

**Personal Protective Equipment Distribution Form**

Employee Name: \_\_\_\_\_ Week of: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Employee Signature: \_\_\_\_\_

**Type of PPE**

Hard Hat      Ear Plugs      Gloves      Safety Glasses      Face Shield      Reflective Vest      Fall Protection

**Reason for needing PPE**

First Time Receiving      Broken or Damaged      Lost

**\*All broken or damaged PPE will be replaced by our company at no charge to the employee. Lost PPE will be deducted from your pay.\***

**Additional Items of Concern:**

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