

Agency Enrollment Application ~ State of Iowa Purchasing Card (Pcard) Program

Department/Agency: _____ Card Program: Pcard and/or Travel Card

Address Line: _____

City: _____ State: _____ Zip Code: _____

For our records, an **Agency Pcard Coordinator, Financial Manager, and Accounts Payable contact** must be designated below. Descriptions of roles and responsibilities for these and other roles (Approver, Supervisor, Cardholder) can be found at <https://das.iowa.gov/procurement/agencies/state-iowa-purchasing-card-program>.

Please note: for Segregation of Duties, Agency Pcard Coordinators who submit Cardholder applications and collect documentation for payment should not serve as level 2 pre-auditors. Separating these functions provides an extra level of control for Pcard purchases. If an Approver is also a Cardholder, his/her Approver must be at least once functional job level higher.

Please indicate below whether your Agency has, or will have, internal procedures in addition to the State Pcard and Travel Card policies and procedures. If so, please submit a copy at the time of enrollment or once the Agency policies are finalized. In the event of a conflict between DAS and internal Agency policies, DAS policies will take precedence.

____ Internal Agency Pcard Procedures attached. ____ Internal Agency Pcard Procedures pending. ____ No Internal Agency Pcard procedures.

By signing below, the designated parties acknowledge their roles and responsibilities in the State of Iowa Pcard Program and agree to adhere to the Program's rules, responsibilities, policies, and procedures contained in the **State of Iowa Purchasing Card Policy and Procedures Manual**, as well as any internal Agency Pcard/Travel Card policies, procedures, or requirements.

Usage violations or failure to follow State policies may result in administrative action, such as card suspension or revocation, or disciplinary action, up to and including termination.

In the event any of the contacts designated below change, please notify State Pcard Program management (Pcard@iowa.gov).

Agency Pcard Coordinator

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Financial Manager

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Accounts Payable Representative

Signature: _____ Date: _____

Print Name: _____ Phone: _____

Department Director or Designee

By signing below, I authorize our organization's participation in the State of Iowa Pcard Program and designated contacts listed.

Signature: _____ Date: _____

Print Name: _____ Phone: _____



All signatures required. Agency Pcard Coordinators: Please send completed forms to Pcard@iowa.gov (or fax to 515-725-0062). Keep one copy for your records.