EXHIBIT H

STATE OF MARYLAND
CORPORATE PURCHASING CARD PROGRAM
AUTHORIZED REVIEWER AGREEMENT

AUTHORIZED REVIEWER INFORMATION

Reviewer Name: Agency: Section:

Address:

Address line 2:

City: State: Zip:

Telephone Number:

RESPONSIBLE FOR THESE ACCOUNT HOLDERS (MUST BE ACCOUNT HOLDER'S IMMEDIATE SUPERVISOR OR BUSINESS MANAGER)

	ACCOUNT HOLDER	DATE ASSIGNED	CREDIT LIMIT	PREVIOUS REVIEWER (IF APPLICABLE)
1				
2				
3				
4				
5				

1. I certify that the cardholder(s) listed on this form are under my supervision or I am the business manager.
2. I understand that I am delegating the authority to purchase supplies and services on behalf of the (*insert name of State agency*), using the State of Maryland Corporate Purchasing Card, provided that the amount of any single purchase does not exceed $5000.00 (unless a higher SPL is approved by GAD), that no personal purchases will be made with the card, and that cash advances are strictly prohibited.
3. If the card is lost or stolen, or if the cardholder leaves employment within the Department/Unit for any reason (including retirement) I agree to immediately (within 48 Hours) notify the Purchasing Card Program Administrator.
4. I agree to review the cardholders' credit card statement each month and to verify that the charges made are appropriate charges for the unit, that the charges are for the benefit of the State of Maryland and are not personal purchases. I will also verify that all purchases have been made in accordance with applicable laws and regulations, including, but not limited to, COMAR, the State of Maryland *Corporate Purchasing Card Program Policy and Procedures,* (or University equivalent). **I understand that my failure to follow established procedures may result in disciplinary actions against me, including reimbursement of unauthorized purchases, loss of leave time, suspension and/or termination of employment, fine, and/or criminal prosecution.**

Reviewer Name: _____ Signature: _____ Date: _____
(print name)

Agency Fiscal Officer: _____ Signature: _____ Date: _____
(print name)

PCPA: _____ Signature: _____ Date: _____
(print name)

Questions should be addressed to your agency PCPA:

_____ Telephone_____