DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Account Override Request Form

Complete this form and submit to the Card Services Department.

NET ID _____ CardHolder(First and Last name) _____

Title _____ Department _____

Cardholder Email _____ Phone _____

Cardholder Signature _____ Date _____

Enter SUNY Account #s (8 digits) Cardholder is authorized to purchase from:

Override Account: _____ Additional Accounts: _____

_____ _____

_____ _____

FINANCE USE ONLY

Hospital non-shared services accounts must be submitted to Hospital Finance for approval.

☐ BUDGET DEPARTMENT APPROVED _____ Signature _____ Date

☐ HOSPITAL FINANCE APPROVED _____ Signature _____ Date

☐ DISAPPROVED - Reason: _____

_____

_____

SECURITY ACCESS ADMINISTRATOR USE ONLY

☐ FINANCE SECURITY COMPLETE Initial: _____ Date: _____