

Family name: AM No: _____
 First name(s):
 Date of birth:

Nature of disaster: _____
 Place of disaster: _____
 Date of disaster:

a = Data not available

b = Attachment

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

ADMINISTRATIVE DATA		a	b	c
100	Responsible agency Street / No. Postcode / Town State / Country Phone / Email	INTERPOL NCB: Police file No:		
105	Information given by Name Street / No. Postcode / Town State / Country Phone / Email Relationship	Date:		
110	Point of contact Name Street / No. Postcode / Town State / Country Phone / Email Relationship	1 <input type="checkbox"/> see 105		
115	Partner If not single see 230	Single - If not, First- / Middle- / Family name of partner: 1 <input type="checkbox"/> _____		
120	Fingerprinted 01 Source	1 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes Where: _____ Specify: _____ Date: _____		
125	If not, are fingerprints obtainable from residence/workplace/other 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)			

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EFFECTS (possibly carried on person or in luggage)							a	b	c	
310 Watch 01 Digital wristwatch 02 Analog wristwatch 03 Digital/analog w. 04 Smartwatch 05 If wristwatch, worn on 06 Watch strap/chain 07 Watch, other type	No:	1 Brand/make	2 Model	3 Main colour	4 Material	5 Inscription				
	Left	Right	Outside	Inside						
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
	Leather	Metal	Rubber	Other (specify):						
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
	Where worn:									
315 Glasses 01 Frame 02 Lenses (glass) 03 Shape of lenses 04 Lenses material/type	1 Brand/make	2 Model	3 Main colour	4 Material	5 Inscription					
	Self tinting	Tinted								
	1 <input type="checkbox"/>	2 <input type="checkbox"/> No	3 <input type="checkbox"/> Yes (specify):							
	Round	Oval	Square	Half	Rimless	Full rim				
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>				
320 Contact lenses	Glass	Polycarbonate	Bi-focal	Progressive						
	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>						
325 Hearing aids 01 Left 02 Right	No	Yes (if coloured specify):	Serial No:							
	1 <input type="checkbox"/>	2 <input type="checkbox"/>								
	No	Yes (specify):	Serial No:							
330 External prostheses	1 <input type="checkbox"/>	2 <input type="checkbox"/>								
	No	Yes (specify):	Serial No:							
335 Jewellery 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".	No:	1 Type/style	2 Main colour	3 Material	4 Inscription	5 Where worn				

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

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

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

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

Collected by Duty Title : Name : Address : Phone / Email :	Signature / Date
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BODY DESCRIPTION (external)					a	b	c				
404 Specific details	Head and neck 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 12 Left hand 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	No: 1	Scars	2	Piercings	3	Tattoos				
		No: 4	Skin marks	5	Malformations	6	Amputations				
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"/>	Wig 4 <input type="checkbox"/>	Implanted 5 <input type="checkbox"/>					
		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"/>							
		Blond 3 <input type="checkbox"/>	Brown 4 <input type="checkbox"/>	Black 5 <input type="checkbox"/>	Red 6 <input type="checkbox"/>						
		Grey 7 <input type="checkbox"/>	White 8 <input type="checkbox"/>	Mixed grey 9 <input type="checkbox"/>	Other (specify): 10 <input type="text"/>						
		Blond 1 <input type="checkbox"/>	Brown 2 <input type="checkbox"/>	Black 3 <input type="checkbox"/>	Red 4 <input type="checkbox"/>						
04 Natural colour	Grey 5 <input type="checkbox"/>	White 6 <input type="checkbox"/>	Mixed grey 7 <input type="checkbox"/>	Other (specify): 8 <input type="text"/>							
	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"/>						
05 Baldness	Describe (and use page Sup. Info. (700's) for details): _____										
06 Distinctive feature(s)	_____										

Collected by	Duty Title	:	Signature / Date
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BODY DESCRIPTION (external + fingerprint)		a	b	c
424 Eyebrows 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 Eyes 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 Nose 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 Facial hair 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 Ears 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 Mouth/teeth 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 Lips 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 Chin 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 Neck 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 Hands/nails 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 Feet/nails 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 Body/pubic hair 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 Circumcision	No 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/>			
476 Ancestry	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"/>			
480 Fingerprint 01 Number retrieved 02 Format 03 Development technique	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"/>			

Collected by	Duty Title : _____ Name : _____ Address : _____ Phone / Email : _____	Signature / Date _____
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Day Month Year Age Male Female Other Unknown

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PATHOLOGY (DNA related information)				a	b	c	
555	Reference	No: 1	Specify	2	Date of sample	3	Laboratory reference
	01 DNA-profile						
	02 Bio bank						
	03 Personal belonging						

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).

Maternal

Paternal

Note: DNA samples of close relatives, especially the mother, both parents or children are more useful than DNA samples from distant relatives.

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Day Month Year Age Male Female Other Unknown

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

Collected by	Duty Title	:	Signature / Date
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Family name: AM No:

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Day
Month
Year
Age
Male
Female
Other
Unknown

835 APPENDIX BODY SKETCH (for optional use)

