VILLAGE OF DOBBS FERRY

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

Ed Manley
Building Inspector

Permit Application

Application Number AT2022-0020 **Date** 03/08/2022

Job Location 93 BUENA VISTA DR **Lot #** 3.160-145-6

Owner: BRYAN MCCLINCHY
93 BUENA VISTA DR
DOBBS FERRY, NY 10522

Applicant: Valmond Landry
83 ravensdale road
Hastings on Hudson , New York 10706
914-478-2124
communitytreesurgeryinc@gmail.com

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

Description of Work: Removal of one Spruce tree covered with Ivy

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	bmcclinchy@yahoo.com
Parcel Owner Phone	9176996627

Job Location: **93 BUENA VISTA DR** Parcel Id: **3.160-145-6**

AFFIDAVIT OF APPLICANT

I Valmond Landry being duly sworn, depose and says: That s/he does business as: President 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.

X 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 8 day of March of 2022

THERESA OSBORN
NOTARY PUBLIC, STATE OF NEW YORK
Registration No. 01OS4835648
Qualified in Westchester County
Commission Expires December 31, 2025

Notary Public / Commissioner of Deeds

Valmond Landry
Applicant's Signature

PROPERTY OWNER'S AUTHORIZATION

I Bryan McClinchy 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 9176996627. Owner email address bmcclinchy@yahoo.com

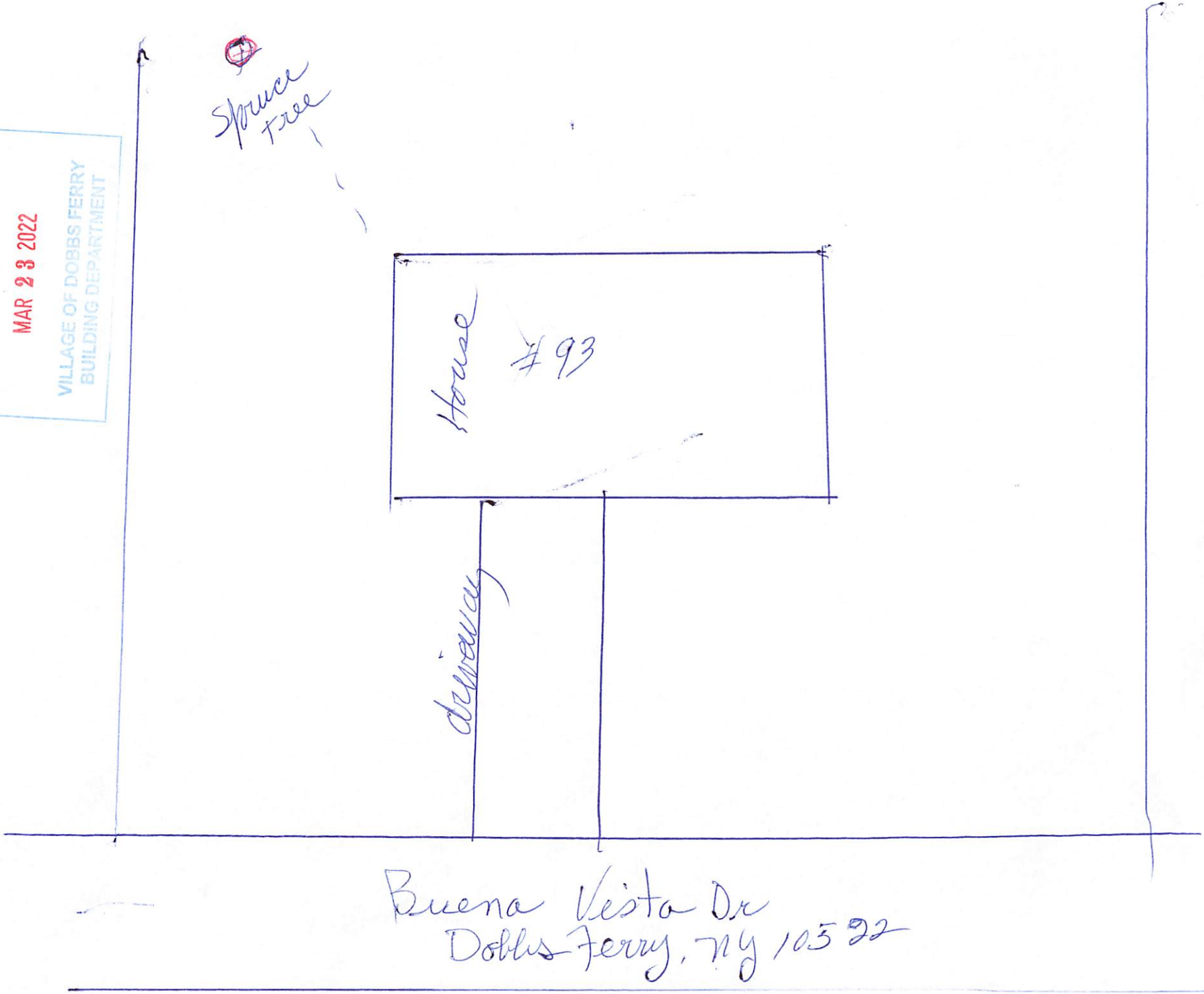
Bryan McClinchy I hereby acknowledge that it is my responsibility as the property owner to ensure that if the permit (if issued) receives a Final Certificate of Approval from the Building Department and further that if a Final Certificate of Approval is not obtained upon completion of the construction,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

