small>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> <small>Day</small> <input type="text"/> <input type="text"/> <small>Month</small> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>Year</small>	Male <input type="checkbox"/> Female <input type="checkbox"/>

86	DENTAL INFORMATION in permanent teeth (Notify temporary teeth specifically)															
51-11															21-61	
52-12															22-62	
53-13															23-63	
54-14															24-64	
55-15															25-65	
16															26	
17															27	
18															28	
18	17	16	15-55	14-54	13-53	12-52	11-51	s u p e r	21-61	22-62	23-63	24-64	25-65	26	27	28
								<input type="checkbox"/>								
48	47	46	45-85	44-84	43-83	42-82	41-81	n u m e r a r y	31-71	32-72	33-73	34-74	35-75	36	37	38
48															38	
47															37	
46															36	
85-45															35-75	
84-44															34-74	
83-43															33-73	
82-42															32-72	
81-41															31-71	
87	Specific data <small>Crowns, bridges, dentures and implants</small>															
88	Further data <small>Occlusion, attrition, anomalies, smoker, periodontal status, etc.</small>															
89	X-rays available <small>Type, region and year</small>															
90	Further material															
91	Age at time of disapp.															
96	Checked by	<small>Date:</small>														<small>Signature:</small>

Collected by	Duty Title : _____ Name : _____ Address : _____ Phone/E-mail : _____	Signature / Date : _____
---------------------	---	--------------------------

MISSING PERSON		No: _____
Family name	: _____	<i>Barcode</i>
Forename(s)	: _____	
Date of birth	: <input type="text"/> <input type="text"/> <i>Day</i> <input type="text"/> <input type="text"/> <i>Month</i> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <i>Year</i>	<i>Male</i> <input type="checkbox"/> <i>Female</i> <input type="checkbox"/>

FURTHER INFORMATION (if referring to data given on a previous page, please indicate item number)

92	
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VICTIM IDENTIFICATION FORM

SILHOUETTE SKETCH

Please choose the appropriate sketches and mark items on D1 and D2

34 02 Head form, front (Shape of head from front)



1 Oval



2 Pointheaded



3 Pyramidal



4 Circular



5 Rectangular



6 Quadrangular

03 Head form, profile (Shape of head from side)



1 Shallow

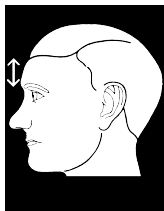


2 Medium

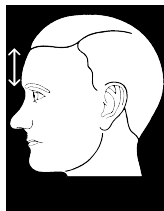


3 Deep

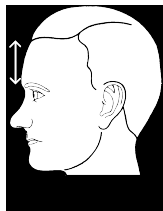
37 01 Forehead - Height/Width



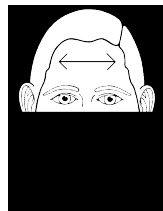
1 Low



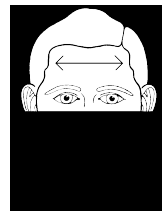
2 Medium



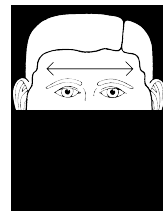
3 High



4 Narrow

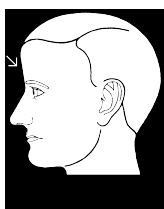


5 Medium

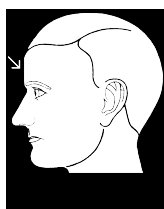


6 Wide

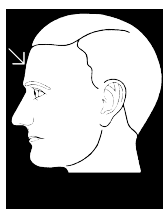
02 Forehead - Inclination



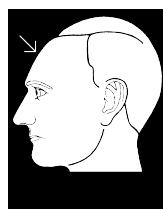
1 Protruding



2 Vertical



3 Receding



4 Receding clearly

40 03 Nose - Curve/Angle



1 Concave



2 Straight



3 Convex



4 Turned down



5 Horizontal



6 Turned up

42 02 Ear lobes



1 Not attached



2 Attached