Kansas PEAK Advisory Team
Volunteer Application

Date: _____

Contact Information	
Name:	
Position/Title:	
Agency Name:	
Address:	
Phone Number:	
E-Mail:	

Membership Type

Long Term Care Ombudsman: ☐ Yes ☐ No Region: _____	PEAK Mentor Home: ☐ Yes ☐ No Number of months/years: _____
Current PEAK Level ☐ Level 1: _____ (number of years) ☐ Level 2: _____ (number of years) ☐ Level 3: _____ (number of years) ☐ Level 4: _____ (number of years)	Have you or your facility ever achieved a PEAK award? ☐ Yes, when: _____ ☐ No

Why do you want to be a member of the Kansas PEAK Advisory Team?

What can you contribute to the Kansas PEAK Advisory Team?

The Kansas PEAK Advisory Team will be subject to the requirement of the Kansas Open Meetings Act (KOMA) K.S.A. 75-4317 through 75-4320a.

Signature:	

Please fill out form and return to:
Codi Thurness, Commissioner
Survey, Certification, and Credentialing
Kansas Department for Aging and Disability Services
612 S. Kansas Avenue
Topeka, KS 66603
Codi.thurness@ks.gov