

## PROJECT 10073 RECORD

|                                                                                                |                                                                           |
|------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|
| 1. DATE - TIME GROUP<br>4 October 68 04/2000<br>04/2400Z                                       | 2. LOCATION<br>Near Dayton, Ohio                                          |
| 3. SOURCE<br>Civilian                                                                          | 10. CONCLUSION<br>INSUFFICIENT DATA FOR EVALUATION                        |
| 4. NUMBER OF OBJECTS<br>One                                                                    | The observer has not returned her AF Form 117 as of 18 Nov 68.            |
| 5. LENGTH OF OBSERVATION<br>20 Minutes                                                         | 11. BRIEF SUMMARY AND ANALYSIS                                            |
| 6. TYPE OF OBSERVATION<br>Ground-Visual                                                        | The observer reported to the FTD Duty Officer that she had sighted a UFO. |
| 7. COURSE<br>Not Reported                                                                      |                                                                           |
| 8. PHOTOS<br><input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No            |                                                                           |
| 9. PHYSICAL EVIDENCE<br><input type="checkbox"/> Yes<br><input checked="" type="checkbox"/> No |                                                                           |

FORM  
FTD SEP 63 0-329 (TDE) Previous editions of this form may be used.



22. HAVE YOU EVER BEEN THIS OR A SIMILAR PHENOMENON BEFORE? ☐ YES ☐ NO. IF "YES," GIVE DATE AND LOCATION.

23. WAS ANYONE WITH YOU AT THE TIME YOU SAW THE PHENOMENON? ☐ YES ☐ NO. IF "YES," DID THEY SEE IT TOO?

A. LIST THEIR NAMES AND ADDRESSES

Husband

24. GIVE THE FOLLOWING INFORMATION ABOUT YOURSELF

LAST NAME, FIRST NAME, MIDDLE NAME

ADDRESS (Street, City, State and Zip Code)

BEAVER CREEK, OHIO 45432

TELEPHONE (Area code and number)

AGE

43

MALE

☒

FEMALE

INDICATE ADDITIONAL INFORMATION INCLUDING OCCUPATION AND ANY EXPERIENCE WHICH MAY BE PERTINENT.

25. WHEN AND TO WHOM DID YOU REPORT THAT YOU HAD SIGHTED THIS PHENOMENON?

NAME \_\_\_\_\_ DAY \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

26. DATE YOU COMPLETED THIS QUESTIONNAIRE.

DAY \_\_\_\_\_ MONTH \_\_\_\_\_ YEAR \_\_\_\_\_



DEPARTMENT OF THE AIR FORCE  
HEADQUARTERS FOREIGN TECHNOLOGY DIVISION (AFSC)  
WRIGHT-PATTERSON AIR FORCE BASE, OHIO 45433



REPLY TO  
ATTN OF:

TDPT (UFO)

SUBJECT:

UFO Observation

, 4 October 1968

TO:

Mr. [REDACTED]

Dayton, Ohio 45432

Reference your recent unidentified flying object sighting which you reported to the Air Force. The information which we have received is not sufficient for a scientific investigation. Request you complete the attached AF Form 117 and return it in the self-addressed envelope. Thank you for reporting your observation to the Air Force.

HECTOR QUINTANILLA, Jr, Lt Colonel, USAF  
Chief, Aerial Phenomena Office  
Aerospace Technologies Division  
Production Directorate

1 Atch  
AF Form 117 w/envelope



*Duty Officer Lps*

AFR 80-17(C1)

SIGHTING OF UNIDENTIFIED PHENOMENA QUESTIONNAIRE

BUDGET BUREAU APPROVAL  
NUMBER 21-2233

THIS QUESTIONNAIRE HAS BEEN PREPARED SO THAT YOU CAN GIVE THE U.S. AIR FORCE AS MUCH INFORMATION AS POSSIBLE CONCERNING THE UNIDENTIFIED PHENOMENON THAT YOU HAVE OBSERVED. PLEASE TRY TO ANSWER ALL OF THE QUESTIONS. THE INFORMATION YOU GIVE WILL BE USED FOR RESEARCH PURPOSES. YOUR NAME WILL NOT BE USED IN CONNECTION WITH ANY OF YOUR STATEMENTS OR CONCLUSIONS WITHOUT YOUR PERMISSION. RETURN TO AIR FORCE BASE INVESTIGATOR FOR FORWARDING TO FTD (TDETR), WRIGHT-PATTERSON AFB, OHIO 45433, 1AW AFR 80-17. (IF ADDITIONAL SHEETS ARE NEEDED FOR NARRATIVE OR SKETCHES ATTACH SECURELY TO THIS FORM OR ANNOTATE WITH YOUR NAME FOR IDENTIFICATION.)

1. WHEN DID YOU SEE THE PHENOMENON?

DAY 4 MONTH OCT YEAR 1968

2. WHAT TIME DID YOU FIRST SIGHT THE PHENOMENON?

HOUR 2000 MINUTES \_\_\_\_\_ ☐ A.M. ☐ P.M.

3. WHAT TIME DID YOU LAST SIGHT THE PHENOMENON?

HOUR 2020 MINUTES \_\_\_\_\_ ☐ A.M. ☐ P.M.

4. TIME ZONE

☐ DAYLIGHT SAVINGS

☐ STANDARD

☒ EASTERN

☐ CENTRAL

☐ MOUNTAIN

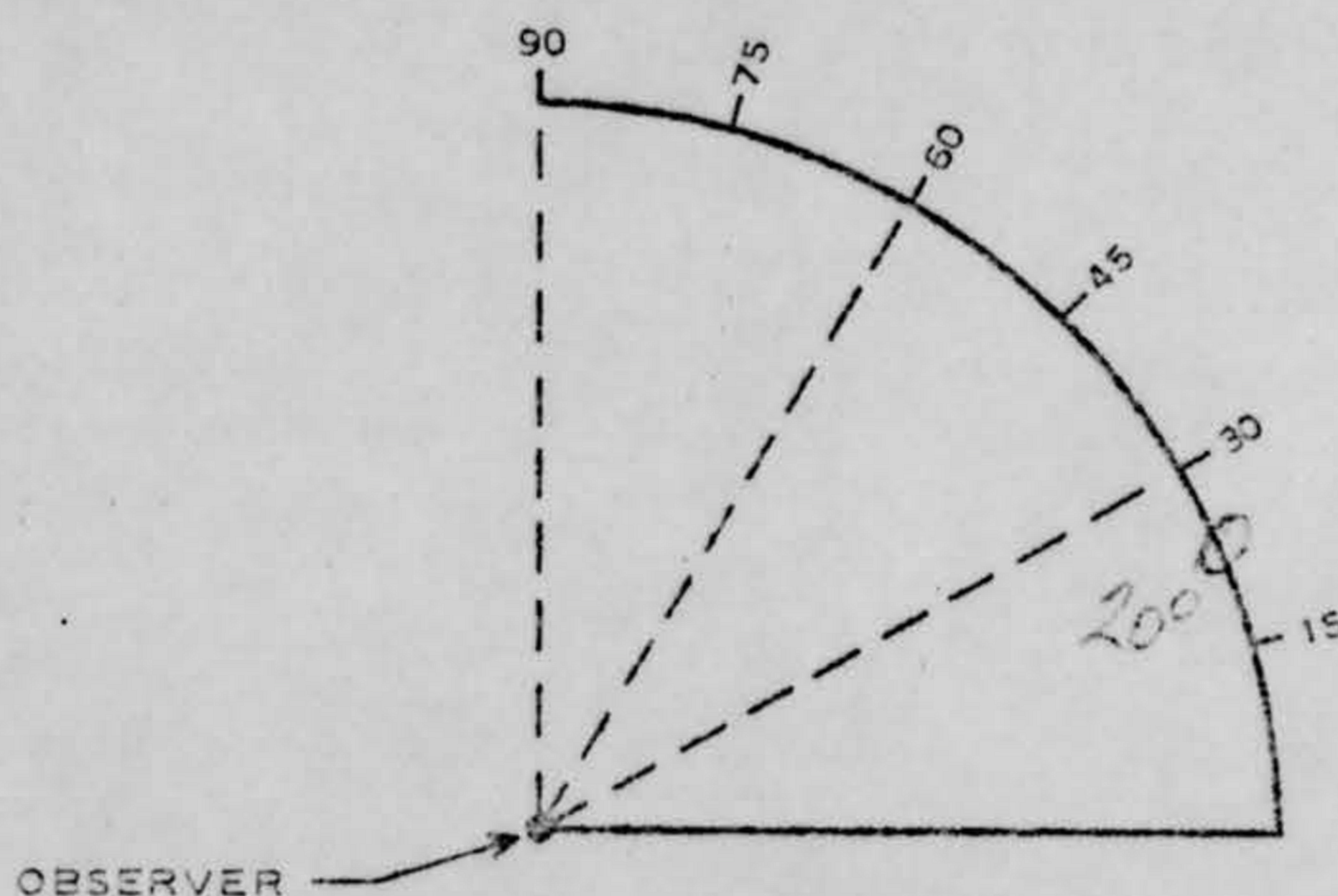
☐ PACIFIC

☐ OTHER

5. WHERE WERE YOU WHEN YOU SAW THE PHENOMENON? IF IN CITY, GIVE THE NEAREST STREET ADDRESS AND INDICATE ON A HAND DRAWN MAP WHERE YOU WERE STANDING WITH REFERENCE TO THE ADDRESS. IF IN THE COUNTRY, IDENTIFY THE HIGHWAY YOU WERE ON OR NEAR AND TRY TO FIX A DISTANCE AND DIRECTION FROM SOME RECOGNIZABLE LANDMARK.

