Print

UNIVERSITY OF MASSACHUSETTS MEDICAL SCHOOL CTS APPLICATION

Please type or print this form. Complete, mail or hand carry to Travel *Card Manager, 12339 - A/P, South St, Shrewsbury*. Signed forms may also be faxed to A/P at 508-856-4866 or scanned and emailed to kim.bucciaglia@umassmed.edu.

APPLICANT SECTION – REQUIRED INFORMATION – PLEASE FILL OUT COMPLETELY!

For ***change or cancel requests*** please provide the last 4 digits of your MasterCard Account Number XXXX-XXXX-XXXX-

Cardholder Employee ID: #

Cardholder Name: Phone #

Email Address:

Campus Address information

Dept Name: Building & Room #

Street Address City, State Zip Code

Cardholder signature: _____ Date

TO BE COMPLETED BY THE REQUESTING DEPARTMENT – REQUIRED INFORMATION
Note: The bank cycle starts on the 16th of each month, and ends on the 15th of the following month.

Dollar limit per bank cycle (if other than $10,000)

Speed Chart Number

Dept Head or Acad Administrator Name (Please print) Date

Dept Head or Acad Admin Signature _____

Reallocation Information - please include ALL reallocators who will access this account

Name PS Login ID

Name PS Login ID

Name PS Login ID