

## **BOMB THREAT CHECKLIST**

### **Policy & Procedure**

#### **Policy:**

It is the policy of this facility to provide a comfortable environment for our residents, employees and visitors. This emergency policy is intended to assist the facility in meeting its responsibility and emphasize the importance of employee training to respond appropriately in the event of a bomb threat.

#### **Procedure:**

It is the responsibility of the manager within the facility to notify the Administrator immediately and complete the Bomb Threat Checklist if a bomb threat occurs. It is critical that the information provided is clear, accurate and timely. The tool should be completed immediately to ensure that facts are remembered accurately and articulated appropriately.

### **Section II**

If a bomb threat is received it is important that the facility manager or person receiving the call attempt to get the caller to reveal the following details:

Exact location of the alleged bomb: \_\_\_\_\_

\_\_\_\_\_

Time of anticipated detonation: \_\_\_\_\_

\_\_\_\_\_

Description of what the bomb looks like: \_\_\_\_\_

\_\_\_\_\_

Identify what explosives were used to create the bomb: \_\_\_\_\_

\_\_\_\_\_

Obtain as much information as you can from the caller. (Legitimate callers usually wish to avoid injury or death.) Request more data by expressing a desire to save lives.

Additional information obtained: \_\_\_\_\_

\_\_\_\_\_

Name of person receiving the call: \_\_\_\_\_

Date and Time of Call: \_\_\_\_\_

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*This policy and procedure is not intended to replace the informed judgment of individual physicians, nurses or other clinicians nor is it intended as a statement of prevailing community standards or minimum standards of practice. It is a suggested method and technique for achieving optimal health care, not a minimum standard below which residents necessarily would be placed at risk.*

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I have read, understand and agree to adhere to the requirements outlined in this policy and procedure.

Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Review Dates: \_\_\_\_\_

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