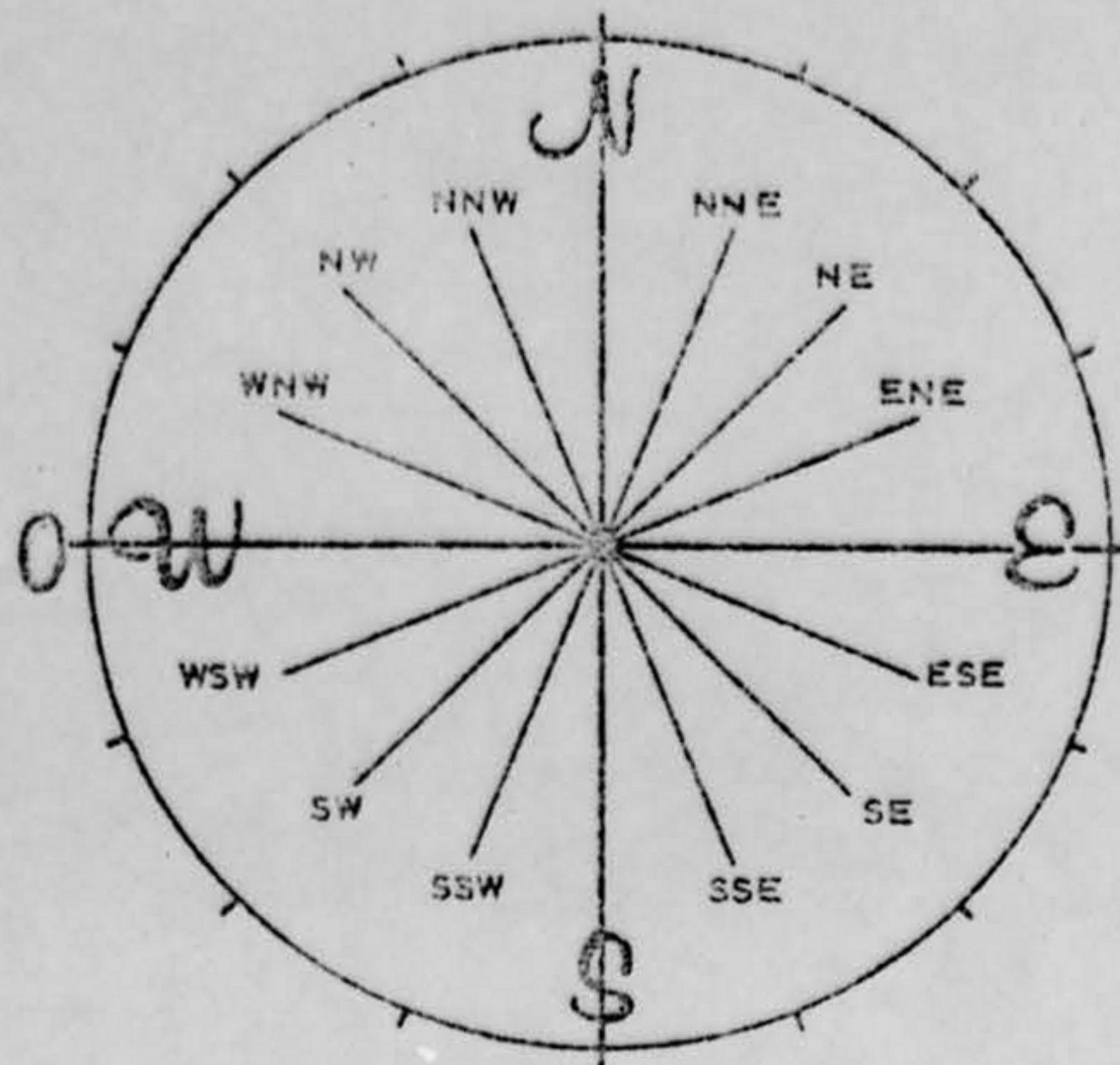
*BEAVER CREEK, DOWN 35 TOWARD DAYTON*

6. IMAGINE YOU ARE AT THE POINT SHOWN IN THE SKETCH, PLACE AN "A" ON THE CURVED LINE TO SHOW HOW HIGH THE PHENOMENON WAS ABOVE THE HORIZON, OR SKYLINE, WHEN FIRST SEEN. PLACE A "B" ON THE SAME CURVED LINE TO SHOW HOW HIGH ABOVE THE HORIZON THE PHENOMENON WAS WHEN LAST SEEN.

