



MISSING PERSONS PACKET



MUPU OR AGENCY CASE NUMBER				AGENCY ORI					
NAME (Last, First, Middle)				ALIAS/NICKNAMES					
SEX <input type="checkbox"/> M <input type="checkbox"/> F		RACE <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK		<input type="checkbox"/> NATIVE AMERICAN <input type="checkbox"/> ASIAN OR PACIFIC ISLANDER		<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC		DATE OF BIRTH MO/DAY/YEAR	AGE
HEIGHT	WEIGHT	EYE COLOR <input type="checkbox"/> BLACK <input type="checkbox"/> BROWN	<input type="checkbox"/> BLUE <input type="checkbox"/> GRAY	<input type="checkbox"/> GREEN <input type="checkbox"/> HAZEL	<input type="checkbox"/> MAROON <input type="checkbox"/> PINK	<input type="checkbox"/> MULTI-COLORED <input type="checkbox"/> UNKNOWN			
HAIR COLOR <input type="checkbox"/> BLACK <input type="checkbox"/> WHITE <input type="checkbox"/> BLOND/STRAWBERRY		<input type="checkbox"/> BLOND <input type="checkbox"/> RED/AUBURN <input type="checkbox"/> BROWN		<input type="checkbox"/> ORANGE <input type="checkbox"/> PURPLE <input type="checkbox"/> PINK		<input type="checkbox"/> BLUE <input type="checkbox"/> GREEN <input type="checkbox"/> SANDY			<input type="checkbox"/> GRAY/PARTIALLY GRAY <input type="checkbox"/> UNKNOWN OR COMPLETELY BALD
SCARS, MARKS, DEFORMITIES (Describe and indicate location on body, including tattoos)									
DRIVER'S LICENSE NUMBER			OPERATOR'S LICENSE STATE			HAS THE MISSING PERSON EVER BEEN FINGERPRINTED? <input type="checkbox"/> NO <input type="checkbox"/> YES IF YES, BY WHOM?			
DATE AND TIME LAST SEEN MO/DAY/YR TIME AM <input type="checkbox"/> PM <input type="checkbox"/>			LOCATION LAST SEEN (City, State)			POSSIBLE DIRECTION OF TRAVEL (City, State)			
LAST SEEN WEARING (Hat, Shirt, Glasses, Pants, Shoes and Shoe Size, etc.)									

ASSOCIATES		PRESENT MENTAL STATE <input type="checkbox"/> DEPRESSED <input type="checkbox"/> SUICIDAL <input type="checkbox"/> AMNESIA <input type="checkbox"/> OTHER _____				
MISSING PERSON'S OCCUPATION						
MEDICATION REQUIRED <input type="checkbox"/> YES <input type="checkbox"/> NO		REASON _____ TYPE _____				
VEHICLE MAKE	MODEL	STYLE	YEAR	LICENSE NUMBER	LICENSE STATE	COLOR
OTHER IDENTIFYING CHARACTERISTICS OF VEHICLE (Vehicle Identification Number, license plate type, decals, damage, etc.)						

BACKGROUND INFORMATION

SOCIAL MEDIA

TRAFFICKING INFORMATION OR CONCERNS

PLEASE INCLUDE ANY PERTINENT INFORMATION REGARDING THE MISSING PERSON NOT ADDRESSED ELSEWHERE ON THIS FORM.

IF POSSIBLE, ENCLOSE A GOOD QUALITY DIGITAL PHOTO OF THE MISSING PERSON AND A CURRENT PHOTOGRAPH OF EACH MISSING PERSON.



MISSING PERSONS PACKET



NAME OF MISSING PERSON (Last, First, Middle)

DATE OF BIRTH

MEDICAL/DENTAL INFORMATION

NAME OF DENTIST	TELEPHONE NUMBER
STREET ADDRESS	CITY, STATE, ZIP
NAME OF PERSONAL PHYSICIAN	TELEPHONE NUMBER
STREET ADDRESS	CITY, STATE, ZIP

THE FOLLOWING DENTAL INFORMATION SHOULD BE SUBMITTED TO THE INVESTIGATING AGENCY:

- **ORIGINAL** X-RAYS (*old and most recent*)
- COPY OF TREATMENT RECORD
- INTRAORAL PHOTOGRAPHS
- DENTAL CASTS

DENTAL RECORDS AVAILABLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	DOCTOR'S RECORDS (x-rays, etc.) AVAILABLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	MISSING ORGANS	BLOOD TYPE
UNUSUAL DENTAL CHARACTERISTICS					DNA AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO

AUTHORIZATION TO RELEASE DENTAL AND MEDICAL INFORMATION

I am a family member, next of kin, or authorized official of the missing person reported on this form. I hereby authorize the release of all medical and dental records to assist law enforcement agencies in locating the missing person or the identification of human remains.

SIGNATURE OF AUTHORIZING PARTY		DATE
RELATIONSHIP	STREET ADDRESS	CITY, STATE, ZIP

**PLEASE NOTIFY THE WSP MISSING AND UNIDENTIFIED PERSONS UNIT
AS SOON AS POSSIBLE AFTER LOCATION OF PERSON HAS BEEN DETERMINED.**

SEND COMPLETED FORM TO:

WASHINGTON STATE PATROL
MISSING AND UNIDENTIFIED PERSONS UNIT
PO BOX 42634
OLYMPIA WA 98504-2634
1-800-543-5678 (KID-LOST)
E-Mail mupu@wsp.wa.gov
FAX (360) 704-2971



MISSING PERSONS PACKET



PUBLICATION REQUEST AND AGREEMENT

Regarding: _____ (missing person)

I request that the Washington State Patrol publish in a law enforcement bulletin the name, age, description, photograph, and circumstances surrounding the status of the Missing Person. Any information supplied by me shall be truthful. I understand that the information I provide may be published in more than 1,000 reports, made available to law enforcement, hospitals, medical examiners, children's shelters, social services, other agencies or organizations involved with missing person and, ultimately, the news media and the public.

In exchange for the distribution of this information, I agree to hold the Washington State Patrol and other law enforcement or state agencies harmless for any liability occasioned by the distribution of the information referenced above, including any liability or defense costs in an action that may be subsequently prosecuted by the subject missing person.

SIGNED

PRINT NAME

RELATIONSHIP TO MISSING PERSON

STREET ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER

E-MAIL ADDRESS

DATE

REPORTING AGENCY

AGENCY CASE #

NIC#

INVESTIGATING OFFICER

PHONE