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

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

** FOLLOW THREAT OF VIOLENCE PROCEDURES IN MANUAL**

TCTI Administrative Clinician or DEA/EAP Manager Notified:

Name: Date: Time:

Clinician: Date: