

**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: <input type="checkbox"/> Yes <input type="checkbox"/> No	PEAK Mentor Home: <input type="checkbox"/> Yes <input type="checkbox"/> No
Region: _____	Number of months/years: _____
Current PEAK Level <input type="checkbox"/> Level 1: _____ (number of years) <input type="checkbox"/> Level 2: _____ (number of years) <input type="checkbox"/> Level 3: _____ (number of years) <input type="checkbox"/> Level 4: _____ (number of years)	Have you or your facility ever achieved a PEAK award? <input type="checkbox"/> Yes, when: _____ <input type="checkbox"/> 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:	
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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