



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

FEB 23 2024

**VILLAGE OF DOBBS FERRY
BUILDING DEPARTMENT**

Permit Application

Application Number AT2024-0015

Date 02/23/2024

Job Location THE LANDING COMMON AREA Lot # 3.40-4-15

Owner: THE LANDING on the Water at Dobbs Ferry
Condominium
50 Plainfield Ave HUDSON NORTH MGT,
LLC

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

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

Description of Work: 5 and 7 Hudson Drive - five (5) Eastern White Pines between units. 12" 15" 18" 22"
16" DBH

Form Questions:

Diameter of Tree to be Removed	12", 15", 18", 22", 16"
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Application Parcel Owner Contact:

Parcel Owner Email	pmcvey@almstead.com
Parcel Owner Phone	9144388184

Job Location: **BROADWAY**

Parcel Id: **3.40-4-3**

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 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 7th day of MARCH of 2024



Notary Public / Commission of Deeds

JAN GOORSKY
Notary Public, State of New York
No. 01GO4659910
Qualified in Westchester County
Commission Expires April 30, 2018
23

Applicant's Signature

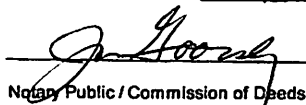
PROPERTY OWNER'S AUTHORIZATION

I James Hornstein 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 914-609-6554 Owner email address jimho@landingscondo.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 7th day of MARCH of 2024



Notary Public / Commission of Deeds



PROPERTY OWNER'S SIGNATURE

JAN GOORSKY
Notary Public, State of New York
No. 01GO4659910
Qualified in Westchester County
Commission Expires April 30, 2018
23

Job Location: **BROADWAY**

Parcel Id: **3.40-4-3**

AFFIDAVIT OF APPLICANT

I Patrick McVey being duly sworn, depose and says: That s/he does business as: Arboret with offices at: 15 Broadway, Hawthorne, NY 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 23 day of February of 2024



ERIK LEVI CARLSON
NOTARY PUBLIC-STATE OF NEW YORK
Notary Public / Commission of Deed No. 01CA6443904
Qualified in Westchester County
My Commission Expires 11-14-2026


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.

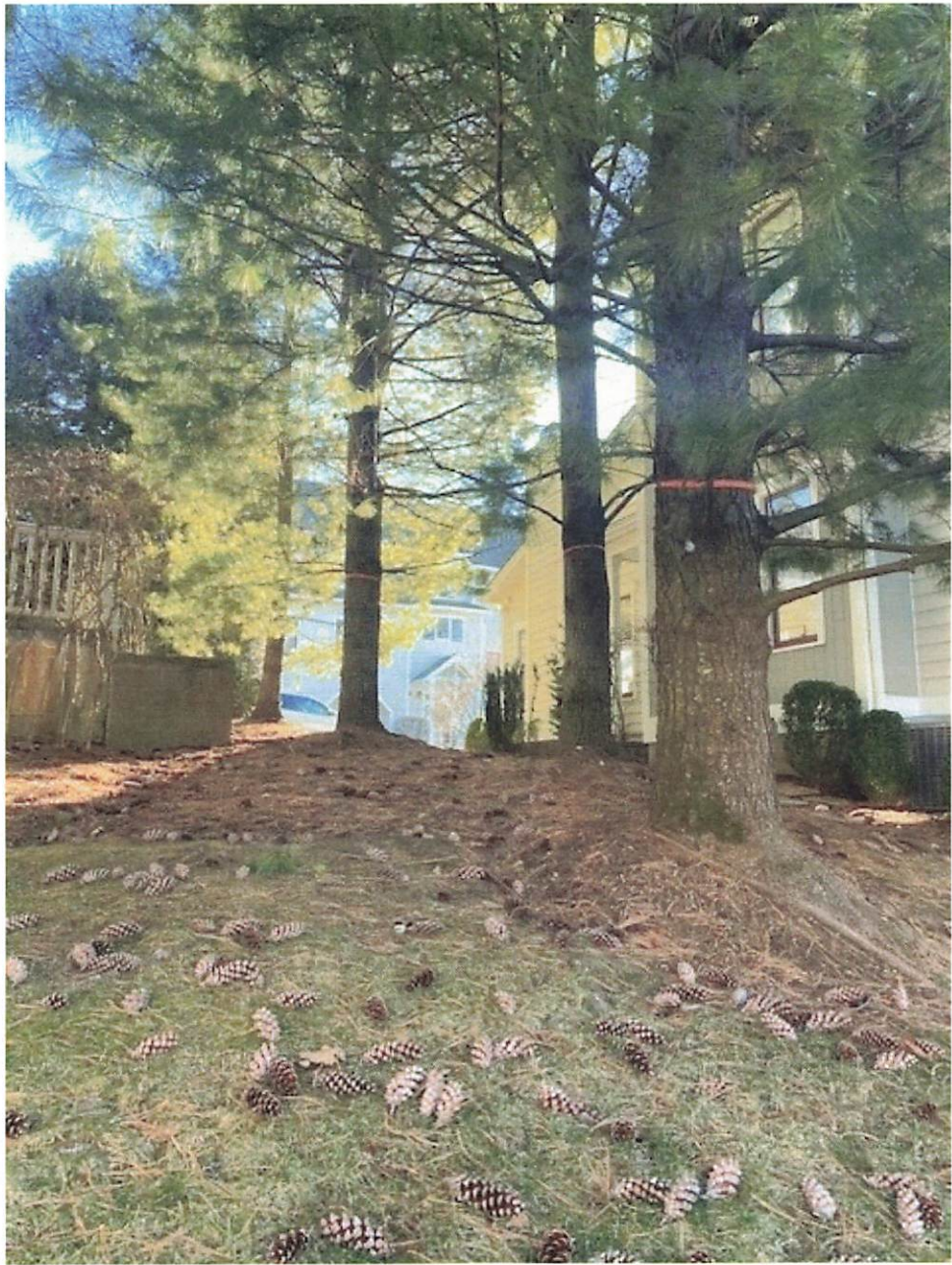
Owner phone number 9144388184. Owner email address pmcvey@almstead.com

