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STATE OF LOUISIANA CARD PROGRAM- APPROVER AGREEMENT FORM

The State of Louisiana and the Department of Health are providing an employee you supervise with a card from the State of Louisiana Card Program. The Card must only be used for State of Louisiana official business. All acceptable charges must be in accordance with current PPM49 allowances, Statewide Card Policy, Department of Health Policy, and all current purchasing rules and regulations, if applicable.

I _____ ("Approver") agree that I shall comply with the applicable rules and policies listed above, this Agreement, and any subsequent revisions to any of the foregoing.

Conditions for State of Louisiana Card Program

As the Approver, I agree to ensure all charges against the card are proper as outlined in this Agreement and all relevant rules and policies, which I have read and completely understand. I further agree to:

1) Never approve the use the Card for the purpose of paying vendors for allowable purchases of goods and services which are not for official state business;
2) Never approve the use of the Card for personal purchases or personal travel;
3) Never approve charges incurred by anyone other than the cardholder;
4) Always verify the charges on the Card and to reject any charges not in compliance with applicable rules and policies
5) Ensure the cardholder has reconciled all charges within the Department of Health prescribed timelines, but in no instance, later than 15 days past the statement date. I understand and agree that DOA/LDH will monitor the use of the Card and that the cardholder will be personally liable for any unauthorized use thereof.

Penalties for Misuse of State of Louisiana Card Program:

I acknowledge and agree that I understand that in the case of my willful or negligent default of my obligations under this Agreement, the State/Department of Health has the following rights, to the extent authorized by law:

1) The State may pursue any remedy for the recovery of improperly charged amounts, including referral to the Office of Debt Recovery for collection;
2) The State/Department of Health may pursue any appropriate corrective action, including cancellation of card privileges, discipline up to dismissal, and criminal charges. Once privileges are revoked, for any reason, the cardholder will not be allowed to receive a new card unless prior approval is granted through the Office of State Travel.

Lost Card:
If the Card is lost, stolen, or compromised in any manner, I shall immediately notify the Department of Health Program Administrator and the issuing bank.

Return of Card:
Upon the transfer, change in duties, termination of employment, suspension, retirement, or cancellation of the cardholder, I agree to notify my Department of Health Program Administrator and to promptly return the Card to my Department of Health Program Administrator.

All fields below are required. Please complete all sections with the correct information.

Approver **Personnel Number:** _____

Department: _____ Facility: _____

Office/Program/Region/Group: _____

Sub Office/Program/Region/Group: _____

Signature: _____ Date: _____ Phone: _____

Print Name: _____ E-Mail: _____

Office Location/Address: _____

Revised 5/25 - JP

I am responsible for the following cardholders:

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____

Cardholder Name: _____