



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:
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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: