

SC Department of Disabilities and Special Needs

PURCHASING CARD CREDIT LIMIT CHANGE REQUEST

(This form is applicable to DDSN Regional Centers only)

Cardholder's Name: _____

Purchasing Card Account Number *(last four (4) digits only)*: _____

Division/Department: _____

Regional Bank Clerk: _____

Current Monthly Limit: \$ _____

Requested *New* Monthly Limit: \$ _____

Explanation for Request:

Signature (*Cardholder*)

Date: _____

Signature (*Regional Bank Clerk*)

Date: _____

FORWARD TO REGIONAL FINANCE DIRECTOR FOR REVIEW AND APPROVAL

Signature (*Regional Finance Director*)

Date: _____