**HEALTH AND HUMAN SERVICES GROUP**
**23392 Madero, Suite "L"**
**Mission Viejo, California 92691**
**1-800-275-7460 FAX (949) 855-7575**

# THREAT OF VIOLENCE ACTION FORM
# DEA EAP

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**

---

HHSG Administrative Clinician or DEA/EAP Manager Notified:

Name: _____ Date: _____ Time: _____

Area Clinician: _____ Date: _____