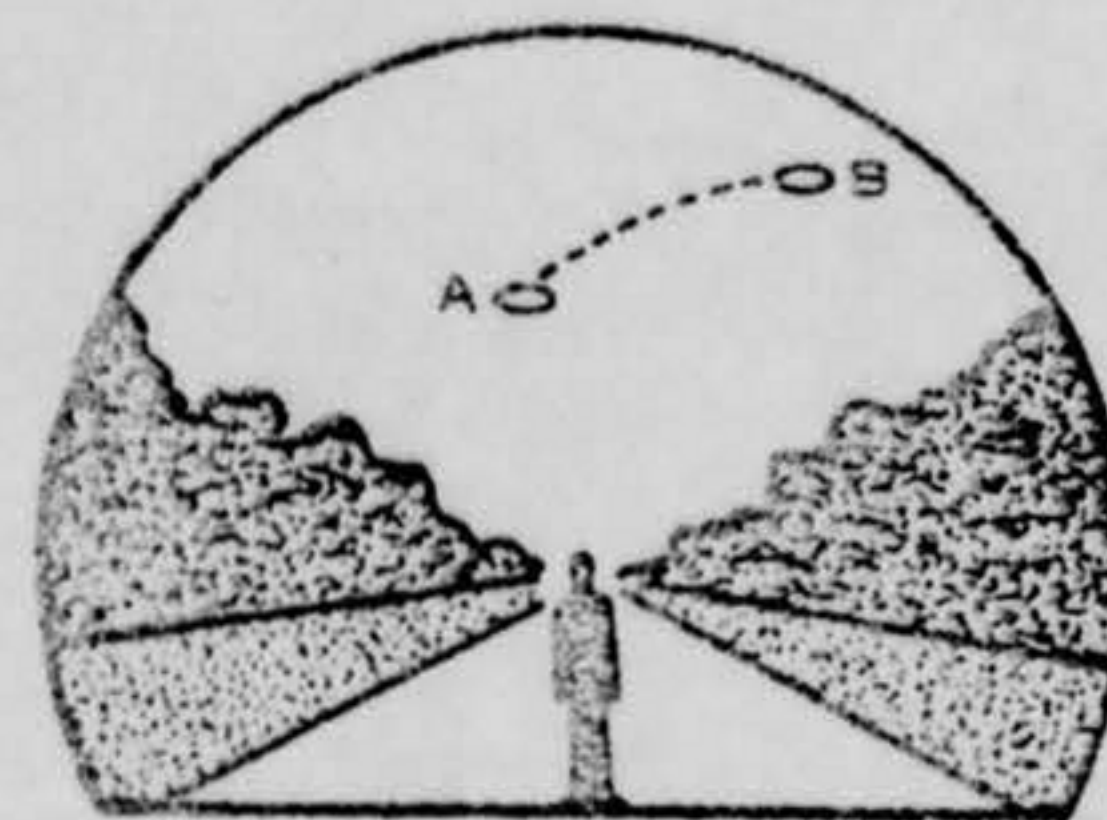
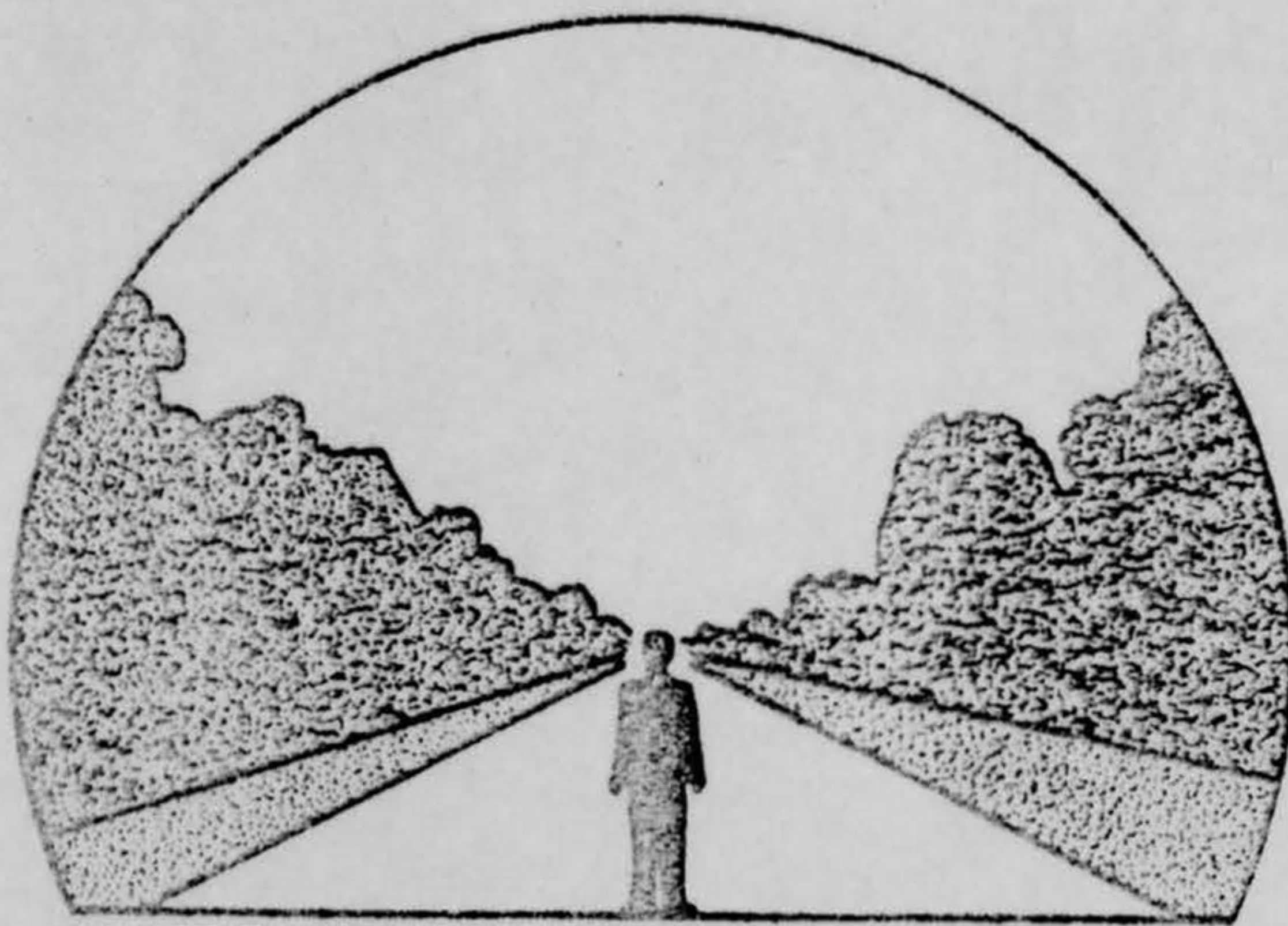




