

Bomb Threat Checklist

Instructions: Fill out the form below with as much information as possible. Remain calm and be courteous with the caller. Do not interrupt the caller.

Time of Threat:	Date:	Phone number call received from:
EXACT WORDING OF THE THREAT:		
ASK THE CALLER:		
1. Where is the bomb going to explode?	5. What will cause the bomb to explode?	
2. When is the bomb going to explode?	6. Did you place the bomb? If so, why?	
3. What does the bomb look like?	7. What is your location?	
4. What kind of bomb is it?	8. What is your name?	
CALLER'S VOICE: <input type="checkbox"/> Southern Accent: <input type="checkbox"/> Local <input type="checkbox"/> Middle East <input type="checkbox"/> Hispanic <input type="checkbox"/> African <input type="checkbox"/> Northern <input type="checkbox"/> Midwestern <input type="checkbox"/> Other: _____	Manner: <input type="checkbox"/> Calm <input type="checkbox"/> Rational <input type="checkbox"/> Coherent <input type="checkbox"/> Deliberate <input type="checkbox"/> Righteous <input type="checkbox"/> Angry <input type="checkbox"/> Irrational <input type="checkbox"/> Incoherent <input type="checkbox"/> Emotional <input type="checkbox"/> Laughing	Background: <input type="checkbox"/> Machines <input type="checkbox"/> Music <input type="checkbox"/> None <input type="checkbox"/> Traffic <input type="checkbox"/> Trains <input type="checkbox"/> Animals <input type="checkbox"/> Voices <input type="checkbox"/> Airplanes <input type="checkbox"/> Other: _____
Voice: <input type="checkbox"/> Loud <input type="checkbox"/> High Pitch <input type="checkbox"/> Raspy <input type="checkbox"/> Intoxicated <input type="checkbox"/> Soft <input type="checkbox"/> Deep <input type="checkbox"/> Other: _____	Speech: <input type="checkbox"/> Fast <input type="checkbox"/> Distinct <input type="checkbox"/> Distorted <input type="checkbox"/> Slurred <input type="checkbox"/> Slow <input type="checkbox"/> Stutter <input type="checkbox"/> Nasal	Threat Language: <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Foul <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Other: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Adult <input type="checkbox"/> Juvenile Age: ()	Call Origin: <input type="checkbox"/> Local <input type="checkbox"/> Non-Local
Your Name:		Your Phone Number:
Your Position:		Date of Report: