ANGELO STATE UNIVERSITY PROCARD PROGRAM
DEPARTMENT APPLICATION/APPROVAL FORM

Department Name: _____

Default Fund/Org Number: _____

Phone Number: _____

E-Mail: _____

Number of cards: **1** or **2** (circle one)

Department's Primary Reconciler:

Name: _____ Phone: _____

E-Mail: _____

Department's Secondary Reconciler:

Name:_____ Phone**:**_____

E-Mail**:**_____

I understand I must attend a training class and agree to follow the procedures set forth in the Cardholder's ProCard Guide. I further agree to adhere to the departmental delegated authority guidelines and to sign the Cardholder ProCard Agreement before a ProCard will be issued. I understand that Department ProCards can be shared, delegated by the responsible reconciler. I understand that the University will audit the use of this card and my department and I will be responsible for any discrepancies.

_____	_____	_____
Reconciler's Name (Print/type)	Reconciler's Signature	Date

I hereby approve the issuance of a Department ProCard. I agree that there will be sufficient funds to pay any and all charges made by the department. I have assigned the duty to assure monthly reconciliation of all statements will be done as required and all documentation retained. I understand that the improper use of this card by any individual may result in disciplinary action up to and including termination of employment.

_____	_____	_____
Financial Manager (Print/type)	Financial Manager's signature	Date