

<b>Family name:</b> _____	<b>AM No:</b> _____
-----	
<b>First name(s):</b> _____	
<b>Date of birth:</b> <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	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

<b>Nature of disaster:</b> _____
<b>Place of disaster:</b> _____
<b>Date of disaster:</b> <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

a = Data not available

b = Attachment

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

ADMINISTRATIVE DATA			a	b	c
<b>100</b>	<b>Responsible agency</b>  Street / No. Postcode / Town State / Country Phone / Email				
		<i>INTERPOL NCB:</i>			
		<i>Police file No:</i>			
<b>105</b>	<b>Information given by</b> Name Street / No. Postcode / Town State / Country Phone / Email <b>Relationship</b>	<i>Date:</i> -----			
<b>110</b>	<b>ID info to</b> Name Street / No. Postcode / Town State / Country Phone / Email <b>Relationship</b>	1 <input type="checkbox"/> see 105			
<b>115</b>	<b>Partner</b> If not single see 230	<i>Single - If not, First- / Middle- / Family name of partner:</i> 1 <input type="checkbox"/> _____			
<b>120</b>	<b>Fingerprinted</b>  01 Source	1 <input type="checkbox"/> No    2 <input type="checkbox"/> Yes <i>Where:</i> _____ <i>Specify:</i> _____ <i>Date:</i> _____			
<b>125</b>	<b>If not, are fingerprints obtainable from residence/workplace/ other</b>  01 Address  See also 480	1 <input type="checkbox"/> No    2 <input type="checkbox"/> Yes  Specify elimination print sources on page Sup. Info. (700's)			

CHECKLIST OF CONTENTS	Enclosed complete	Not available	Remarks
Administrative Data (fields 1xx)			
Nominal data (fields 2xx)			
Effects (fields 3xx)			
Body description (fields 4xx)			
Pathology (fields 5xx)			
Odontology (fields 6xx)			
Supporting information (fields 7xx)			
Appendix (fields 8xx) (optional)			

<b>Family name:</b> _____	<b>AM No:</b> _____
<b>First name(s):</b> _____	
<b>Date of birth:</b> <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	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

b = Attachment

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

NOMINAL DATA		a	b	c
<b>200</b>	<b>Family name at birth</b>	Mother's maiden name:		
<b>205</b>	<b>Nicknames</b>			
<b>210</b>	<b>Aliases</b>	First name: _____ Family name: _____ 01 Alias Name 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 Birthplace: _____ Place: _____ Country: _____		
		First name: _____ Family name: _____ 02 Alias Name 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 Birthplace: _____ Place: _____ Country: _____		
<b>215</b>	<b>Nationality</b>	Country: _____ Multiple nationality: _____		
<b>220</b>	<b>Birthplace</b>	Place: _____ Country: _____		
<b>225</b>	<b>National ID number</b>	Number _____ Issuing country: <input type="text"/> <input type="text"/> <input type="text"/> Enter ISO 3166-1 alpha-3 code (e.g. AUS for Australia)		
<b>230</b>	<b>Marital status</b>	Engaged (date) 1 <input type="checkbox"/> _____ Cohabiting 2 <input type="checkbox"/> _____ Married (date) 3 <input type="checkbox"/> _____ Divorced 4 <input type="checkbox"/> _____ Widowed 5 <input type="checkbox"/> _____ If single see 115		
<b>235</b>	<b>Occupation</b>			
<b>240</b>	<b>Current physical address</b>	Street / No. _____ Postcode / Town _____ State / Country _____ Phone / Email _____ Mobile phone _____		
<b>245</b>	<b>Religion</b>	No 1 <input type="checkbox"/> Yes (specify): 2 <input type="checkbox"/> _____		

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

**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year  Age  Male  Female  Unknown

a = Data not available

b = Attachment

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

EFFECTS (possibly carried on person or in luggage)								a	b	c		
<b>300 Clothing Items</b>	<b>No:</b>	<b>1</b>	<b>Type</b>	<b>2</b>	<b>Colour</b>	<b>3</b>	<b>Label</b>	<b>4</b>	<b>Material</b>			
	<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											
	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".												
<b>305 Footwear</b>	<b>No:</b>	<b>1</b>	<b>Type</b>	<b>2</b>	<b>Colour</b>	<b>3</b>	<b>Label</b>	<b>4</b>	<b>Material</b>			
01 Boots												
02 Open footwear												
03 Shoes												
99 Other												
Describe the kind of footwear in column "1 Type", e.g. sports shoes, sandals												