6A. NOW IMAGINE YOU ARE AT THE CENTER OF THE COMPASS ROSE. PLACE AN "A" ON THE COMPASS TO INDICATE THE DIRECTION TO THE PHENOMENON WHEN FIRST SEEN. PLACE A "B" ON THE COMPASS TO INDICATE THE DIRECTION TO THE PHENOMENON WHEN LAST SEEN.



7. IN THE SKETCH BELOW, PLACE AN "A" AT THE POSITION OF THE PHENOMENON WHEN FIRST SEEN, AND A "B" AT THE POSITION OF THE PHENOMENON WHEN LAST SEEN. CONNECT THE "A" AND "B" WITH A LINE TO APPROXIMATE THE MOVEMENT OF THE PHENOMENON BETWEEN "A" AND "B". THAT IS, SCHEMATICALLY SHOW WHETHER THE MOVEMENT APPEARED TO BE STRAIGHT, CURVED OR ZIG-ZAG. REFER TO SMALLER SKETCH AS AN EXAMPLE OF HOW TO COMPLETE THE LARGER SKETCH.



Slowly Moved  
N to S



| 8. WHERE WERE YOU WHEN YOU SAW THE PHENOMENON? (Check appropriate blocks.)                                                                                                                                                                                                                                          |                                                                          |                                                                                                                  |                                                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| OUTDOORS                                                                                                                                                                                                                                                                                                            |                                                                          | IN BUSINESS SECTION OF CITY                                                                                      |                                                   |
| IN BUILDING                                                                                                                                                                                                                                                                                                         |                                                                          | <input checked="" type="checkbox"/> IN RESIDENTIAL SECTION OF CITY                                               |                                                   |
| IN CAR                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> AS DRIVER <input type="checkbox"/> AS PASSENGER | IN OPEN COUNTRYSIDE                                                                                              |                                                   |
| IN BOAT                                                                                                                                                                                                                                                                                                             |                                                                          | NEAR AIRFIELD                                                                                                    |                                                   |
| IN AIRPLANE                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> AS PILOT <input type="checkbox"/> AS PASSENGER  | FLYING OVER CITY                                                                                                 |                                                   |
| OTHER <i>be come Kitchen</i>                                                                                                                                                                                                                                                                                        |                                                                          | FLYING OVER OPEN COUNTRY                                                                                         |                                                   |
|                                                                                                                                                                                                                                                                                                                     |                                                                          | OTHER                                                                                                            |                                                   |
| A. IF YOU WERE IN A VEHICLE, COMPLETE THE FOLLOWING:                                                                                                                                                                                                                                                                |                                                                          |                                                                                                                  |                                                   |
| WHAT DIRECTION WERE YOU MOVING?                                                                                                                                                                                                                                                                                     |                                                                          | HOW FAST WERE YOU MOVING?                                                                                        |                                                   |
| NORTH                                                                                                                                                                                                                                                                                                               | EAST                                                                     | DID YOU STOP ANYTIME WHILE OBSERVING THE PHENOMENON?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                                                   |
| SOUTH                                                                                                                                                                                                                                                                                                               | WEST                                                                     |                                                                                                                  |                                                   |
| NORTHEAST                                                                                                                                                                                                                                                                                                           | SOUTHEAST                                                                |                                                                                                                  |                                                   |
| NORTHWEST                                                                                                                                                                                                                                                                                                           | SOUTHWEST                                                                |                                                                                                                  |                                                   |
| EXPLAIN WHETHER SUCH MOVEMENT AFFECTS YOUR SKETCHES IN ITEMS 5 AND 6.                                                                                                                                                                                                                                               |                                                                          |                                                                                                                  |                                                   |
| DESCRIBE TYPE OF VEHICLE YOU WERE IN AND TYPE OF ROAD, TERRAIN OR BODY OF WATER YOU TRAVERSED DURING THE SIGHTING. STATE WHETHER WINDOWS OR CONVERTIBLE TOP WERE UP OR DOWN.                                                                                                                                        |                                                                          |                                                                                                                  |                                                   |
| HOW MUCH OTHER TRAFFIC WAS THERE?                                                                                                                                                                                                                                                                                   |                                                                          |                                                                                                                  |                                                   |
| DID YOU NOTICE ANY AIRPLANES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO. IF "YES," DESCRIBE WHEN THEY WERE IN SIGHT RELATIVE TO THE TIME OF SIGHTING THE PHENOMENON AND WHERE THEY WERE IN THE SKY RELATIVE TO THE POSITION OF THE PHENOMENON.<br><i>1 AIRCRAFT</i>                       |                                                                          |                                                                                                                  |                                                   |
| 9. HOW LONG WAS THE PHENOMENON IN SIGHT?                                                                                                                                                                                                                                                                            |                                                                          |                                                                                                                  |                                                   |
| LENGTH OF TIME                                                                                                                                                                                                                                                                                                      |                                                                          | CERTAIN OF TIME                                                                                                  | <input checked="" type="checkbox"/> NOT VERY SURE |
| <i>20 min</i>                                                                                                                                                                                                                                                                                                       |                                                                          | FAIRLY CERTAIN                                                                                                   | JUST A GUESS                                      |
| HOW WAS TIME DETERMINED?<br><i>GUESS</i>                                                                                                                                                                                                                                                                            |                                                                          |                                                                                                                  |                                                   |
| WAS THE PHENOMENON IN SIGHT CONTINUOUSLY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO. IF "NO," INDICATE WHETHER THIS IS DUE TO YOUR MOVEMENT OR THE BEHAVIOR OF THE PHENOMENON, AND DESCRIBE SUCH MOVEMENT OR BEHAVIOR. INDICATE DISAPPEARANCES ON PREVIOUS SKETCHES.<br><i>Stationary</i> |                                                                          |                                                                                                                  |                                                   |



