



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

RECEIVED

JUN - 9 2021

Village of Dobbs Ferry
Building Department

Permit Application

Application Number AT2021-0056

Date 04/25/2021

Job Location 37 DEVOE ST Lot # 3.90-51-20

Owner: MARSHALL ANDREW
37 DEVOE ST
DOBBS FERRY, NY 10522

Applicant: Rebecca Marshall
37 Devoe Street
Dobbs Ferry, NY 10522
(408)605-2143
cunningham.lynn.rebecca@gmail.com

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

Description of Work: We are applying for a permit to remove a tree that is a potential hazard, as it is a large pine tree right next to our neighbor's house and also causing problems for their solar panels. We are especially concerned, as pines have notoriously shallow roots and it would cause significant harm if the tree fell.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	cunningham.lynn.rebecca@gmail.com
Parcel Owner Phone	4086052143

Job Location: 37 DEVOE ST

Parcel Id: 3.90-51-20

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 Rebecca Lynn Marshall _____ 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 4086052143. Owner email address cunningham.lynn.rebecca@gmail.com

Rebecca Lynn Marshall _____ 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 _____ second _____ day of _____ May _____ of 2021



Petal-Dawn Loubert
Notary Public / Commission of Deeds



Applicant's Signature

ALL-PURPOSE ACKNOWLEDGMENT

State/Commonwealth of FLORIDA)

☐ City ☒ County of Broward)

On 05/02/2021 before me, Petal-Dawn Loubert,
Date *Notary Name*

personally appeared Rebecca Lynn Marshall
Name(s) of Signer(s)

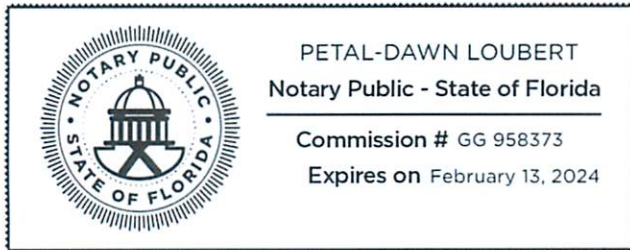
☐ personally known to me -- OR --

☐ proved to me on the basis of the oath of _____ -- OR --
Name of Credible Witness

☒ proved to me on the basis of satisfactory evidence: driver license
Type of ID Presented

to be the individual(s) whose name(s) is (are) subscribed to the within instrument, and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies) and by proper authority, and that by his/her/their signature(s) on the instrument, the individual(s), or the person(s) or entity upon behalf of which the individual(s) acted, executed the instrument for the purposes and consideration therein stated.

WITNESS my hand and official seal.



Notary Public Signature: _____

Notary Name: Petal-Dawn Loubert

Notary Commission Number: GG 958373

Notary Commission Expires: 02/13/2024

Notarized online using audio-video communication

DESCRIPTION OF ATTACHED DOCUMENT

Title or Type of Document: Owner's Authorization

Document Date: 05/02/2021 Number of Pages (w/ certificate): 2

Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

☐ Corporate Officer Title: _____

☐ Partner – ☐ Limited ☐ General

☐ Individual ☐ Attorney in Fact

☐ Trustee ☐ Guardian of Conservator

☐ Other: _____

Signer Is Representing: _____

Capacity(ies) Claimed by Signer(s)

Signer's Name: _____

☐ Corporate Officer Title: _____

☐ Partner – ☐ Limited ☐ General

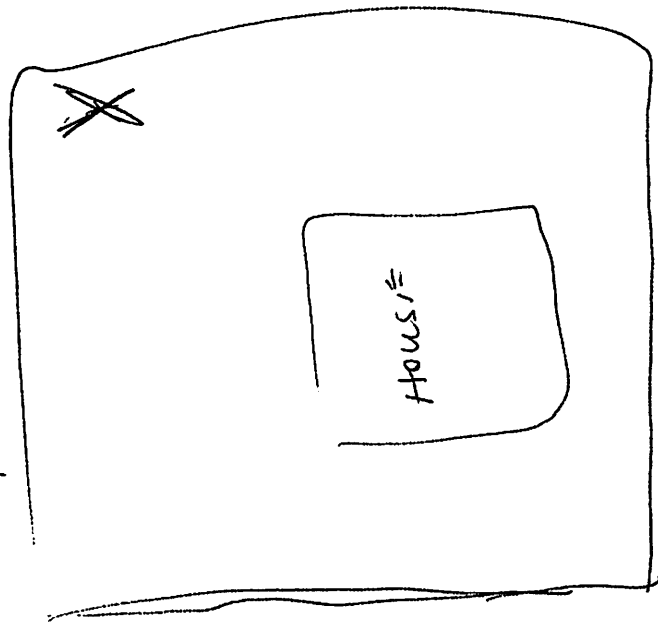
☐ Individual ☐ Attorney in Fact

☐ Trustee ☐ Guardian of Conservator

☐ Other: _____

Signer Is Representing: _____

Maple St.



