



Case Number: _____

Shadow Research, Inc.

CROP CIRCLE 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. _____

FORMATION DETAILS

How did you find the formation? _____

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

Did you enter the formation? Yes No

Did you notice any other aircraft, people or vehicles in the area? Yes No **If yes, explain** _____

Did you take pictures or video? Yes No **Did you take samples of the crops / soil?** Yes No

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

On what type of surface was the formation made?

- a. Wheat
- b. Barley
- c. Soybean
- d. Linseed
- e. Oilseed Rape
- f. Corn
- g. Grass
- h. Ice
- i. Snow
- j. Rock
- k. Dirt
- l. Sand
- m. 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 "unwellness" | Yes | No | Don't Recall |
| s. Angry | Yes | No | Don't Recall |
| t. Happy | Yes | No | Don't Recall |
| u. Other: | _____ | | |

Were there any animals, insects or objects in or near the formation area? Yes No

If yes, explain: _____

Did you notice any unusual behavior on items, such as a car radio, or wristwatch? Yes No

If yes, explain: _____

Explain in more detail: _____

Did you notice any unusual lights near the formation?

Yes No **If yes, explain:** _____

FORMATION ACCOUNT

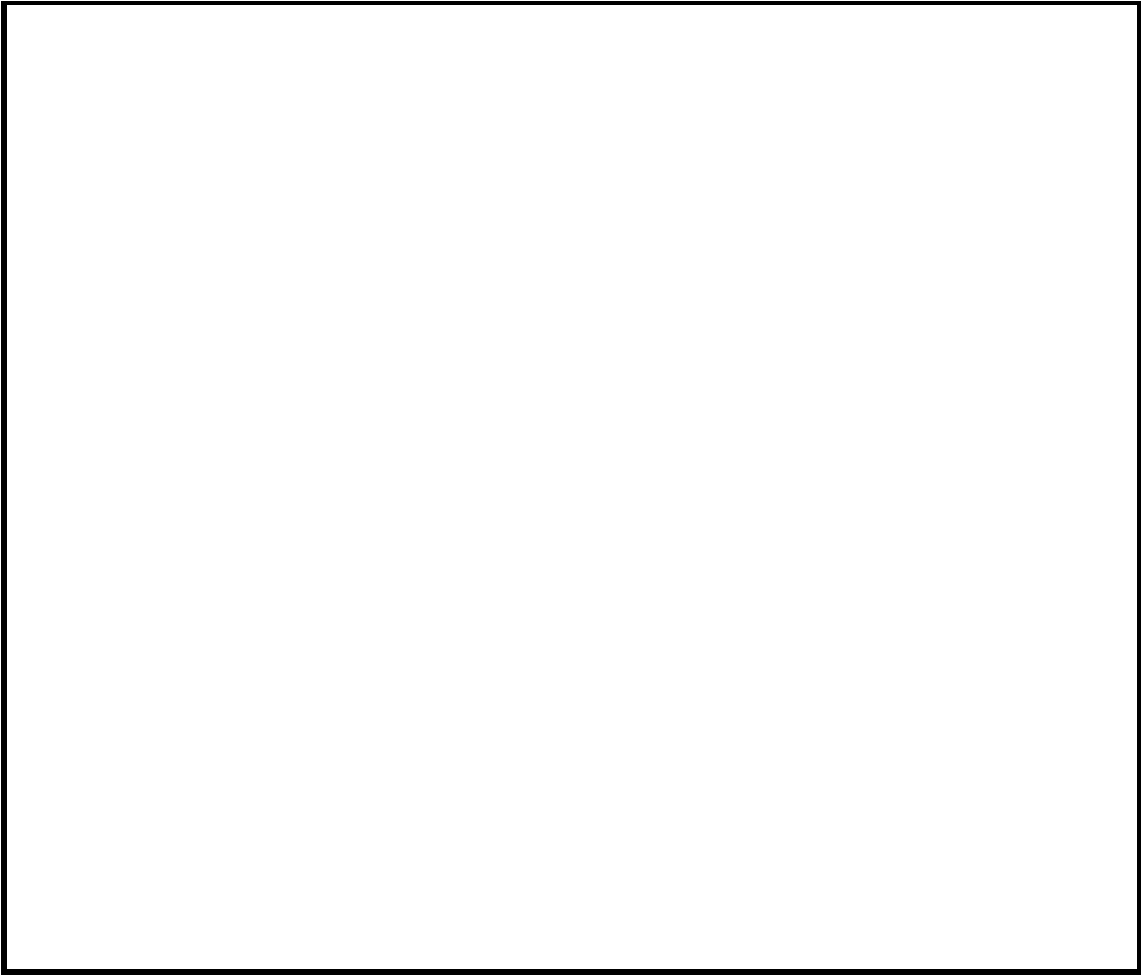
Please write an account of what you observed. You may repeat information that you already used in this form. Please try to present information in the order in which the events occurred. Please make an additional sketch and add details such as trees, roads, landscapes, buildings or other items in the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

FORMATION IMAGE

Was there any sound? Yes No If yes, explain: _____

Did you or anyone you were with experience any type of healing? Yes No
If yes, explain: _____

SKETCH THE 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 ()