10. IF THERE WERE MORE THAN ONE PHENOMENON, HOW MANY WERE THERE? DRAW A PICTURE TO SHOW HOW THEY WERE ARRANGED. DID THIS ARRANGEMENT CHANGE DURING THE SIGHTING?

11. CONDITIONS (Check appropriate blocks.)

| A. SKY                                       |  | B. WEATHER                                                           |                                                |
|----------------------------------------------|--|----------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> DAY                 |  | <input type="checkbox"/> CUMULUS CLOUDS (Low fluffy)                 | <input type="checkbox"/> FOG OR MIST           |
| <input type="checkbox"/> TWILIGHT            |  | <input type="checkbox"/> CIRRUS CLOUDS (High fleecy or Herring-bone) | <input type="checkbox"/> HEAVY RAIN            |
| <input checked="" type="checkbox"/> NIGHT    |  |                                                                      | <input type="checkbox"/> LIGHT RAIN OR DRIZZLE |
| <input type="checkbox"/> CLEAR               |  | <input type="checkbox"/> NIMBUS CLOUDS (Rain)                        | <input type="checkbox"/> HAIL                  |
| <input type="checkbox"/> PARTLY CLOUDY       |  | <input type="checkbox"/> CUMULONIMBUS CLOUDS (Thunderstorms)         | <input type="checkbox"/> SNOW OR SLEET         |
| <input type="checkbox"/> COMPLETELY OVERCAST |  |                                                                      | <input type="checkbox"/> UNKNOWN               |
|                                              |  | <input type="checkbox"/> HAZE OR SMOG                                | <input type="checkbox"/> NONE OF THE ABOVE     |

C. IF THE SIGHTING WAS AT TWILIGHT OR NIGHT, WHAT DID YOU NOTICE ABOUT THE STARS AND MOON?

| (1) STARS                                 | (2) MOON                                                  |
|-------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> NONE             | <input type="checkbox"/> BRIGHT MOONLIGHT                 |
| <input checked="" type="checkbox"/> A FEW | <input type="checkbox"/> MOON WITH HALO                   |
| <input type="checkbox"/> MANY             | <input checked="" type="checkbox"/> MOON HIDDEN BY CLOUDS |
| <input type="checkbox"/> UNKNOWN          | <input type="checkbox"/> PARTIAL (New or quarter)         |

D. IF SIGHTING WAS IN DAYLIGHT, WAS THE SUN VISIBLE? ☐ YES ☐ NO. IF "YES," WHERE WAS THE SUN AS YOU FACED THE PHENOMENON?

|                                          |                                        |                                               |
|------------------------------------------|----------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> IN FRONT OF YOU | <input type="checkbox"/> TO YOUR RIGHT | <input type="checkbox"/> OVERHEAD (Near noon) |
| <input type="checkbox"/> IN BACK OF YOU  | <input type="checkbox"/> TO YOUR LEFT  | <input type="checkbox"/> UNKNOWN              |

E. SPECIFY THE MAJOR SOURCE OF ILLUMINATION PRESENT DURING THE SIGHTING, SUCH AS THE SUN, HEADLIGHTS OR STREET LAMP, ETC. FOR TERRESTRIAL ILLUMINATION, SPECIFY DISTANCE TO LIGHT SOURCE.

12. GIVE A BRIEF DESCRIPTION OF THE PHENOMENON, INDICATING WHETHER IT APPEARED DARK OR LIGHT, WHETHER IT REFLECTED LIGHT OR WAS SELF-LUMINOUS AND WHAT COLORS YOU NOTICED. DESCRIBE YOUR IMPRESSION OF WHETHER IT WAS SOLID OR TRANSPARENT, WHETHER EDGES WERE SHARP OR FUZZY. DESCRIBE THE SHAPE OR INDICATE IF IT APPEARED AS A POINT OF LIGHT. INDICATE COMPARISONS WITH OTHER OBSERVED OBJECTS, LIKE STARS, A LIGHT OR OTHER OBJECT IN YOUR FIELD OF VIEW.

light yellow white white



| 13.                             | DID THE PHENOMENON | YES                                 | NO                                  | UNKNOWN |
|---------------------------------|--------------------|-------------------------------------|-------------------------------------|---------|
| MOVE IN A STRAIGHT LINE?        | VERY slowly        | <input checked="" type="checkbox"/> |                                     |         |
| STAND STILL AT ANYTIME?         |                    | <input checked="" type="checkbox"/> |                                     |         |
| SUDDENLY SPEED UP AND RUN AWAY? |                    |                                     | <input checked="" type="checkbox"/> |         |
| BREAK UP IN PARTS AND EXPLODE?  |                    |                                     | <input checked="" type="checkbox"/> |         |
| CHANGE COLOR?                   | Redish             | <input checked="" type="checkbox"/> |                                     |         |
| GIVE OFF SMOKE?                 |                    |                                     | <input checked="" type="checkbox"/> |         |
| CHANGE BRIGHTNESS?              |                    |                                     | <input checked="" type="checkbox"/> |         |
| CHANGE SHAPE?                   |                    |                                     | <input checked="" type="checkbox"/> |         |
| FLASH OR FLICKER?               |                    |                                     | <input checked="" type="checkbox"/> |         |
| DISAPPEAR AND REAPPEAR?         |                    |                                     | <input checked="" type="checkbox"/> |         |
| SPIN LIKE A TOP?                |                    |                                     | <input checked="" type="checkbox"/> |         |
| MAKE A NOISE?                   |                    |                                     | <input checked="" type="checkbox"/> |         |
| FLUTTER OR WOBBLE?              |                    |                                     | <input checked="" type="checkbox"/> |         |

14. WHAT DREW YOUR ATTENTION TO THE PHENOMENON?

Just looking out window and saw it.

A. HOW DID IT FINALLY DISAPPEAR?

behind trees

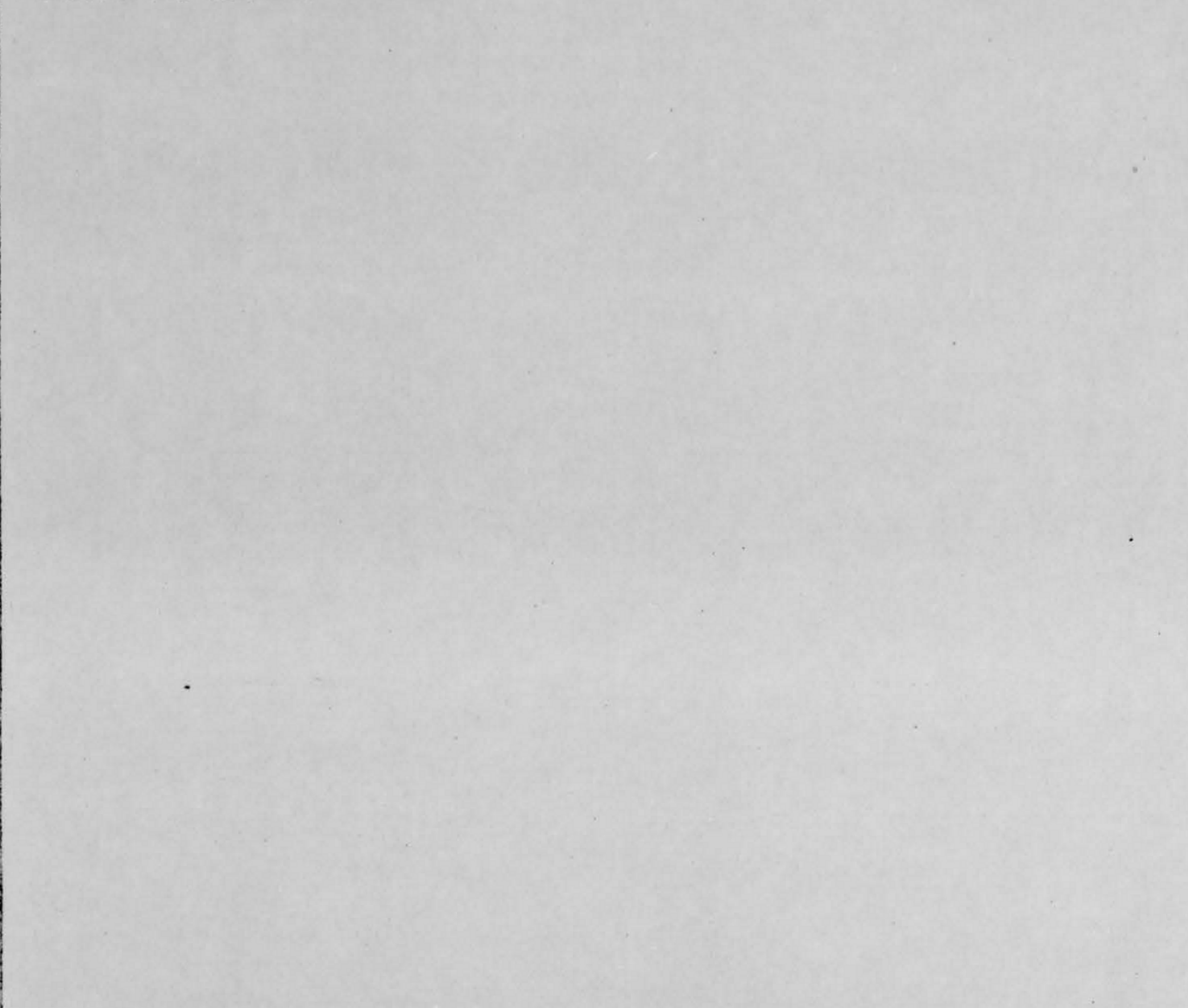
B. DID THE PHENOMENON MOVE BEHIND OR IN FRONT OF SOMETHING, LIKE A CLOUD, TREE, OR BUILDING AT ANY TIME?