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

<b>Collected by</b>	Duty Title	:	<b>Signature / Date</b>
	Name	:	
	Address	:	
	Phone / Email	:	

**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year

Age  Male  Female  Unknown

a = Data not available

b = Attachment

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

EFFECTS (possibly carried on person or in luggage)								a	b	c				
<b>310 Watch</b> 01 Digital wristwatch 02 Analog wristwatch 03 Digital/analog w.  04 If wristwatch, worn on 05 Watch strap/chain 06 Watch, other type	<b>No:</b>	<b>1</b>	<b>Make</b>	<b>2</b>	<b>Model</b>	<b>3</b>	<b>Colour</b>	<b>4</b>	<b>Material</b>	<b>5</b>	<b>Inscription</b>			
	<i>Left</i>	<input type="checkbox"/>	<i>Right</i>	<input type="checkbox"/>	<i>Outside</i>	<input type="checkbox"/>	<i>Inside</i>	<input type="checkbox"/>						
	<i>Leather</i>	<input type="checkbox"/>	<i>Metal</i>	<input type="checkbox"/>	<i>Rubber</i>	<input type="checkbox"/>	<i>Other (specify):</i>							
	<i>Where worn:</i>													
<b>315 Glasses</b> 01 Frame  02 Lenses (glass)  03 Shape of lenses  04 Lenses material/type	<b>1</b>	<b>Make</b>	<b>2</b>	<b>Model</b>	<b>3</b>	<b>Colour</b>	<b>4</b>	<b>Material</b>	<b>5</b>	<b>Inscription</b>				
	<i>Self tinting</i>	<input type="checkbox"/>	<i>Tinted</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes (specify):										
	<i>Round</i>	<input type="checkbox"/>	<i>Oval</i>	<input type="checkbox"/>	<i>Square</i>	<input type="checkbox"/>	<i>Half</i>	<input type="checkbox"/>	<i>Rimless</i>	<input type="checkbox"/>	<i>Full rim</i>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Glass</i>	<input type="checkbox"/>	<i>Polycarbonate</i>	<input type="checkbox"/>	<i>Bi-focal</i>	<input type="checkbox"/>	<i>Progressive</i>	<input type="checkbox"/>						
<b>320 Contact lenses</b>	<b>No</b>	<input type="checkbox"/>	<b>Yes (if coloured specify):</b>		<input type="checkbox"/>									
<b>325 Hearing aids</b> 01 Left  02 Right	<b>No</b>	<input type="checkbox"/>	<b>Yes (specify):</b>		<input type="checkbox"/>		<b>Serial No:</b> _____							
<b>330 External prostheses</b>	<b>No</b>	<input type="checkbox"/>	<b>Yes (specify):</b>		<input type="checkbox"/>		<b>Serial No:</b> _____							
<b>335 Jewellery</b> 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".	<b>No:</b>	<b>1</b>	<b>Type</b>	<b>2</b>	<b>Colour</b>	<b>3</b>	<b>Material</b>	<b>4</b>	<b>Inscription</b>	<b>5</b>	<b>Where worn</b>			

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

<b>Collected by</b>	Duty Title	:	<b>Signature / Date</b>
	Name	:	
	Address	:	
	Phone / Email	:	

**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

-----

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year  Age  Male  Female  Unknown

a = Data not available

b = Attachment

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

EFFECTS (possibly carried on person or in luggage)								a	b	c
<b>340 Identity documents</b>	<b>No:</b>	<b>1 Nationality</b>	<b>2 Number</b>	<b>3 Details</b>	<b>4 Biometrics</b>	<b>5 Chip</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>345 Effects</b>	<b>No:</b>	<b>1 Make</b>	<b>2 Model</b>	<b>3 Colour</b>	<b>4 Material</b>	<b>5 Serial No.</b>	<b>6 Markings</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>350 Electronic devices</b>	<b>No:</b>	<b>1 Make</b>	<b>2 Model</b>	<b>3 Colour</b>	<b>4 Material</b>	<b>5 Serial No.</b>	<b>6 Markings</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".									