Devoest.



George Latimer
Westchester County Executive

Westchester
gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection Home Improvement License

HICKORY HOMES & PROPERTIES INC

PO BOX 244

MOUNT KISCO, NY-10549

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-06490-H95



Date of Expiration

01/13/2023



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
04/23/2021

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 Marshall & Sterling, Inc. 420 E. Main Street Middletown NY 10940		CONTACT NAME: Sonia Lewis PHONE (A/C, No, Ext): (845) 343-2138 FAX (A/C, No): (845) 343-9157 E-MAIL ADDRESS: slewis@marshallsterling.com	
INSURED Hickory Homes & Properties Inc P.O. Box 244 Mount Kisco NY 10549		INSURER(S) AFFORDING COVERAGE INSURER A: Michigan Millers Mutual NAIC # 14500 INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES

CERTIFICATE NUMBER: CL2121095782

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	ADOL INSD	SUBR 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 GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			C053649301	01/09/2021	01/09/2022	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 - COMP/OP AGG \$ 2,000,000 Professional Liability \$ 1,000,000
	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> 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			V051084401	01/09/2021	01/09/2022	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			C053649301	01/09/2021	01/09/2022	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000 \$
	<input checked="" type="checkbox"/> 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 <input type="checkbox"/>	N/A				PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/> 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)

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
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CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
4/22/2021

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 John M. Glover Agency Insurance Services 45 Knollwood Road Elmsford NY 10523	CONTACT NAME: Janice Caldararo	FAX (A/C, No): 203-274-9471	
	PHONE (A/C, No, Ext): 914-829-9077	E-MAIL ADDRESS: jcaldararo@johnmglover.com	
INSURED Hickory Homes & Properties Inc. PO Box 244 Mount Kisco NY 10549	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A : Continental Indemnity Company		28258
	INSURER B :		
	INSURER C :		
	INSURER D :		
	INSURER E :		
INSURER F :			

License#: PC-904790
HICKOM-01

COVERAGES **CERTIFICATE NUMBER:** 1480242298 **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
	COMMERCIAL GENERAL LIABILITY						
	<input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> OCCUR						EACH OCCURRENCE \$
							DAMAGE TO RENTED PREMISES (Ea occurrence) \$
							MED EXP (Any one person) \$
							PERSONAL & ADV INJURY \$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE \$
	<input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC						PRODUCTS - COMP/OP AGG \$
	OTHER:						\$
	AUTOMOBILE LIABILITY						
	<input type="checkbox"/> ANY AUTO						COMBINED SINGLE LIMIT (Ea accident) \$
	<input type="checkbox"/> 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) \$
							\$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR						EACH OCCURRENCE \$
	EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE						AGGREGATE \$
	DED <input type="checkbox"/> RETENTION \$						\$
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			46-357540-01-04	4/1/2021	4/1/2022	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	<input type="checkbox"/> Y <input type="checkbox"/> N	N/A				X PER STATUTE OTH-ER
	if yes, describe under DESCRIPTION OF OPERATIONS below						E.L. EACH ACCIDENT \$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE \$ 1,000,000
							E.L. DISEASE - POLICY LIMIT \$ 1,000,000

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

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 <i>John D. Forlino</i>

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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

<p>1a. Legal Name & Address of Insured (use street address only) HICKORY HOMES & PROPERTIES INC.</p> <p>PO BOX 244 MOUNT KISCO, NY 10549</p> <p><i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</i></p>	<p>1b. Business Telephone Number of Insured 914-666-6300</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number 133392876</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) Village of Dobbs Ferry 112 Main Street 112 Main Street Dobbs Ferry, NY 10522</p>	<p>3a. Name of Insurance Carrier ShelterPoint Life Insurance Company</p> <p>3b. Policy Number of Entity Listed in Box "1a" DBL473817</p> <p>3c. Policy effective period 10/09/2020 to 10/08/2022</p>

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 4/23/2021 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 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.

