



## 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

APR 16 2024

VILLAGE OF DOBBS FERRY  
BUILDING DEPARTMENT

### Permit Application

Application Number AT2024-0037

Date 04/16/2024

Job Location 39 NORTH DR | Lot # 3.160-142-34

Owner: FRANKMURPHY  
39 N DRIVEWAY  
DOBBS FERRY, NY 10522

Applicant: Frank Murphy  
39 North DR  
Dobbs Ferry, NY 10522  
(917)881-7634 mysticcello@aol.com

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

Description of Work: 90 ft Silver Maple Tree in center of deck is leaning to the North since storm on 4/12/24 which partially uprooted it on the S and SW sides and pulled the deck several inches away from house on South end of deck. The tree has many dead branches at its top.

#### Form Questions:

Diameter of Tree to be Removed	45 inches
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#### Application Parcel Owner Contact:

Parcel Owner Email	mysticcello@aol.com
Parcel Owner Phone	9178817634

Job Location: 39 NORTH DR Parcel Id: 3.160-142-34

#### 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

#### PROPERTY OWNER'S AUTHORIZATION

I FRANKIE MURPHY 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 9178817634 .Owner email address mysticcello@aol.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 16<sup>th</sup> day of April of 2024

Margaret Parr  
Notary Public / Commission of Deeds

PROPERTY OWNER'S SIGNATURE

Th E

MARGARET PARR  
Notary Public, State of New York  
Reg. No. 01PA6342470  
Qualified in Putnam County  
Commission Expires 8/18/2024

Craig Company  
Consulting  
Craig H. Stevens  
1110 Milton Avenue  
Peekskill, New York 10566-5804  
(914) 736-3858 home  
(914) 879-2360 cell  
ISA Certified Arborist # NY-5533A



April 16, 2024

Re: Taking down of one very large tree at 39 North Drive, Dobbs Ferry, NY.

To whom it may concern:

This afternoon I checked on a very large tree being requested to be taken down.

What I found was a 45" DBH Silver Maple growing up, and through, a deck on the rear of the house. The Maple is about 90' tall.

The tree is showing significant signs of decline. Dead branches have been falling and the recent storms have left signs of uprooting and twisting. This tree is vulnerable to Westerly winds as they sweep across the Hudson and up the slope to 39 North Drive.

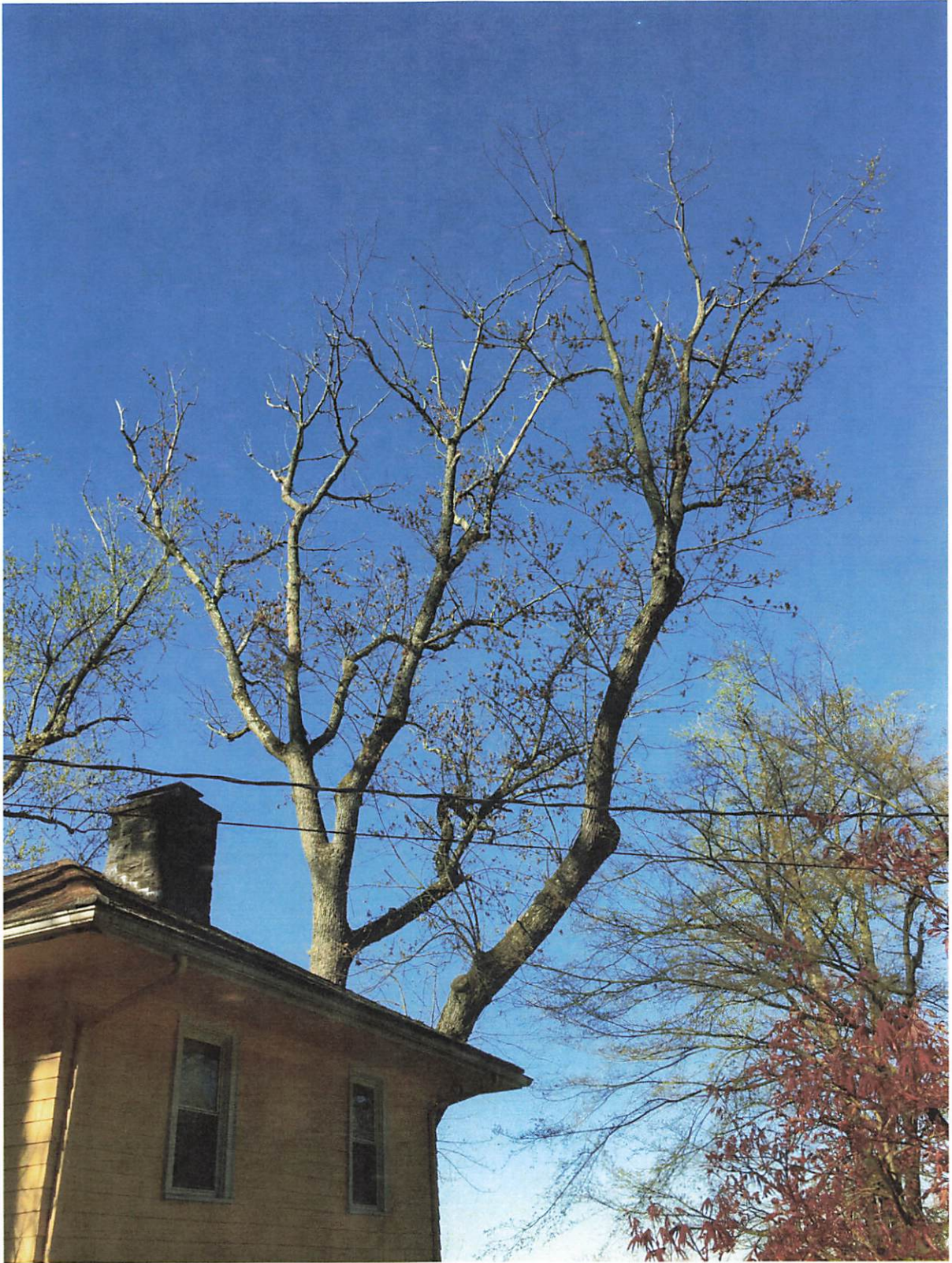
For the reasons mentioned, plus others, I recommend the tree be taken down soon.

