



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:

<u>Person(s) Notified:</u>	<u>Title/Company Organization:</u>	<u>Telephone:</u>	<u>Time:</u>	<u>Date:</u>	<u>Contacts Made By:</u>
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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: \_\_\_\_\_