



## VILLAGE OF DOBBS FERRY

Building Department  
112 Main Street, Dobbs Ferry, NY 10522  
Phone: (914) 231-8509 | Fax: (914) 693-3470

Daniel Roemer  
Building Inspector

**RECEIVED**

**JAN 03 2023**

VILLAGE OF DOBBS FERRY  
BUILDING DEPARTMENT

### Permit Application

Application Number AT2022-0135

Date 12/30/2022

Job Location 100 BUENA VISTA DR Lot # 3.160-142-36

Owner: PENELOPEGAY  
100 BUENA VISTA DR  
DOBBS FERRY, NY 10522

Applicant: Damonique Jackson  
15 Broadway  
Hawthorne, NY 10532  
(914)741-1510 [djackson@almstead.com](mailto:djackson@almstead.com)

Application Type: Tree Removal Estimated Cost of Construction: \$

Description of Work: Removal of (1) Sugar Maple 40" and (1) Black Locust 22" DBH

#### Form Questions:

#### Application Parcel Owner Contact:

Parcel Owner Email	<a href="mailto:pgsheely@gmail.com">pgsheely@gmail.com</a>
Parcel Owner Phone	914-356-5534

Job Location: 100 BUENA VISTA DR

Parcel Id: 3.160-142-37

**AFFIDAVIT OF APPLICANT**

I \_\_\_\_\_ being duly sworn, depose and says: That s/he does business as: \_\_\_\_\_ with offices at: \_\_\_\_\_ and that s/he is.

\_\_\_ The owner of the property described herein

\_\_\_ The \_\_\_\_\_ of the New York Corporation \_\_\_\_\_ with offices at: \_\_\_\_\_  
\_\_\_\_\_ duly authorized by resolution of the Board of Directors, and that

said corporation is duly authorized by the owner to make this application.

\_\_\_ A general partner of \_\_\_\_\_ with offices \_\_\_\_\_ and that said  
Partnership is duly authorized by the Owner to make this application.

\_\_\_ The Lessee of the premises, duly authorized by the owner to make this application.

\_\_\_ The Architect or Engineer duly authorized by the owner to make this application.

\_\_\_ The contractor authorized by the owner to make this application.

That the information contained in this application and on the accompanying drawings is true to the best of his knowledge and belief. The undersigned hereby agrees to comply with all the requirements of the New York State Uniform Fire Prevention and Building Code, the Village of Dobbs Ferry Building Code, Zoning Ordinance and all other laws pertaining to same, in the construction applied for, whether or not shown on plans or specify in this application.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ of \_\_\_\_\_

Notary Public / Commission of Deeds

Applicant's Signature

**PROPERTY OWNER'S AUTHORIZATION**

I Sean Sheely as the owner of the subject premises and have authorized the contractor named above to perform the work under the subject application.

Owner phone number 914-356-5534. Owner email address pgsheely@gmail.com

SEAN Q. SHEELY I hereby acknowledge that it is my responsibility as the property owner to ensure that if the permit (if issued) receives a Final Certificate of Approval from the Building Department and further that if a Final Certificate of Approval is not obtained upon completion of the construction, a property violation may be placed on the property for which this permit is being requested.

Sworn to before me this 14th day of December of 2022

Corinthia A. Bernard

Notary Public / Commission of Deeds

Sean Q. Sheely

PROPERTY OWNER's SIGNATURE

**CORINTHIA A. BERNARD**  
Notary Public, State of New York  
No. 01BE4926858  
Qualified in Bronx County  
Commission Expires January 18, 2023

Job Location: 100 BUENA VISTA DR

Parcel Id: 3.160-142-36

**AFFIDAVIT OF APPLICANT**

*Almstead Tree Care Co*

\* Patrick McVey being duly sworn, depose and says: That s/he does business as: \_\_\_\_\_ with offices at:  
15 Broadway Hawthorne NY 10532 and that s/he is:

\_\_\_ The owner of the property described herein.

\_\_\_ The \_\_\_\_\_ of the New York Corporation \_\_\_\_\_ with offices at:  
\_\_\_\_\_ duly authorized by resolution of the Board of Directors, and that

said corporation is duly authorized by the owner to make this application.

\_\_\_ A general partner of \_\_\_\_\_ with offices \_\_\_\_\_ and that said  
Partnership is duly authorized by the Owner to make this application.

\_\_\_ The Lessee of the premises, duly authorized by the owner to make this application.

☒ The Architect of Engineer duly authorized by the owner to make this application.

☒ The contractor authorized by the owner to make this application.

That the information contained in this application and on the accompanying drawings is true to the best of his knowledge and belief. The undersigned hereby agrees to comply with all the requirements of the New York State Uniform Fire Prevention and Building Code, the Village of Dobbs Ferry Building Code, Zoning Ordinance and all other laws pertaining to same, in the construction applied for, whether or not shown on plans or specify in this application.

Sworn to before me this 3rd day of January of 2023

Notary Public / Commission of Deeds

ELIZABETH A. DREAPER  
Notary Public, State of New York  
No: 01DR6177050  
Qualified In Westchester County  
Commission Expires November 5, 2023

Applicant's Signature

**PROPERTY OWNER'S AUTHORIZATION**

I \_\_\_\_\_ as the owner of the subject premises and have authorized the contractor named above to perform the work under the subject application.

Owner phone number 914-356-5534. Owner email address pgsheely@gmail.com

\_\_\_\_\_ I hereby acknowledge that it is my responsibility as the property owner to ensure that if the permit (if issued) receives a Final Certificate of Approval from the Building Department and further that if a Final Certificate of Approval is not obtained upon completion of the construction, a property violation may be placed on the property for which this permit is being requested.

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ of \_\_\_\_\_

\_\_\_\_\_  
Notary Public / Commission of Deeds

\_\_\_\_\_  
PROPERTY OWNER's SIGNATURE

December 30, 2022

Village of Dobbs Ferry

RE: Penelope Sheely – 100 Buena Vista Drive  
Request for Two (2) Tree Removals

Request for tree removal of one (1) Sugar Maple 40" DBH due to decline. Multiple limb drop on right side of lawn area. Note: Hazardous tree.

Request for tree removal of one (1) Black Locust 22" DBH. Tree is uprooted and leaning on multiple trees. Note: Hazardous tree.

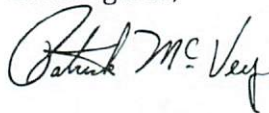
Both trees noted above should be removed to remove the risk of failure or limb drop. Trees border neighboring property.

All brush to be chipped, wood from Black Locust to be removed. Sugar Maple brush to be chipped, wood may be left for customer.

Cost for all Labor, Equipment and Disposal .....\$ 5,950

If you should have any questions, please feel free to contact me at (914)741-1510 ext. #13.

Best Regards,



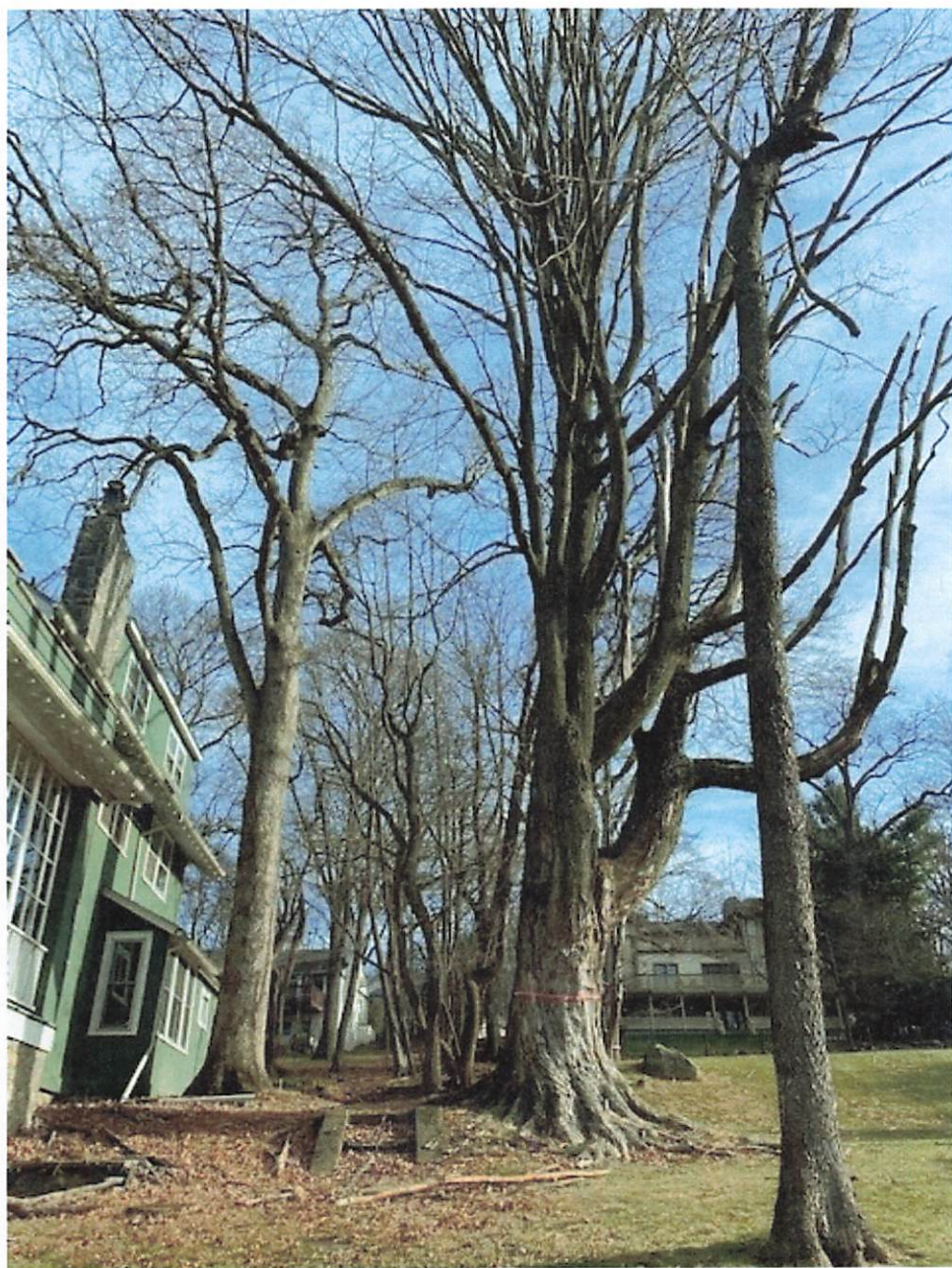
Patrick McVey  
ISA Certified Arborist-NY #5385













ALMSTRE-01

JYUAN

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
12/22/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> License # 0757776 HUB International Insurance Services Inc. PO Box 3310 Santa Barbara, CA 93130-3310		<b>CONTACT NAME:</b> Iris Garcia-Cuellar <b>PHONE (A/C, No, Ext):</b> (805) 618-3704 <b>FAX (A/C, No):</b> (805) 832-6581 <b>E-MAIL ADDRESS:</b> CAL-CC-CertReqs@hubinternational.com	
<b>INSURED</b>  Almstead Tree & Shrub Care Co., LLC 58 Beechwood Avenue New Rochelle, NY 10801		<b>INSURER(S) AFFORDING COVERAGE</b>	
		<b>INSURER A:</b> Arch Insurance Company <b>NAIC #</b> 11150	
		<b>INSURER B:</b> Merchants Mutual Insurance Company <b>23329</b>	
		<b>INSURER C:</b>	
		<b>INSURER D:</b>	
		<b>INSURER E:</b>	

## COVERAGES

## CERTIFICATE NUMBER:

## REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR  GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER: Capped at \$5,000,000	X		ZAGLB1100502	1/1/2022	1/1/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 300,000 MED EXP (Any one person) \$ 10,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
A	<input checked="" type="checkbox"/> AUTOMOBILE LIABILITY <input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY			ZACAT1200802	1/1/2022	1/1/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			CUP0001822	1/1/2022	1/1/2023	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
A	<input checked="" type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	ZAWCI5802804	1/1/2022	1/1/2023	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)  
RE: 100 Buena Vista Drive, Dobbs Ferry, NY 10522.

