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

Permit Application

Application Number AT2022-0058 **Date** 07/18/2023

Job Location 21 RIVERSIDE PL **Lot #** 3.80-36-22

Owner: AMY JO NEILL
21 RIVERSIDE PL
DOBBS FERRY, NY 10522
917 579 7316

Applicant: AMY JO NEILL
21 RIVERSIDE PL
DOBBS FERRY, NY 10522
917 579 7316 amyjo101@gmail.com

Application Type: Tree Removal **Estimated Cost of Construction: $** 300

Description of Work: Remove a tree on my property.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	amyjo101@gmail.com
Parcel Owner Phone	914-308-0640

Job Location: **21 RIVERSIDE PL** Parcel Id: **3.80-36-22**

AFFIDAVIT OF APPLICANT

I Val Landry being duly sworn, depose and says: That s/he does business as Community Tree with offices at: 83 Ravensdale Rd, Hastings on Hudson NY 10706 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.

Lic # WC 07512-H96 Exp 4/2024

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 2nd day of August of 2023

Notary Public / Commission of Deeds

SHANNON JAMES LINES
NOTARY PUBLIC-STATE OF NEW YORK
No. 01JA6439384
Qualified in Westchester County
My Commission Expires 08-29-26

Val Landry
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 914-308-0640. Owner email address amyjo101@gmail.com

Amy Jo Neill 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 2nd day of August of 2023

Notary Public / Commission of Deeds

SHANNON JAMES LINES
NOTARY PUBLIC-STATE OF NEW YORK
No. 01JA6439384
Qualified in Westchester County
My Commission Expires 08-29-26

Amy Jo Neill
PROPERTY OWNER's SIGNATURE

George Latimer
Westchester County Executive

Westchester gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection
Home Improvement License

COMMUNITY TREE SURGERY, INC.

83 RAVENSDALE ROAD

HASTINGS ON HUDSON,NY-10706

This license is issued in accordance with Article XVI of the Westchester County Consumer Protection Code and is valid only upon presence of the official department seal. Proof of citizenship or immigration status is not required for issuance of this license.
NOT FOR FEDERAL PURPOSES

Department of Consumer Protection
Westchester County, NY

License Number

WC-07512-H96

Date of Expiration

04/24/2024

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NEW YORK STATE | 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)
COMMUNITY TREE SURGERY INC
83 RAVENSDALE RD
HASTINGS ON HUDSON, NY 10706

Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*

1b. Business Telephone Number of Insured
(914) 478-2124

1c. Federal Employer Identification Number of Insured or Social Security Number
132980372

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
New York State Insurance Fund (NYSIF)

3b. Policy Number of Entity Listed in Box "1a"
DBL 351 27 - 1

3c. Policy effective period
07/01/2022 to 07/01/2024

4. Policy provides the following benefits:
- [X] A. Both disability and paid family leave benefits
- [ ] B. Disability benefits only
- [ ] C. Paid family leave benefits only

5. Policy covers:
- [X] 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 6/6/2023 By Kristin Markwica
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (866) 697-4332 Name and Title Kristin Markwica, Head of Disability Insurance Unit

IMPORTANT: If Box 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, DB 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.

Certificate Number 737724

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) COMMUNITY TREE SURGERY INC 83 RAVENSDALE RD HASTINGS ON HUDSON, NY 10706 Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured 914-478-2124 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 13-2960372
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 FARM FAMILY CASUALTY INS CO 3b. Policy Number of Entity Listed in Box "1a" 3160W6355 3c. Policy effective period 04/13/2023 to 04/13/2024 3d. The Proprietor, Partners or Executive Officers are ☐ included. (Only check box if all partners/officers included) ☑ all excluded or certain partners/officers excluded.

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".

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (These notices may be sent by regular mail.) **Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.**

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: JEFFREY KAVOVIT
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ 06/06/2023
(Signature) (Date)

Title: AGENT

Telephone Number of authorized representative or licensed agent of insurance carrier: 845-562-0701

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.