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 AT2021-0092 **Date** 06/15/2021

Job Location 51 MAPLE ST **Lot #** 3.50-16-41

Owner: RICHARD K SALERNO TRUST
51 MAPLE ST
DOBBS FERRY, NY 10522

Applicant: RICHARD K SALERNO
51 MAPLE ST
DOBBS FERRY, NY 10522

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

Description of Work: Removal of 60 ft pine tree which is 10 ft off the southwest corner of the foundation. May damage foundation and wind storms violently move the tree.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	evrlone@aol.com / SALERNO@OPTONLINE.NET
Parcel Owner Phone	914 879 2934

Job Location: **51 MAPLE ST** Parcel Id: **3.50-16-41**

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 _____ day of _____ of _____

Notary Public / Commission of Deeds Applicant's Signature

OWNER'S AUTHORIZATION

I RICHARD SALERNO 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 914 879-2934 Owner email address SALERNO@OPTONLINE.NET

_____ 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 25th day of March of 2022

_____ _____

Notary Public / Commission of Deeds Applicant's Signature

ALAN CHAUT
Notary Public, State of New York
No. 02CH4842764
Qualified in Westchester County
Commission Expires 10/31/20 25

George Latimer
Westchester County Executive

Westchestergov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection
Home Improvement License

RAMOS & V. TREE SERVICES INC.

PO BOX 80

HAWTHORNE,NY-10532

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-20245-H08

Date of Expiration

03/13/2024

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/23/2022

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: CHRISTOPHER TARR	
CHRISTOPHER TARR 500 ROUTE 32 PO BOX 1014 HIGHLAND MILLS NY 10930	PHONE (A/C, No, Ext): 845-738-8801	FAX (A/C, No): 845-395-0011
	E-MAIL ADDRESS: Highlandmillsoffice@american-national.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A: FARM FAMILY CASUALTY INSURANCE CO	13803
INSURED RAMOS & V TREE SERVICES INC 49 MIDLAND TER YONKERS NY 10704	INSURER B: UNITED FARM FAMILY INSURANCE CO	29963
	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 [ ] CLAIMS-MADE [X] OCCUR [X] SELECT BUSINESS PACKAGE [X] INLAND MARINE GEN'L AGGREGATE LIMIT APPLIES PER: [X] POLICY [ ] PRO-JECT [ ] LOC [X] OTHER: DEDUCTIBLE $500	X	X	3102X0326	9/24/21	9/24/22	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 2,000,000 $ 100,000 $ 10,000 $ 2,000,000 $ 4,000,000 $ 4,000,000
B	AUTOMOBILE LIABILITY [ ] ANY AUTO [ ] OWNED AUTOS ONLY [X] SCHEDULED AUTOS [X] HIRED AUTOS ONLY [X] NON-OWNED AUTOS ONLY			3101C4702	5/16/21	5/16/22	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	[ ] UMBRELLA LIAB [ ] OCCUR [ ] EXCESS LIAB [ ] CLAIMS-MADE [ ] DED [ ] RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y/N [ ] If yes, describe under DESCRIPTION OF OPERATIONS below	N/A					[ ] PER STATUTE [ ] OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ $ $

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

Location: 51 Maple St, Dobbs Ferry NY 10522

Village of Dobbs Ferry is listed as additional insured

CERTIFICATE HOLDER

Village of Dobbs Ferry
112 MAIN ST
DOBBS FERRY, NY 10522-4622

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 INSURANCE COVERAGE
NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

PART 1. To be completed by NYS disability and Paid Family Leave benefits carrier or licensed insurance agent of that carrier

1a. Legal Name & Address of Insured (use street address only)
RAMOS & V. TREE SERVICES INC.

P.O. BOX 80
HAWTHORNE, NY 10532

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
914-391-4293

1c. Federal Employer Identification Number of Insured or Social Security Number
208107376

2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)
VILLAGE OF DOBBS FERRY
112 MAIN ST
DOBBS FERRY NY 10522

3a. Name of Insurance Carrier
ShelterPoint Life Insurance Company

3b. Policy Number of Entity Listed in Box "1a"
DBL256964

3c. Policy effective period
07/10/2021 to 07/09/2023

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 4/4/2022 By _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100 Name and Title Richard White, Chief Executive Officer

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 emailed to PAU@wcb.ny.gov or it can 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 4B, 4C or 5B have 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(Article 9 of the Workers' Compensation Law) with respect to all of their 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.

DB-120.1 (12-21)

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box 3 on this form is certifying that it is insuring the business referenced in Box 1a for disability and/or Paid Family Leave benefits under the NYS Disability and Paid Family Leave Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance Coverage (Certificate) to the entity listed 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 cancelled 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 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 NYS disability and/or Paid Family Leave benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability and/or Paid Family Leave benefits 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 Insurance Coverage for NYS disability and/ or Paid Family Leave Benefits or other authorized proof that the business is complying with the mandatory coverage requirements of the NYS Disability and Paid Family Leave Benefits Law.

NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand and twenty-one, the payment of family leave benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits and after January first, two thousand eighteen, the payment of family leave benefits for all employees has been secured as provided by this article.

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Ramos & V. Tree Services, Inc. dba Ramos & V. Tree Services, Inc. PO Box 80 Hawthorne, NY 10532-0080 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)391-4293 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 208107376
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 Continental Indemnity Co. 3b. Policy Number of Entity Listed in Box "1a" 46-853973-01-11 3c. Policy effective period 08/05/21 to 08/05/22 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

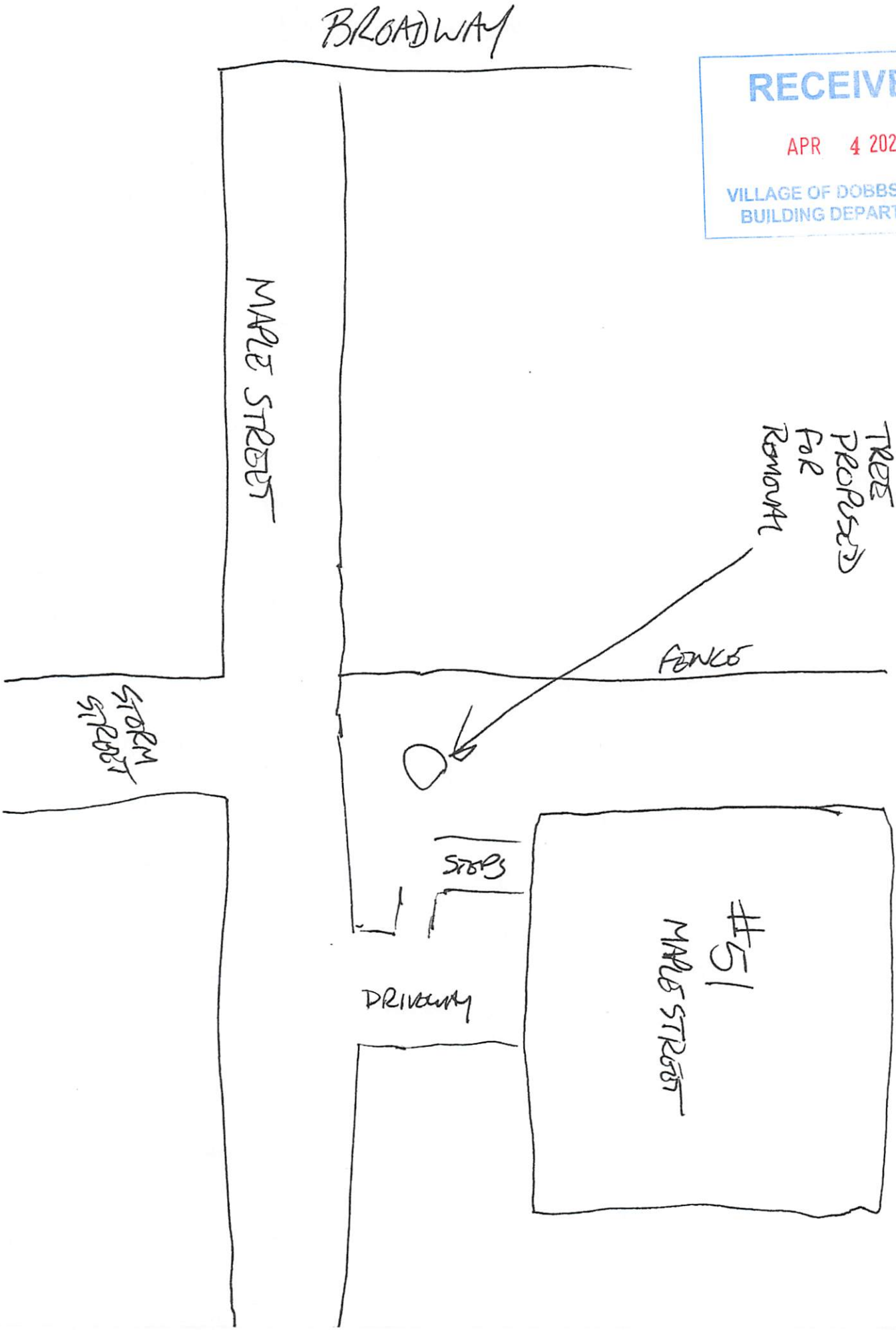
Approved by: Todd Brown
(Print name of authorized representative or licenced agent of insurance carrier)

Approved by: _____ 03/29/2022
(Signature) (Date)

Title: Authorized Representative

Telephone Number of authorized representative or licensed agent of insurance carrier: (877) 234-4424

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.



51 Maple St

PROPOSED TREE FOR REMOVAL