Any questions, call me.

Sincerely,

Craig H. Stevens  
Arborist - Village of Scarsdale  
Tree Warden - Town of Ossining









George Latimer  
Westchester County Executive

Westchester  
County

James Maisano  
Director, Consumer Protection

## Department of Consumer Protection Home Improvement License

TIMBERLAND TREE CARE INC.

117 OSCALETA ROAD

SOUTH SALEM, NY-10590

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-05538-H93



Date of Expiration

09/17/2025



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/29/2024

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 <b>Anthony Cirino</b> 426 North Main Street Southington, CT 06489	CONTACT NAME: <b>TONY CIRINO</b> PHONE (A/C No. Ext): <b>(860)329-0103</b> FAX (A/C No.): <b>(860)620-0504</b> E-MAIL ADDRESS: <b>InsGuy@aol.com</b>
INSURED <b>TIMBERLAND TREE CARE INC</b> 117 OSCALETA ROAD SOUTH SALEM, NY 10590 NY 10590	INSURER(S) AFFORDING COVERAGE INSURER A: <b>FARM FAMILY CASUALTY INSURANCE</b> NAIC # 0408-13803 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 SUBR INSD 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 <input checked="" type="checkbox"/> CONTRACTUAL LIABILITY GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y Y	3160X0648	3/3/2024	3/3/2025	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COM/PO/ AGG \$ 2,000,000
A	AUTOMOBILE LIABILITY ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY		3160C0654	3/3/2024	3/3/2025	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<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 \$ 10,000.00		3160E1170	3/3/2024	3/3/2025	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N Y N/A	3160W6367	6/29/2023	6/29/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 100,000 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)

THE VILLAGE OF DOBBS FERRY IS INCLUDED AS ADDITIONAL INSURED ON GENERAL LIABILITY

## CERTIFICATE HOLDER

## CANCELLATION

The 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 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) TIMBERLAND TREE CARE, INC. 117 OSCALETA ROAD SOUTH SALEM, NY 10590  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 914-763-9461  1c. Federal Employer Identification Number of Insured or Social Security Number 133229150
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) The Village of Dobbs Ferry 122 Main Street Dobbs Ferry, NY 10522	3a. Name of Insurance Carrier ShelterPoint Life Insurance Company  3b. Policy Number of Entity Listed in Box "1a" DBL194293  3c. Policy effective period 02/01/2024 to 01/31/2025
4. Policy provides the following benefits: <input checked="" type="checkbox"/> A. Both disability and paid family leave benefits. <input type="checkbox"/> B. Disability benefits only. <input type="checkbox"/> C. Paid family leave benefits only.	
5. Policy covers: <input checked="" type="checkbox"/> A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law. <input type="checkbox"/> 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 4/17/2024 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

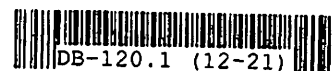
According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law (Article 9 of the Workers' Compensation Law) with respect to all of their employees.

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)





Workers'  
Compensation  
Board

## CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

<b>1a. Legal Name &amp; Address of Insured (use street address only)</b>  TIMBERLAND TREE CARE INC 117 OSCALETA RD SOUTH SALEM NY 10590  <b>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</b>	<b>1b. Business Telephone Number of Insured</b>  914-763-9461  <b>1c. NYS Unemployment Insurance Employer Registration Number of Insured</b>    <b>1d. Federal Employer Identification Number of Insured or Social Security Number</b>  13-3229150
<b>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</b>    The Village of Dobbs Ferry 112 Main Street Dobbs Ferry NY 10522	<b>3a. Name of Insurance Carrier</b>  FARM FAMILY CASUALTY INSURANCE COMPANY  <b>3b. Policy Number of Entity Listed in Box "1a"</b>    <b>3c. Policy effective period</b>  6-29-2023 to 6-29-2024  <b>3d. The Proprietor, Partners or Executive Officers are</b> <input type="checkbox"/> included. (Only check box if all partners/officers included) <input checked="" type="checkbox"/> 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.

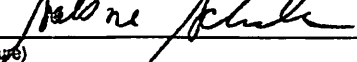
This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

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: SABINE SCHENK  
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  3-01-2024  
(Signature) (Date)

Title: ACCOUNT EXECUTIVE

Telephone Number of authorized representative or licensed agent of insurance carrier: 860-329-0103

**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.

C-105.2 (9-17)

www.wcb.ny.gov