☒ YES ☐ NO. IF "YES," DESCRIBE.

trees and telephone pole



13. DRAW A PICTURE THAT WILL SHOW THE SHAPE OF THE PHENOMENON. INCLUDE AND LABEL ANY DETAILS THAT MIGHT HAVE APPEARED AS WINGS OR PROTRUSIONS, AND INDICATE EXHAUST OR VAPOR TRAILS. INDICATE BY AN ARROW THE DIRECTION THE PHENOMENON WAS MOVING.



15. WHAT WAS THE ANGULAR SIZE? HOLD A MATCH AT ARM'S LENGTH IN FRONT OF A KNOWN OBJECT, SUCH AS A STREET LAMP OR THE MOON. NOTE HOW MUCH OF THE OBJECT IS COVERED BY THE HEAD OF THE MATCH. NOW IF YOU HAD BEEN ABLE TO PERFORM THIS EXPERIMENT AT THE TIME OF THE SIGHTING, ESTIMATE WHAT FRACTION OF THE PHENOMENON WOULD HAVE BEEN COVERED BY THE MATCH HEAD.





|                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| 17. DID YOU OBSERVE THE PHENOMENON THROUGH ANY OF THE FOLLOWING? INCLUDE INFORMATION ON MODEL, TYPE, FILTER, LENS PRESCRIPTION OR OTHER APPLICABLE DATA.                                                                                                                                                                                       |                                                                                                    |
| <input checked="" type="checkbox"/> EYEGLASSES                                                                                                                                                                                                                                                                                                 | CAMERA VIEWER                                                                                      |
| SUNGLASSES                                                                                                                                                                                                                                                                                                                                     | BINOCULARS                                                                                         |
| WINDSHIELD                                                                                                                                                                                                                                                                                                                                     | <input checked="" type="checkbox"/> TELESCOPE <i>could not see it</i>                              |
| SIDE WINDOW OF VEHICLE                                                                                                                                                                                                                                                                                                                         | THEODOLITE                                                                                         |
| <input checked="" type="checkbox"/> WINDOWPANE                                                                                                                                                                                                                                                                                                 | OTHER                                                                                              |
| A. DO YOU ORDINARILY WEAR GLASSES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO                                                                                                                                                                                                                                         | B. DO YOU USE READING GLASSES? <input type="checkbox"/> YES <input type="checkbox"/> NO            |
| 18. WHAT WAS YOUR IMPRESSION OF THE SPEED OF THE PHENOMENON? GIVE ESTIMATE OF SPEED <i>10 mph</i>                                                                                                                                                                                                                                              | 19. WHAT WAS YOUR IMPRESSION OF THE DISTANCE OF THE PHENOMENON? GIVE ESTIMATE OF DISTANCE <i>2</i> |
| 20. IN ORDER THAT WE MAY OBTAIN AS CLEAR A PICTURE AS POSSIBLE OF WHAT YOU SAW, DESCRIBE IN YOUR OWN WORDS A COMMON OBJECT OR OBJECTS WHICH, WHEN PLACED IN THE SKY, SIMILAR TO WHERE YOU NOTED THE PHENOMENON, WOULD BEAR SOME RESEMBLANCE TO WHAT YOU SAW. DESCRIBE SIMILARITIES AND DIFFERENCES BETWEEN THE COMMON OBJECT AND WHAT YOU SAW. |                                                                                                    |
| <i>light</i>                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |
| 21. DID YOU NOTICE ANY ODOR, NOISE, OR HEAT EMANATING FROM THE PHENOMENON OR ANY EFFECT ON YOURSELF, ANIMALS OR MACHINERY IN THE VICINITY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO. IF "YES," DESCRIBE.                                                                                                            |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |
| A. DID THE PHENOMENON DISTURB THE GROUND OR LEAVE ANY PHYSICAL EVIDENCE. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO. IF "YES," DESCRIBE.                                                                                                                                                                              |                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |