



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

AUG 17 2023

**VILLAGE OF DOBBS FERRY
BUILDING DEPARTMENT**

Permit Application

Application Number AT2023-0076

Date 08/15/2023

Job Location 65 HICKORY HILL DR Lot # 3.100-98-6

Owner: ZACHARY Y. INOUE
65 HICKORY HILL DR
DOBBS FERRY, NY 10522
415-728-4287

Applicant: Courtney Roberts
2-8 Johnes St.
Newburgh, NY 12550
(845)219-8031
Courtney@empiresolarny.com

Application Type: Tree Removal Estimated Cost of Construction: \$1,500

Description of Work: Removal of 1 tree located in the driveway and trimming of branches hanging above roof.

Form Questions:

Application Parcel Owner Contact:

Parcel Owner Email	zyinoue@hotmail.com
Parcel Owner Phone	(415) 728-4287

Job Location: 65 HICKORY HILL DR

Parcel Id: 3.100-98-6

AFFIDAVIT OF APPLICANT

I Courtney Roberts being duly sworn, depose and says: That s/he does business as: Operations Specialist with offices at: Empire Solar Solutions; 2-8 Johnes St. Newburgh, NY 12550 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 15 day of August of 2023

ERIN McCONNELL
Notary Public, State of New York
No. 01MC6325258
Qualified in Orange County
Commission Expires 05/26/2027
Notary Public / Commission of Deeds

Applicant's Signature

PROPERTY OWNER'S AUTHORIZATION

I Zach Inoue 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 (415) 728-4287. Owner email address zyinoue@hotmail.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 15 day of August of 2023

Notary Public / Commission of Deeds

PROPERTY OWNER's SIGNATURE

ERIN McCONNELL
Notary Public, State of New York
No. 01MC6325258
Qualified in Orange County
Commission Expires 05/26/2027





George Latimer
Westchester County Executive

Westchester
County

James Maisano
Director, Consumer Protection

Department of Consumer Protection Home Improvement License

EMPIRE SOLAR SOLUTIONS LLC

2-8 JOHNES STREET

NEWBURGH, NY-12550

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-29806-H17



Date of Expiration

08/04/2025



EMPISOL-01

CDOLCE

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
8/30/2022

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 Levitt-Fulst Associates, LTD 520 White Plains Road 2nd Floor Tarrytown, NY 10591	CONTACT NAME: Kevin Kelley		
	PHONE (A/C, No, Ext): (914) 457-4200	FAX (A/C, No): (914) 457-4200	
	E-MAIL ADDRESS: info@levittfulst.com		
INSURED Empire Solar Solutions LLC 2-8 Johnes St Newburgh, NY 12550	INSURER(S) AFFORDING COVERAGE		NAIC #
	INSURER A : Southwest Marine & General Insurance Company		12294
	INSURER B : National Casualty Company		2921898
	INSURER C : Standard Security Life Insurance Company		23185
	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 <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input checked="" type="checkbox"/> PROJECT <input type="checkbox"/> LOC OTHER:			GL202200013231	8/26/2022	8/26/2023	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 - COMPI/OP AGG \$ 2,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> HIRED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS ONLY						COMBINED SINGLE LIMIT (Ea accident) \$
							BODILY INJURY (Per person) \$
							BODILY INJURY (Per accident) \$
							PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB EXCESS LIAB DED RETENTION \$						EACH OCCURRENCE \$
							AGGREGATE \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y <input type="checkbox"/> N If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	WCC334526A	1/5/2023	1/5/2024	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTHER \$
							E.L. EACH ACCIDENT \$ 1,000,000
							E.L. DISEASE - EA EMPLOYEE \$ 1,000,000
							E.L. DISEASE - POLICY LIMIT \$ 1,000,000
C	NYS Disability			Z23185-000	1/5/2023	1/8/2024	LIMIT - STATUTORY

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
Village of Dobbs Ferry -is included as Additional Insured for covered operations of the named insured

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

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) EMPIRE SOLAR SOLUTIONS, LLC 2-8 JOHNES ST NEWBURGH, NY 12550 <small>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</small>	1b. Business Telephone Number of Insured 845-728-2165 1c. Federal Employer Identification Number of Insured or Social Security Number 47-4896823
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 Z23185-000 3c. Policy Effective Period 1/5/2023 to 1/8/2024

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 1/9/2023 By Beth A. J. J. J. J.
(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 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 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 (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.





Workers'
Compensation
Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (use street address only) Empire Solar Solutions, LLC. 2-8 Johnes St. Newburgh, NY 12550 <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>	1b. Business Telephone Number of Insured 845-561-3403 1c. NYS Unemployment Insurance Employer Registration Number of Insured 2921898 1d. Federal Employer Identification Number of Insured or Social Security Number 47-4896823
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 National Casualty Company 3b. Policy Number of Entity Listed in Box "1a" WCC334526A 3c. Policy effective period 01/05/2023 to 01/05/2024 3d. The Proprietor, Partners or Executive Officers are <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.**

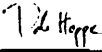
This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

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: Dale Hoppe
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by:  01/06/2023
(Signature) (Date)

Title: Underwriting Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: 515-508-3221

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.