



Case Number: _____

Shadow Research, Inc.

CONTRAIL EVENT FORM

Investigator: First _____ Middle _____ Last _____

WITNESS INFORMATION

First _____ Middle _____ Last _____ Age _____

Address _____ City _____ State _____ Zip _____

Country _____ Phone 1 _____ Phone 2 _____

Email Address _____ Occupation _____

Additional information about yourself that you would like to share: _____

WEATHER INFORMATION

Circle all that apply to the weather conditions.

Precipitation	Wind	Clouds	Temperature
a. Rain	a. None	a. None (Clear)	a. Cool
b. Sleet	b. Slight Breeze	b. Scattered	b. Cold
c. Snow	c. Strong Wind	c. Overcast	c. Below Freezing
d. Hail	d. Cold	d. Heavy	d. Warm
e. None	e. Warm	e. _____	e. Hot
f. Fog	f. Hot		f. _____
g. _____	g. _____		

Other weather events Additional detail about the weather that you would like to add: _____

a. Humid _____

b. Lightning _____

c. _____

CONTRAIL DETAILS

What were you doing when you first noticed the contrail (s)? _____

How did you feel when you first saw the contrail? _____

Did you notice any other aircraft, in the sky? Yes No If yes, explain _____

Did you take pictures or video? Yes No

Were there any news media, military or police present? Yes No If yes, explain: _____

On what type of formation did the contrails make?

- a. Single Straight Line
- b. Two Lines
- c. Three Lines
- d. Four Lines.
- e. More than 4 lines.
- f. An 'X' pattern
- g. A 45 degree angle
- h. A curved, round or oval shape
- i. Waffle Pattern
- j. Other:

Did you experience any of the following physical/psychological effects that you may attribute to the event.

- | | | | |
|-------------------------|-------|----|--------------|
| a. None | Yes | No | Don't Recall |
| b. Pain | Yes | No | Don't Recall |
| c. Tingling | Yes | No | Don't Recall |
| d. Headache | Yes | No | Don't Recall |
| e. Migraine | Yes | No | Don't Recall |
| f. Fatigue | Yes | No | Don't Recall |
| g. Nausea | Yes | No | Don't Recall |
| h. Breathing Difficulty | Yes | No | Don't Recall |
| i. Vibrations | Yes | No | Don't Recall |
| j. Nervousness | Yes | No | Don't Recall |
| k. Appetite loss | Yes | No | Don't Recall |
| l. Vomiting | Yes | No | Don't Recall |
| m. Stillness | Yes | No | Don't Recall |
| n. Heat | Yes | No | Don't Recall |
| o. Cold | Yes | No | Don't Recall |
| p. Paralysis | Yes | No | Don't Recall |
| q. Confusion | Yes | No | Don't Recall |
| r. Lethargy | Yes | No | Don't Recall |
| s. Angry | Yes | No | Don't Recall |
| t. Happy | Yes | No | Don't Recall |
| u. Other: | _____ | | |

Did any substance fall from the sky? Yes No
If yes, explain:

Did you notice any unusual lights or objects near the contrails formation? Yes No If yes, explain:

Explain in more detail: _____

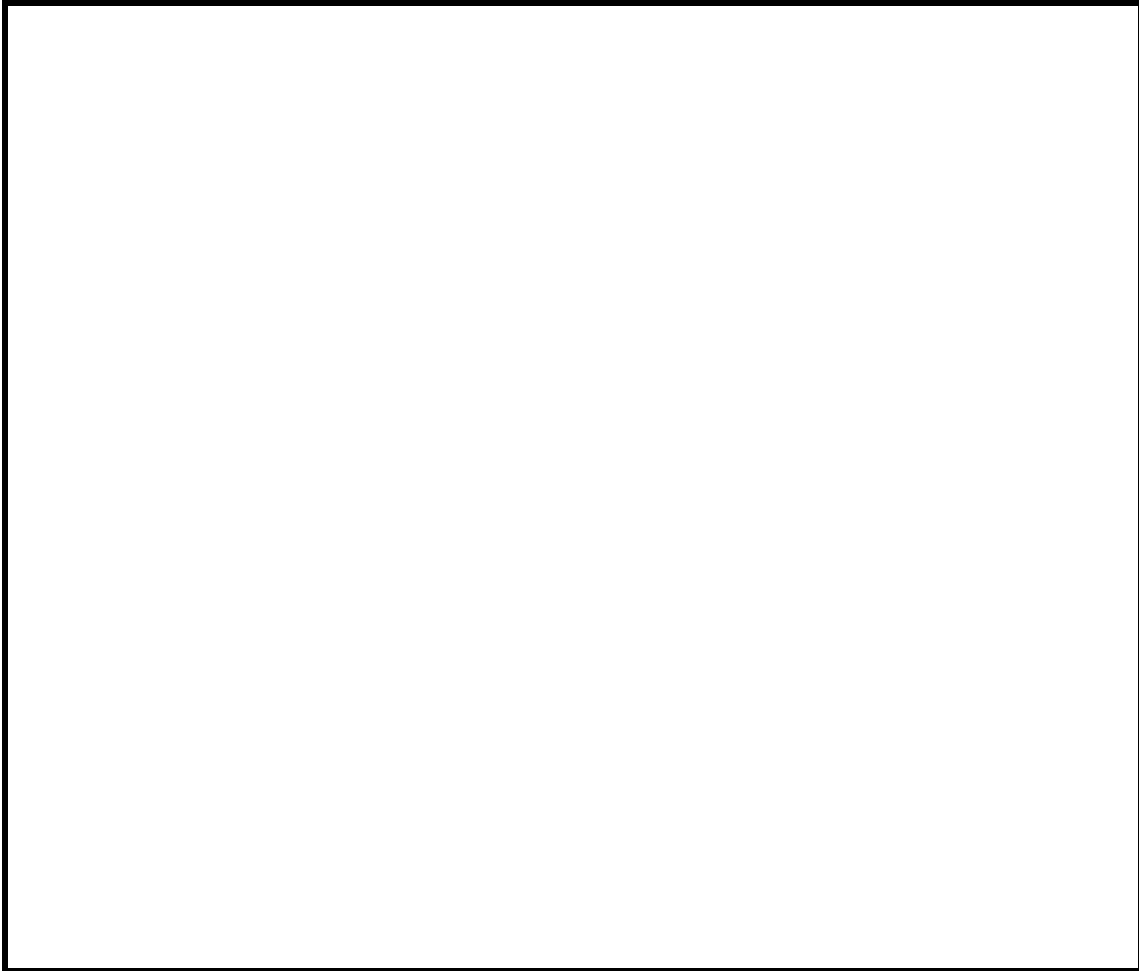
CONTRAIL ACCOUNT

Please write an account of what you observed. You may repeat information that you already used in this form. Please try to present information in the order in which the events occurred. Please make an additional sketch and add details such as trees, roads, landscapes, buildings or other items in the area.

CONTRAIL IMAGE

Shadow Research, Inc.

SKETCH THE CONTRAIL FORMATION



Any additional details that you would like to add: _____

Name: _____ Signature: _____ Date: _____

Yes, you can use my name () No, you may not use my name ()