

**School of Allied Health Professions
Prior Approval for P-Card Purchase**

Cardholder Name: _____

Department: _____

Vendor: _____

Purpose: _____

Item Description: _____

Estimated Cost: \$ _____

Department ID: _____

Fund: _____

Program: _____

Class: _____

Project: _____

Speedtype: _____

PS Account: _____

Product Code _____

Purchase Detail

Transaction Date: _____

Transaction Amount: _____

Initials: _____

Reconciled:

Approved: _____

Department Head

Date: _____

Approved: _____

Dean

Date: _____