Village of Dobbs Ferry is included as Additional Insured with respect to General Liability coverage as required by written contract for ongoing operations per attached endorsement CG 20 10 04 13.

## CERTIFICATE HOLDER

## CANCELLATION

Village of Dobbs Ferry  
112 Main Street  
Dobbs Ferry, NY 10522

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



Workers'  
Compensation  
Board

## CERTIFICATE OF INSURANCE COVERAGE DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

### PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only) ALMSTEAD TREE & SHRUB CARE COMPANY, LLC  58 BEECHWOOD AVENUE New Rochelle NY 10801 Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)	1b. Business Telephone Number of Insured (914) 576-0193  1c. Federal Employer Identification Number of Insured or Social Security Number 13-4031893
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Village of Dobbs Ferry  112 Main Street DOBBS FERRY, NY 10522	3a. Name of Insurance Carrier Standard Security Life Insurance Company of New York  3b. Policy Number of Entity Listed in Box "1a" L11179-000  3c. Policy effective period 1/1/2019 to 5/18/2023

4. Policy provides the following benefits:

- ☒ A. Both disability and paid family leave benefits.  
☐ B. Disability benefits only.  
☐ C. Paid family leave benefits only.

5. Policy covers:

- ☒ A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.  
☐ B. Only the following class or classes of employer's employees:

\_\_\_\_\_  
\_\_\_\_\_

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability and/or Paid Family Leave Benefits insurance coverage as described above.

Date Signed 5/19/2022 By Bebi A. Ishmail  
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141 Name and Title Bebi Ishmail, Supervisor-DBL/Policy Services

**IMPORTANT:** If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.

If Box 4B, 4C or 5B is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.

### PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box 4C or 5B of Part 1 has been checked)

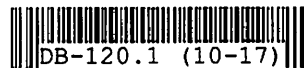
#### State of New York Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law with respect to all of his/her employees.

Date Signed \_\_\_\_\_ By \_\_\_\_\_  
(Signature of Authorized NYS Workers' Compensation Board Employee)

Telephone Number \_\_\_\_\_ Name and Title \_\_\_\_\_

**Please Note:** Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.







**Workers'  
Compensation  
Board**

**CERTIFICATE OF  
NYSWORKERS' COMPENSATION INSURANCE COVERAGE**

<p>1a. Legal Name &amp; Address of Insured (use street address only)</p> <p><b>Almstead Tree &amp; Shrub Care Co., LLC</b>  <b>58 Beechwood Avenue</b>  <b>New Rochelle, NY 10801</b></p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured</p> <p><b>914-576-0193</b></p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p><b>29-31835 9</b></p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p><b>Village of Dobbs Ferry</b>  <b>112 Main Street</b>  <b>Dobbs Ferry, NY 10522</b></p>	<p>3a. Name of Insurance Carrier</p> <p><b>Arch Insurance Company</b></p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p><b>ZAWCI5802804</b></p> <p>3c. Policy effective period</p> <p><b>1/01/2022</b> to <b>01/01/2023</b></p> <p>3d. The Proprietor, Partners or Executive Officers are</p> <p><input checked="" type="checkbox"/> included. (Only check box if all partners/officers included)</p> <p><input type="checkbox"/> all excluded or certain partners/officers excluded.</p>

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. **(To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy).** The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? ☐ YES ☒ NO

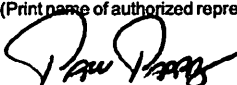
This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Workers' Compensation contract of insurance only while the underlying policy is in effect.

**Please Note: Upon cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.**

**Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.**

Approved by: Paul Pappas  
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  01/06/2022  
(Signature) (Date)

Title: Vice President

Telephone Number of authorized representative or licensed agent of insurance carrier: 646-563-5802

**Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it.**