Return These Forms To:

MUFON Investigator :

Investigator Address :

Investigator Phone: Email:

Date of Sighting: Day: Month: Year:

Place of Sighting : City/Town: County: St./Prov:

Country

Sighting Time : ( ) AM ( ) PM Time Zone:

Duration of Sighting: Seconds ( ) Minutes ( ) Hours ( )

Witness Information

Witness Name: Age:

Street Address:

Town / City: Home Phone: cell:

Fax:

State / Province: Country:

Occupation:

Employed By:

Witness Data

Education:

Degree: Major:

Minor:

Special or Advanced Training:

Vision: Good ( ) Fair ( ) Poor ( ) Eyeglasses or Contacts? Yes ( ) No ( )

Colorblind? Yes ( ) No (Type:

Hearing: Good ( ) Fair ( ) Poor ( ) Use Hearing Aid? Yes ( ) no ( )

Health: Before Sighting?

During Sighting? After Sighting?

Weather Information

Temperature: Visibility:

Wind Direction: Wind Speed:

Ceiling: Other:

Cloud Base:

Witness Signature

Witness Confidentiality (check one): YES, You May Use My Name: ( ) NO, Please Do Not Use My Name: ( )

Witness Signature: Date:

Any Other Agency Contact You? YES [ ] NO [ ]	
Please List The Names Of Other Witnesses:	
1	
2	
3	
4	