

**STATE OF MARYLAND
CORPORATE PURCHASING CARD TRAVEL 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 account holder(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 make travel arrangements on behalf of the (insert name of State agency), using the State of Maryland Corporate Purchasing Travel Account, provided that the amount of any single purchase does not exceed \$15,000.00, and that no capital outlay cost are authorized, that no personal purchases will be made with the account, and that cash advances are strictly prohibited.
3. If the account is compromised, or if the account holder 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 account holders' bank statement each month and to verify that the charges made are appropriate charges for the unit, that the travel is authorized and for the benefit of the State of Maryland and not personal travel. I will also verify that all purchases have been made in accordance with applicable laws and regulations, including, but not limited to: University or Department of Budget and Management Travel Policy, COMAR, the State of Maryland Corporate Purchasing Card Program Policy and Procedures Manual, (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 _____