_____ 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





George Latimer
Westchester County Executive



James Maisano
Director, Consumer Protection

Department of Consumer Protection Home Improvement License

ALMSTEAD TREE & SHRUB CARE COMPANY, LLC
58 BEECHWOOD AVENUE
NEW ROCHELLE, NY-10801

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

License Number

WC-16727-H05



Date of Expiration

06/22/2025



ALMSTRE-01

BYANG

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/27/2024

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).

PRODUCER License # 0757776 HUB International Insurance Services Inc. PO Box 3310 Santa Barbara, CA 93130-3310	CONTACT NAME: Linda Kengott		
	PHONE (A/C, No, Ext): (805) 618-3702	FAX (A/C, No): (805) 832-6581	
	E-MAIL ADDRESS: CAL-CC-CertReqs@hubinternational.com		
INSURED Almstead Tree & Shrub Care Co., LLC 58 Beechwood Avenue New Rochelle, NY 10801	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A: Arch Insurance Company		11150
	INSURER B: Merchants Mutual Insurance Company		23329
	INSURER C:		
	INSURER D:		
	INSURER E:		
	INSURER F:		

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	X		ZAGLB1100504	1/1/2024	1/1/2025	EACH OCCURRENCE	\$ 1,000,000
	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 300,000
							MED EXP (Any one person)	\$ 10,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	\$ 1,000,000
	<input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC						GENERAL AGGREGATE	\$ 2,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	\$ 2,000,000
								\$
A	AUTOMOBILE LIABILITY			ZACAT1200804	1/1/2024	1/1/2025	COMBINED SINGLE LIMIT (Ea accident)	\$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS	BODILY INJURY (Per person)	\$					
	<input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY	BODILY INJURY (Per accident)	\$					
							PROPERTY DAMAGE (Per accident)	\$
								\$
B	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR			CUP0001822	1/1/2024	1/1/2025	EACH OCCURRENCE	\$ 5,000,000
	<input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE	AGGREGATE	\$ 5,000,000					
	DED <input checked="" type="checkbox"/> RETENTION \$ 10,000		\$					
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			ZAWCI5802806	1/1/2024	1/1/2025	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y/N	E.I. EACH ACCIDENT				\$ 1,000,000	
	If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	E.I. DISEASE - EA EMPLOYEE				\$ 1,000,000	
							E.I. 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: The Landing at Dobbs Ferry, Landing 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

5/29/2024

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 5/31/2023

By

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 355-4141

Name and Title 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 & Address of Insured (use street address only)</p> <p>Almstead Tree & Shrub Care Co., LLC 58 Beechwood Avenue New Rochelle, NY 10801</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</i></p>	<p>1b. Business Telephone Number of Insured</p> <p>914-576-0193</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>29-31835 9</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>Village of Dobbs Ferry 112 Main Street Dobbs Ferry, NY 10522</p>	<p>3a. Name of Insurance Carrier</p> <p>Arch Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a"</p> <p>ZAWCI5802806</p> <p>3c. Policy effective period</p> <p style="text-align: center;"><u>01/01/2024</u> to <u>01/01/2025</u></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

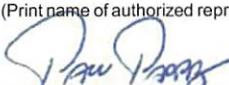
This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

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:  01/08/2024
(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.