Sworn to before me this 11TH day of March of 2022

EDWARD CANORA
STATE OF NEW YORK
NOTARY PUBLIC
Qualified in Westchester County
01CA6227828
MY COMMISSION EXPIRES 09-07-2022

Notary Public / Commission of Deeds

Bryan McClinchy
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.

Department of Consumer Protection Westchester County NY

License Number

WC-07512-H96

Date of Expiration

04/24/2022

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/15/2022

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).

PRODUCER	CONTACT NAME:	
JEFFREY D KAVOVIT FARM FAMILY CASUALTY INSURANCE CO 88 OLD ROUTE 9W, SUITE 100 NEW WINDSOR, NY 12553	PHONE (A/C, No, Ext): 845-562-0701	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: FARM FAMILY CASUALTY INS. CO.	408-13803
INSURED COMMUNITY TREE SURGERY INC 83 RAVENSDALE RD PO BOX 87 HASTINGS ON HUDSON, NY 10706	INSURER B:	
	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	[X] COMMERCIAL GENERAL LIABILITY			3160X0500	12/07/21	12/07/22	EACH OCCURRENCE	$ 1,000,000
	[ ] CLAIMS-MADE [X] OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$ 100,000
	[X] SELECT BUSINESS PKG						MED EXP (Any one person)	$ 5,000
							PERSONAL & ADV INJURY	$ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$ 2,000,000
	[X] POLICY [ ] PRO-JECT [ ] LOC						PRODUCTS - COMP/OP AGG	$ 2,000,000
	OTHER:							$
A	AUTOMOBILE LIABILITY			3160C0532	12/07/21	12/07/22	COMBINED SINGLE LIMIT (Ea accident)	$ 1,000,000
	[ ] ANY AUTO						BODILY INJURY (Per person)	$
	[ ] OWNED AUTOS ONLY [X] SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	[X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	[ ] UMBRELLA LIAB [ ] OCCUR						EACH OCCURRENCE	$
	[ ] EXCESS LIAB [ ] CLAIMS-MADE						AGGREGATE	$
	[ ] DED [ ] RETENTION $							$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N			3160W6355	04/13/21	04/13/22	[X] PER STATUTE [ ] OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? [Y] (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$ 100,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ 100,000
							E.L. DISEASE - POLICY LIMIT	$ 500,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

NAMES: MR. & MRS. BRYAN MCCLINCHY
ADDRESS: 93 BUENA VISTA DRIVE, DOBBS FERRY, NY 10522
JOB DESCRIPTION: TREE REMOVAL OF ONE DISEASED SPRUCED COVERED IN IVY.

CERTIFICATE HOLDER

VILLAGE OF DOBBS FERRY
112 MAIN STREET
DOBBS FERRY, NY 10522

CANCELLATION

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

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 04/13/2021 to 04/13/2022 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: Jeffrey A. Kavovit 03/15/2022
(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.

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	1b. Business Telephone Number of Insured (914) 478-2124
Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1c. Federal Employer Identification Number of Insured or Social Security Number 132960372
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 07/01/2021 to 07/01/2022

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 3/15/2022 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.***