

## CSUSM CORPORATION PROCARD AGREEMENT FORM

PRINT CARDHOLDER NAME (First Name, Middle Initial, Last Name)  DEPARTMENT NAME:	EMPLOYEE ID#  PHONE EXT:	Position appointment over 6 months: Yes No (If no, a ProCard cannot be issued) See ProCard Manual.
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EMAIL:	NAME OF APPROVING OFFICIAL (with fiscal authority)
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<b>Type of Card:</b> ProCard Declining Balance Card	<b>ProCard:</b> Single Purchase Limit: <b>\$2,500</b> Monthly Purchase Limit: <b>\$10,000</b> <b>Note:</b> Card can only be used by employee.
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OSP or Campus Program Chartfield	Account	Fund	Dept.	Program	Class	Project

Will this ProCard be used for Sponsored Projects?    Yes        No  
If Yes, in the boxes below, please provide your Campus Program Chartfield for all unallowable expenses.

(For OSP ONLY)	Account	Fund	Dept.	Program	Class	Project

**Declining Balance ProCard:** Value for Declining Balance Card:  
Name & Address of Vendor:  
Type of authorized purchases:

### CARDHOLDER SIGNATURE

I understand all items purchased using a ProCard, regardless of dollar amount, are CSUSM Corporation property and must be tracked accordingly. I understand that non-adherence to any responsibilities or procedures outlined in the ProCard Manual may result in the revocation of my cardholder privileges. I understand that any unallowable grant expenses will be billed to the Campus Programs Chartfield listed above. I understand that I am personally responsible to reimburse CSUSM Corporation for any unallowable CSUSM Corporation purchases.  
**By signing below, I certify that I have read and understood the ProCard Manual.**

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### APPROVING OFFICIAL

- I understand and accept the responsibilities of a ProCard Approving Official, as described in the ProCard Manual.
- I agree to review and approve the Cardholder's Monthly Transaction Report, overseeing that the transactions are appropriate and in compliance with ProCard policies and that the corresponding documents are accurate, complete, and kept on file in the department for a period of five years.
- I agree to assume the Cardholder's monthly ProCard responsibilities in the event that he/she is unable to do so.

**By signing below, I hereby grant to the employee listed above fiscal authority to make purchases with a ProCard.**

Approving Official Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CSUSM CORPORATION OFFICIAL

**By signing below, I hereby verify that the chartfield(s) listed above are correct.**

CSUSM Corp Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PROCARD ADMINISTRATOR SIGNATURE

ProCard Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CARD RETURN

*The signatures below indicate the ProCard has been returned to the ProCard Administrator.*

Cardholder Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ProCard Administrator Signature: \_\_\_\_\_ Date: \_\_\_\_\_