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

<b>Collected by</b>	Duty Title	:	<b>Signature / Date</b>
	Name	:	
	Address	:	
	Phone / Email	:	

**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year  Age   Male  Female  Unknown

a = Data not available

b = Attachment

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

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

<b>Collected by</b>	Duty Title	:	Signature / Date
	Name	:	
	Address	:	
	Phone / Email	:	

<b>Family name:</b> _____	<b>AM No:</b> _____
<b>First name(s):</b> _____	
<b>Date of birth:</b> <input type="text"/> <input type="text"/> Day <input type="text"/> <input type="text"/> Month <input type="text"/> <input type="text"/> <input type="text"/> Year	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

b = Attachment

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

BODY DESCRIPTION (external + fingerprint)		a	b	c																		
<b>424</b>	<b>Eyebrows</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>428</b>	<b>Eyes</b> 01 Colour (Left and Right) 02 Distinctive feature(s)	<table style="width:100%; border: none;"> <tr> <td style="width: 25%;">Blue 1 <input type="checkbox"/> <input type="checkbox"/></td> <td style="width: 25%;">Grey 2 <input type="checkbox"/> <input type="checkbox"/></td> <td style="width: 25%;">Green 3 <input type="checkbox"/> <input type="checkbox"/></td> <td style="width: 25%;">Brown 4 <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Black 5 <input type="checkbox"/> <input type="checkbox"/></td> <td>Hazel 6 <input type="checkbox"/> <input type="checkbox"/></td> <td>Maroon 7 <input type="checkbox"/> <input type="checkbox"/></td> <td>Pink 8 <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>Cross-eyed 1 <input type="checkbox"/> <input type="checkbox"/></td> <td>Squint-eyed 2 <input type="checkbox"/> <input type="checkbox"/></td> <td>Artificial eye 3 <input type="checkbox"/> <input type="checkbox"/></td> <td>Other (specify): 5 <input type="checkbox"/> _____</td> </tr> </table>		Blue 1 <input type="checkbox"/> <input type="checkbox"/>	Grey 2 <input type="checkbox"/> <input type="checkbox"/>	Green 3 <input type="checkbox"/> <input type="checkbox"/>	Brown 4 <input type="checkbox"/> <input type="checkbox"/>	Black 5 <input type="checkbox"/> <input type="checkbox"/>	Hazel 6 <input type="checkbox"/> <input type="checkbox"/>	Maroon 7 <input type="checkbox"/> <input type="checkbox"/>	Pink 8 <input type="checkbox"/> <input type="checkbox"/>	Cross-eyed 1 <input type="checkbox"/> <input type="checkbox"/>	Squint-eyed 2 <input type="checkbox"/> <input type="checkbox"/>	Artificial eye 3 <input type="checkbox"/> <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____							
Blue 1 <input type="checkbox"/> <input type="checkbox"/>	Grey 2 <input type="checkbox"/> <input type="checkbox"/>	Green 3 <input type="checkbox"/> <input type="checkbox"/>	Brown 4 <input type="checkbox"/> <input type="checkbox"/>																			
Black 5 <input type="checkbox"/> <input type="checkbox"/>	Hazel 6 <input type="checkbox"/> <input type="checkbox"/>	Maroon 7 <input type="checkbox"/> <input type="checkbox"/>	Pink 8 <input type="checkbox"/> <input type="checkbox"/>																			
Cross-eyed 1 <input type="checkbox"/> <input type="checkbox"/>	Squint-eyed 2 <input type="checkbox"/> <input type="checkbox"/>	Artificial eye 3 <input type="checkbox"/> <input type="checkbox"/>	Other (specify): 5 <input type="checkbox"/> _____																			
<b>432</b>	<b>Nose</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>436</b>	<b>Facial hair</b> 01 Type 02 Colour	<table style="width:100%; border: none;"> <tr> <td style="width: 16.6%;">Shaved 1 <input type="checkbox"/></td> <td style="width: 16.6%;">Moustache 2 <input type="checkbox"/></td> <td style="width: 16.6%;">Goatee 3 <input type="checkbox"/></td> <td style="width: 16.6%;">Whiskers 4 <input type="checkbox"/></td> <td style="width: 16.6%;">Full beard 5 <input type="checkbox"/></td> <td style="width: 16.6%;">Other (specify on page 700's) 6 <input type="checkbox"/> _____</td> </tr> <tr> <td>Blond 1 <input type="checkbox"/></td> <td>Brown 2 <input type="checkbox"/></td> <td>Black 3 <input type="checkbox"/></td> <td>Red 4 <input type="checkbox"/></td> <td colspan="2">Grey 5 <input type="checkbox"/></td> </tr> <tr> <td>Grey 5 <input type="checkbox"/></td> <td>White 6 <input type="checkbox"/></td> <td>Mixed grey 7 <input type="checkbox"/></td> <td colspan="3">Other (specify): 8 <input type="checkbox"/> _____</td> </tr> </table>		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"/>		Grey 5 <input type="checkbox"/>	White 6 <input type="checkbox"/>	Mixed grey 7 <input type="checkbox"/>	Other (specify): 8 <input type="checkbox"/> _____			
