

Arkansas State University

Credit Limit Increase Request

Card Profile: ☐ PCard

CARDHOLDER OR CUSTODIAN INFORMATION

First Name: _____ Last Name: _____

Last 4 Digits of Card #: _____ Department: _____

Work Phone #: _____ Request Date: _____

PLEASE NOTE: PERMANENT LIMIT INCREASE REQUIRES A MEMO EXPLAINING JUSTIFICATION FOR INCREASE

One-Time Increase (monthly limit will be reset to original limit after one month) \$ _____ to \$ _____

Permanent increase (please attach memo explaining increase) \$ _____ to \$ _____

AUTHORIZATION BY DEPARTMENT DEAN OR DIRECTOR (IF APPLICABLE) REQUIRED FOR ALL LIMIT CHANGES

Department Chair: _____ Signature: _____ Date: _____

Dean/Director: _____ Signature: _____ Date: _____

Vice Chancellor: _____ Signature: _____ Date: _____

I, fully understand and agree to the terms for the increase request on this card. I, as an authorized card holder or custodian, have reviewed the department budget assigned to this card and agree that the budget will not be impaired by this increase. I will not use the card for unauthorized or personal purchases.

Cardholder Signature: _____ Date: _____

FOR USE BY PCARD COORDINATOR ONLY (Do not write in space below)

Request Completed: _____ Date: _____

Reset to Original Limit : _____ Date: _____

Original Limit: _____

Temporary Limit: _____

Permanent Limit: _____