



NATIONAL SKI PATROL SYSTEM, INC.
EUROPEAN DIVISION
MISSING PERSON REPORT



INCIDENT NO:

DATE OF INCIDENT:

TIME:

AM PM

PERSON REPORTING INCIDENT	NAME:										
	RELATIONSHIP TO MISSING PERSON:										
MISSING PERSON DATA	NAME:										
	ADDRESS:										
	CITY/STATE:						PHONE:				
	<input type="checkbox"/> MALE	RACE:			COLOR EYES:			HT:			
	<input type="checkbox"/> FEMALE	AGE:			COLOR HAIR:			WT:			
	BUILD:										
	OTHER PHYSICAL CHARACTERISTICS:										
CLOTHING	HAT:				SHIRT:				GLOVES:		
	COAT:				SHOES:				GLASSES:		
	PANTS:				BOOTS:				GOGGLES:		
TRAVEL	STARTED FROM:					DATE/TIME:					
	PLACE LAST SEEN:										
	LAST SEEN BY:										
	WHERE?					DATE/TIME:					
	DESTINATION, HEADING OR DIRECTION:										
	WITH COMPANIONS?		<input type="checkbox"/> NO	IF YES, WHO?							
		<input type="checkbox"/> YES									
EQUIPMENT	PREPARED FOR AN EMERGENCY?		<input type="checkbox"/> NO	MATCHES?	<input type="checkbox"/> NO	EQUIPPED FOR OVERNIGHT?		<input type="checkbox"/> NO	FOOD?		<input type="checkbox"/> NO
			<input type="checkbox"/> YES		<input type="checkbox"/> YES			<input type="checkbox"/> YES			<input type="checkbox"/> YES
OUTDOOR / SKIING EXPERIENCE	<input type="checkbox"/> ALPINE			<input type="checkbox"/> BEGINNER			<input type="checkbox"/> INTERMEDIATE			<input type="checkbox"/> MOUNTAINEERING	
	<input type="checkbox"/> NORDIC			<input type="checkbox"/> NOVICE			<input type="checkbox"/> ADVANCED/EXPERT			<input type="checkbox"/> CAMPER/HIKER	
	<input type="checkbox"/> OTHER:										
MEDICAL / HEALTH / PERSONAL FACTS	ALLERGIES?		<input type="checkbox"/> NONE	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> IF YES, WHAT?						
	MEDICATIONS?		<input type="checkbox"/> NONE	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> IF YES, WHAT?						
	DRUGS?		<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> IF YES, WHAT?						
	DRINKER?		<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> IF YES, ARE THEY A:		<input type="checkbox"/> LIGHT DRINKER?	<input type="checkbox"/> SOCIAL DRINKER?	<input type="checkbox"/> HEAVY DRINKER?	<input type="checkbox"/> ALCOHOLIC?	
	SMOKER?		<input type="checkbox"/> NO	<input type="checkbox"/> YES	AFRAID OF DARK?				HISTORY OF DEPRESSION?		
		<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> UNKNOWN		