

# Personal Protective Equipment (PPE) Register



**Company Name:**

**Worker Name:**

**Personal Protective Equipment (PPE) Issued:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Protective Overalls | <input type="checkbox"/> Steel Cap Boots | <input type="checkbox"/> Hearing Protection |
| <input type="checkbox"/> Eye Protection      | <input type="checkbox"/> Gloves          | <input type="checkbox"/> Dust Masks         |
| <input type="checkbox"/> High Vis Vest       | <input type="checkbox"/> Hard Hat        | <input type="checkbox"/> Other              |

If ticked "Other", please specify:

**Date PPE Issued:**

**Monthly Visual Inspections:**

**Inspection Date:**

**Inspection Completed By:**

**Inspection Date:**

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