The Counseling Team International
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THREAT OF VIOLENCE ACTION FORM

Name of Person Making Threat: _____

Address: _____ Phone: _____

Employee Classification: _____ Location: _____

Nature of Threat: _____

_____

_____

Potential victim [or note if not identified]: _____

Name: _____

Address: _____ Phone: _____

OFFICIALS NOTIFIED IN CASE OF THREAT TO PERSONS, FACILITIES OR ASSETS:

Person(s) Notified:	Title/Company Organization:	Telephone:	Time:	Date:	Contacts Made By:

Check High Risk Factors:

- ☐ Suicide
- ☐ Homicide
- ☐ Domestic Violence
- ☐ Assault
- ☐ Child Abuse
- ☐ Sexual Abuse
- ☐ Threat of Violence to Facilities, Assets, or Equipment

List Apparent Indicators or Symptoms for each/ Checked High Risk Factor Present:

_____
_____
_____
_____
_____
_____
_____

** FOLLOW THREAT OF VIOLENCE PROCEDURES IN MANUAL**

_____

TCTI Administrative Clinician or DEA/EAP Manager Notified:

Name: _____ Date: _____ Time: _____

Clinician: _____Date: _____