

100/125/150 CambridgePark Drive BOMB THREAT CHECK LIST

CALL 911 IMMEDIATELY: *(If possible, have someone else call 911 during the call.) After calling 911, immediately contact The Property Management Office at 857-415-2830.*

All employees, especially those answering phones, should keep a copy of this checklist on their desk or near their phone at all times in the event a bomb threat is received.

Tenant Company Name: _____
 Name of Person Taking Call: _____ Title: _____

Date: _____ Phone number call came in on: _____
 Time call was received: _____

IF POSSIBLE, ASK THE CALLER THE FOLLOWING QUESTIONS:

When is the bomb going to explode? _____
 Where is it right now? _____
 What will cause the bomb to explode? _____
 Did you place the bomb? _____
 Why did you place the bomb? _____
 Sex of caller: _____
 Approximate length of call: _____

PLEASE CHECK THE ADJECTIVES THAT APPLY TO THE SOUND OF THE CALLER'S VOICE:

- | | | |
|--|---|---|
| <input type="checkbox"/> Calm | <input type="checkbox"/> Clearing Throat | <input type="checkbox"/> Factory or Machinery |
| <input type="checkbox"/> Laughing | <input type="checkbox"/> Stutter | <input type="checkbox"/> Local |
| <input type="checkbox"/> Lisp | <input type="checkbox"/> Deep Breathing | <input type="checkbox"/> Long Distance |
| <input type="checkbox"/> Disguised | <input type="checkbox"/> Soft | <input type="checkbox"/> Telephone Booth |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Describe Threat Language: | <input type="checkbox"/> Clear |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Well spoken | <input type="checkbox"/> Cell Phone |
| <input type="checkbox"/> Raspy | <input type="checkbox"/> Educated | <input type="checkbox"/> Music |
| <input type="checkbox"/> Accent | <input type="checkbox"/> Foul | <input type="checkbox"/> Animals |
| <input type="checkbox"/> Excited | <input type="checkbox"/> Irrational | <input type="checkbox"/> Office |
| <input type="checkbox"/> Normal | <input type="checkbox"/> Incoherent Taped | <input type="checkbox"/> Other |
| <input type="checkbox"/> Deep | <input type="checkbox"/> Describe Any Background | |
| <input type="checkbox"/> Familiar (if so, who did it
sound like?) _____ | <input type="checkbox"/> Sounds Heard: | |
| <input type="checkbox"/> Slow | <input type="checkbox"/> Street Noises | |
| <input type="checkbox"/> Cracking Voice | <input type="checkbox"/> Crockery | |
| <input type="checkbox"/> Slurred Voice | <input type="checkbox"/> Voices | |
| <input type="checkbox"/> Loud | <input type="checkbox"/> PA System | |
| <input type="checkbox"/> Nasal | <input type="checkbox"/> Static | |
| <input type="checkbox"/> Rapid | <input type="checkbox"/> House Noises Motor | |