UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL PROCARD APPLICATION

Please type or print this form. Complete, mail or hand carry to *Procurement Card Manager, Purchasing, South St, Shrewsbury*. Signed forms may also be faxed to Purchasing at 508-856-7880 or scanned and emailed to purchasing@umassmed.edu.

APPLICANT SECTION - REQUIRED INFORMATION - PLEASE FILL OUT COMPLETELY!

Changes to existing card accounts may be emailed to the Procard Manager at <u>purchasing@umassmed.edu</u>. Please include the last 4 digits of your card account number in your message. Card limit change requests must have the approval of your Department Head or Academic Administrator.

Regula	ar Card (12311/8072)	Declining Balance Card (123)	12/6305)	
Cardholder Employee ID:	#			
		(Nickname, 24 Cha	aracter limit, appears	below name on credit card)
Cardholder Name:		Pho	ne #	
Email Address: Campus Address info	rmation			_
Dept Name:		Building & Room #		
treet Address		City, State		Zip Code
Cardholder signature:				Date
Fotal card limit (for declaring limit) (if Speed Chart Number Department Procard Cor PI Name (for grant fund	rtact cards)	Account Code	Phone #	
I Signature (for grant for Pept Head or Acad Adm				Date
,		signated Cardholder, the Autho lder.	orized Account Sign	er agrees to be
Reallocation Informati	on - please include ALL rea	llocators who will access this a	ccount	
Vame		PS L	ogin ID	
Jame		PS L	ogin ID	
lame		PS L	Login ID	
Order Date:	CH Agreement Sent:	PS U	Updated	