STATE OF LOUISIANA PCARD & TRAVEL CARD PROGRAM

PROGRAM ADMINISTRATOR FORM

Agency Name: _____

Program (Check One):

☐ PCard Program Only

☐ Travel Card Program Only

Program Administrator(s):

_____	_____	_____
Print Name: Program Administrator	Personnel Number	Signature (Primary PA)
_____		_____
Email Address		Phone Number
_____	_____	_____
Print Name: Program Administrator	Personnel Number	Signature (Backup PA)
_____		_____
Email Address		Phone Number

_____

Office Physical Address City State Zip

_____

Office Mailing Address (if different from above) City State Zip

Please include a copy of the Agreement Form and training certificate with the form submission

I,_____, Department Head of_____(Agency Name) hereby authorize the above employee to act on behalf of the Agency for the Statewide Credit Card Program(s) identified above as the Program Administrator.

_____	_____	_____
Print Name: Department Head	Department Head Signature	Date

Scan or Email this form to:

StateTravel@la.gov