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"/>																		
Grey 5 <input type="checkbox"/>	White 6 <input type="checkbox"/>	Mixed grey 7 <input type="checkbox"/>	Other (specify): 8 <input type="checkbox"/> _____																			
<b>440</b>	<b>Ears</b> 01 Ear lobes/pierced 02 Distinctive feature(s)	<table style="width:100%; border: none;"> <tr> <td style="width: 33.3%;">Attached 1 <input type="checkbox"/> No</td> <td style="width: 33.3%;">2 <input type="checkbox"/> Yes</td> <td style="width: 33.3%;">Pierced - specify number of piercings 3 <input type="checkbox"/> Left _____ 4 <input type="checkbox"/> Right _____</td> </tr> <tr> <td>No 1 <input type="checkbox"/></td> <td colspan="2">Yes (describe and use page Sup. Info. (700's) for details): 2 <input type="checkbox"/> _____</td> </tr> </table>		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"/> _____														
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"/> _____																					
<b>444</b>	<b>Mouth/teeth</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>448</b>	<b>Lips</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>452</b>	<b>Chin</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>456</b>	<b>Neck</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>460</b>	<b>Hands/nails</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>464</b>	<b>Feet/nails</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>468</b>	<b>Body/pubic hair</b> 01 Distinctive feature(s)	No <input type="checkbox"/> Yes (describe and use page Sup. Info. (700's) for details): <input type="checkbox"/>																				
<b>472</b>	<b>Circumcision</b>	No <input type="checkbox"/> Yes <input type="checkbox"/>																				
<b>476</b>	<b>Ancestry</b>	<table style="width:100%; border: none;"> <tr> <td style="width: 25%;">European 1 <input type="checkbox"/> White</td> <td style="width: 25%;">African 2 <input type="checkbox"/> Black</td> <td style="width: 25%;">Asian 3 <input type="checkbox"/></td> <td style="width: 25%;">Other (specify): 4 <input type="checkbox"/> _____</td> </tr> <tr> <td colspan="4">Mixed (specify): 5 <input type="checkbox"/> _____</td> </tr> </table>		European 1 <input type="checkbox"/> White	African 2 <input type="checkbox"/> Black	Asian 3 <input type="checkbox"/>	Other (specify): 4 <input type="checkbox"/> _____	Mixed (specify): 5 <input type="checkbox"/> _____														
European 1 <input type="checkbox"/> White	African 2 <input type="checkbox"/> Black	Asian 3 <input type="checkbox"/>	Other (specify): 4 <input type="checkbox"/> _____																			
Mixed (specify): 5 <input type="checkbox"/> _____																						
<b>480</b>	<b>Fingerprint</b> 01 Number retrieved 02 Format 03 Development technique	<table style="width:100%; border: none;"> <tr> <td colspan="4">No: _____</td> </tr> <tr> <td style="width: 25%;">Lifts 1 <input type="checkbox"/></td> <td style="width: 25%;">Digital photo 2 <input type="checkbox"/></td> <td style="width: 25%;">35mm photo 3 <input type="checkbox"/></td> <td style="width: 25%;">Other (specify): 4 <input type="checkbox"/> _____</td> </tr> <tr> <td>Powder 1 <input type="checkbox"/></td> <td>Chemicals 2 <input type="checkbox"/></td> <td colspan="2">Other (specify): 3 <input type="checkbox"/> _____</td> </tr> </table>		No: _____				Lifts 1 <input type="checkbox"/>	Digital photo 2 <input type="checkbox"/>	35mm photo 3 <input type="checkbox"/>	Other (specify): 4 <input type="checkbox"/> _____	Powder 1 <input type="checkbox"/>	Chemicals 2 <input type="checkbox"/>	Other (specify): 3 <input type="checkbox"/> _____								
No: _____																						
Lifts 1 <input type="checkbox"/>	Digital photo 2 <input type="checkbox"/>	35mm photo 3 <input type="checkbox"/>	Other (specify): 4 <input type="checkbox"/> _____																			
Powder 1 <input type="checkbox"/>	Chemicals 2 <input type="checkbox"/>	Other (specify): 3 <input type="checkbox"/> _____																				

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

<b>Family name:</b> _____	<b>AM No:</b> _____
-----	
<b>First name(s):</b> _____	
<b>Date of birth:</b> <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	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

b = Attachment

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

PATHOLOGY			a	b	c
<b>500</b>	<b>General practitioner</b> Name Street / No. Postcode / Town State / Country Phone / Email				
<b>505</b>	<b>Medical record lists</b>  01 Diagnoses 02 Findings 03 Fractures 04 Hospitalizations 05 Operation scars 06 Organs missing 07 Prescriptions 08 Ref. to specialist 09 Symptoms 10 Treatments 11 Other scars 12 Other  <b>Addicted to</b> 20 Alcohol 21 Drugs 22 Narcotics 23 Tobacco  <b>Infectious diseases</b> 30 AIDS/HIV 31 Hepatitis 32 Tuberculosis 33 Other  <b>In women</b> 40 Births 41 Hysterectomy 42 Intrauterine contra- ceptive devices 43 Pregnancy	<b>No:</b> 1 _____ <i>Specify</i>			
		<b>515</b>	<b>Implants</b> 01 Breast 02 Pacemaker 03 Insulin pump 04 Other surgical implants	<b>No:</b> 1 _____ <i>Specify</i> 2 _____ <i>Serial No.</i>	
<b>520</b>	<b>Prostheses</b>	<i>No</i> 1 <input type="checkbox"/> <i>Yes (specify):</i> 2 <input type="checkbox"/> _____			
<b>525</b>	<b>Other artificial aids</b>	<i>No</i> 1 <input type="checkbox"/> <i>Yes (specify):</i> 2 <input type="checkbox"/> _____			
<b>530</b>	<b>Organs removed</b>	<i>No</i> 1 <input type="checkbox"/> <i>Yes (specify):</i> 2 <input type="checkbox"/> _____			

<b>Collected by</b>	Duty Title : _____	<i>Signature / Date</i>
	Name : _____	
	Address : _____	
	Phone / Email : _____	



<b>Family name:</b> _____	<b>AM No:</b> _____
-----	
<b>First name(s):</b> _____	
<b>Date of birth:</b> <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	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

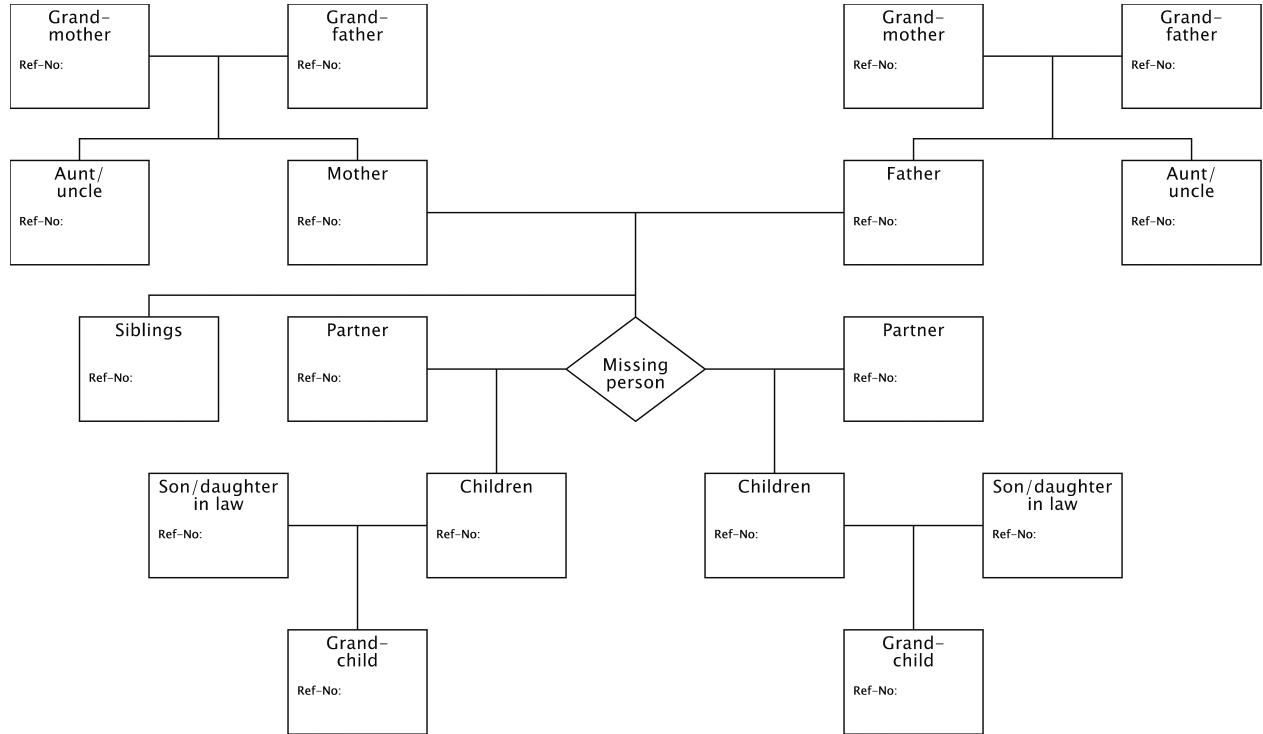
b = Attachment

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

PATHOLOGY (DNA related information)				a	b	c	
<b>555</b>	<b>Reference</b> Missing person (Direct reference)	Type of sample: DNA-profile 1 <input type="checkbox"/> Date of sample: _____	Biobank 2 <input type="checkbox"/> Laboratory reference: _____	Personal belonging (specify): 3 <input type="checkbox"/> _____			

**FAMILY TREE OF BIOLOGICAL RELATIONSHIPS**

Add a Ref-No. of the relative on tree. Add any information, not represented on biological relationships family tree, on page Sup. Info. (700's).



<b>560</b>	Family Reference No: _____ Relationship _____ <small>(Please mark the reference of the family tree)</small>	Name(s): _____ National ID-number: _____ Type of sample: _____	Laboratory reference: _____ Date of sample: _____			
	Family Reference No: _____ Relationship _____ <small>(Please mark the reference of the family tree)</small>	Name(s): _____ National ID-number: _____ Type of sample: _____	Laboratory reference: _____ Date of sample: _____			
	Family Reference No: _____ Relationship _____ <small>(Please mark the reference of the family tree)</small>	Name(s): _____ National ID-number: _____ Type of sample: _____	Laboratory reference: _____ Date of sample: _____			

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

<b>Family name:</b> _____	<b>AM No:</b> _____
-----	
<b>First name(s):</b> _____	
<b>Date of birth:</b> <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	Age <input type="text"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/>

a = Data not available

b = Attachment

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

ODONTOLOGY				a	b	c	
<b>600</b>	<b>Dentist/clinic</b>	Name Street / No. Postcode / Town State / Country Phone / Email					
	01 Period covered <input type="checkbox"/>						
	02 Enclosed <input type="checkbox"/>	Radiographs <input type="checkbox"/> Casts <input type="checkbox"/> Photos <input type="checkbox"/> Other (specify): _____					
<b>605</b>	<b>Dentist/clinic</b>	Name Street / No. Postcode / Town State / Country Phone / Email					
	01 Period covered <input type="checkbox"/>						
	02 Enclosed <input type="checkbox"/>	Radiographs <input type="checkbox"/> Casts <input type="checkbox"/> Photos <input type="checkbox"/> Other (specify): _____					
<b>615</b>	<b>Dental images available</b>	1 <i>Digital</i>	2 <i>State number of</i>	3 <i>Non digital</i>	4 <i>State number of</i>		
		<input type="checkbox"/>		<input type="checkbox"/>			
		01 PA		<input type="checkbox"/>			
		02 BW		<input type="checkbox"/>			
		03 OPG		<input type="checkbox"/>			
		04 CT		<input type="checkbox"/>			
		05 Other radiographs		<input type="checkbox"/>			
06 Photographs		<input type="checkbox"/>					
<b>620</b>	<b>Further material</b>						

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

**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year

Age  Male  Female  Unknown

a = Data not available

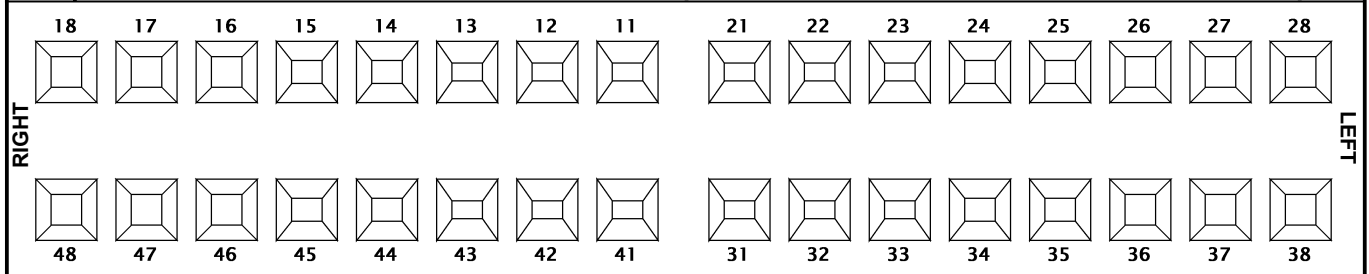
b = Attachment

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

**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

<b>635 Specific data</b>	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				
<b>640 Other findings</b>	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			
<b>645 Type of dentition</b>	01 Specify	1 <input type="checkbox"/> Primary dentition	2 <input type="checkbox"/> Mixed dentition	3 <input type="checkbox"/> Permanent dentition			
<b>650 Quality check</b>	F0d 1	Date:	Signature:				
	F0d 2 (If available)	Date:	Signature:				

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



**Family name:** \_\_\_\_\_ **AM No:** \_\_\_\_\_

**First name(s):** \_\_\_\_\_

**Date of birth:**   Day   Month     Year Age  Male  Female  Unknown

a = Data not available

b = Attachment

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

**805 APPENDIX DNA** **a** **b** **c**

<b>810</b>	<b>Typing Laboratory</b>	Name: _____ Email: _____ Address: _____ City: _____ Date of sample: _____																																																																																	
<b>815</b>	<b>Laboratory Standards</b>	Accredited according to: _____ Not accredited 1 <input type="checkbox"/>																																																																																	
<b>820</b>	<b>STR kit(s) used</b>	Name(s) of kit(s) used: _____																																																																																	
<b>825</b>	<b>DNA</b>	<table border="1" style="width: 100%;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 30%;">Missing person</th> <th style="width: 40%;">Reference - Ref.no: _____</th> </tr> </thead> <tbody> <tr><td>VWA</td><td></td><td></td></tr> <tr><td>TH01</td><td></td><td></td></tr> <tr><td>D21S11</td><td></td><td></td></tr> <tr><td>FGA</td><td></td><td></td></tr> <tr><td>D8S1179</td><td></td><td></td></tr> <tr><td>D3S1358</td><td></td><td></td></tr> <tr><td>D18S51</td><td></td><td></td></tr> <tr><td>Amelogenin</td><td></td><td></td></tr> <tr><td>TPOX</td><td></td><td></td></tr> <tr><td>CSF1PO</td><td></td><td></td></tr> <tr><td>D13S317</td><td></td><td></td></tr> <tr><td>D7S820</td><td></td><td></td></tr> <tr><td>D5S818</td><td></td><td></td></tr> <tr><td>D16S539</td><td></td><td></td></tr> <tr><td>D2S1338</td><td></td><td></td></tr> <tr><td>D19S433</td><td></td><td></td></tr> <tr><td>Penta D</td><td></td><td></td></tr> <tr><td>Penta E</td><td></td><td></td></tr> <tr><td>D1S1656</td><td></td><td></td></tr> <tr><td>D2S441</td><td></td><td></td></tr> <tr><td>D10S1248</td><td></td><td></td></tr> <tr><td>D22S1045</td><td></td><td></td></tr> <tr><td>D12S391</td><td></td><td></td></tr> <tr><td>SE33</td><td></td><td></td></tr> <tr><td>D6S1043</td><td></td><td></td></tr> </tbody> </table>		Missing person	Reference - Ref.no: _____	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					
	Missing person	Reference - Ref.no: _____																																																																																	
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																																																																																			

Add any information not represented of the markers above, using c-column/page 700's Supporting information.

**830** Additional DNA profile page (805-825) 1  No 2  Yes

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

Family name: \_\_\_\_\_

AM No: \_\_\_\_\_

First name(s): \_\_\_\_\_

Date of birth:   Day

Month

Year

Age

Male

Female

Unknown

835 APPENDIX BODY SKETCH (for optional use)

