Kansas PEAK Advisory Team
Volunteer Application

Date: ________________

**Contact Information**

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<thead>
<tr>
<th>Name:</th>
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<td>Position/Title:</td>
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<td>Agency Name:</td>
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<td>Address:</td>
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<td>Phone Number:</td>
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<td>E-Mail:</td>
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**Membership Type**

- Long Term Care Ombudsman: [ ] Yes [ ] No
- PEAK Mentor Home: [ ] Yes [ ] No
- Region: __________________________
- 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:**

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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](mailto:Codi.thurness@ks.gov)