



# REVIEWER/ALLOCATOR SETUP APPLICATION

Arkansas Department of Transformation and Shared Services Office of State Procurement

This form shall be completed and submitted by the Agency Liaison for an employee's *initial* online access to US Bank.

**NOTE: This form is only used for employees that do not currently have US Bank user access.**

ALL COMPLETED APPLICATIONS MUST BE EMAILED TO [Creditcards@dfa.arkansas.gov](mailto:Creditcards@dfa.arkansas.gov)

**\*Required Fields**

**Reviewer Information**

*Last Name	*First Name	Middle Initial	*AASIS Personnel #	*Last 4 digits of SSN:
*Agency Business Area		Agency Business Name		
*Agency Mailing Address				
*City	*State AR	*Zip Code	*Phone Number (include area code)	
*E-mail Address		*USER ID (must be 7-20 characters in length)		

**Type of Role Needed (Check each that apply)**

<input type="checkbox"/>	PAV001 - Viewing Only - no editing allowed	<input type="checkbox"/>	REP001 - Reporting Only
<input type="checkbox"/>	PAS004 - Review and Reallocate Transactions	<input type="checkbox"/>	CHF001 - Cardholder Access

**Specific Cardholder Accounts to be Reviewed by the Applicant**

*Type of Account: PCARD / TCARD / CTS	*Last 4 digits on Cardholder Account	*Name on Cardholder Account

**Specific Managing Accounts to be Reviewed by the Applicant. (if the reviewer needs access to all cards under a specific managing account). This may include Division and Department Numbers.**

*Type of Account: PCARD / TCARD / CTS	*Last 4 digits of Managing Account	*Name of Managing Account	*Bank Number (4 digits)	*Agent Number (4 digits)	*Company Number (5 digits)	*Division Number (5 digits)	*Dept Number (4 digits)

I understand and accept full responsibility as an Agency Reviewer to review and/or reallocate all accounts assigned to me and verify all transactions have been approved on a weekly basis.

*Employee Signature:	*Date
*Liaison Name:	*Liaison Signature:
*Approving Manager Name:	*Approving Manager Signature:
	*Date

DTSS CREDIT CARD SECTION USE ONLY	
Signature:	Date Completed:

# State of Arkansas Credit Card Reviewer Agreement Form

Printed Name: \_\_\_\_\_ AASIS # \_\_\_\_\_

Agency: \_\_\_\_\_ Business Area: \_\_\_\_\_

As an authorized and approved Credit Card Reviewer, I fully understand and agree to the following terms and conditions regarding the oversight of credit card holder(s) purchases.

1. I have or will receive classroom training on the Credit Card Reviewer policies and procedures.
2. I acknowledge that I do not have any accounts payable duties or functions; and if I do, then my Reviewer role will be revoked.
3. I will ensure that all purchases, I am assigned to review, are for State Business use ONLY.
4. I will reconcile the cardholder's original receipts on all transactions.
5. I will reallocate and/or ensure all allocations are correct and complete on each transaction.
6. I will ensure the Use Tax is charged properly on each transaction.
7. I will assist in resolving disputes on cardholder accounts.
8. I will notify my agency Liaison if any of the following occurs:
  - a. Questionable activity/purchases by a cardholder
  - b. Fraudulent Charges
  - c. Lost or Stolen Card
  - d. If a cardholder is terminated, transfers, or resigns

I understand that failure to follow any of the above listed terms and conditions may result in (a) revocation of Reviewer role, (b) disciplinary action, (c) termination of employment.

I hereby accept the above terms and conditions.

***\*\*This agreement includes all future types of accounts as a Credit Card Reviewer.***

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed