



Only copies from the original of the same work, or as copied of the said Surveyors instrument and not taken and shall be considered to be true, valid copies.

Notwithstanding that any such copy is given for others the survey is approved and no further action by the said governing governmental agency and Planning Administrative Board is necessary. Compliance with any applicable subdivision regulations or village ordinances.

Conventional reference to a station in a survey may indicate a ground level measurement or a reduction of surface (1985) unless noted. Call the New York State Office for more info.

Provision may be made in said instrument.

Whenever property lines are shown or measured or recorded to a corner or adjacent right of way, easement and public or private street, the same shall be correct.

Undisclosed utilities shown on this agreement shall be shown by utility before recording.

Adjacent unrecorded surveys are not shown or recorded. Surveyors have not examined prior deeds, plans, or those on record.

Indices of easements, encroachments, encroachments, conditions and agreements referred.

Previous Survey 1889 by T.M. as shown on a certain map entitled "Condition Map Subdiv. No. 3 Cooks Hill, Situated in the Town of North Castle, Westchester County, New York".

Previous Survey 1889 by T.M. as shown on a certain map entitled "Condition Map Subdiv. No. 3 Cooks Hill, Situated in the Town of North Castle, Westchester County, New York".

Previous Survey 1889 by T.M. as shown on a certain map entitled "Condition Map Subdiv. No. 3 Cooks Hill, Situated in the Town of North Castle, Westchester County, New York".

Survey in accordance with Civil Practice Code Section 3405(b)(1).

Survey conducted by T.M. as shown on a certain map entitled "Condition Map Subdiv. No. 3 Cooks Hill, Situated in the Town of North Castle, Westchester County, New York".

**SURVEY OF PROPERTY
PREPARED FOR
GINA DECRASCENZO**
SITE LIAISON IN THE
TOWN OF NORTH CASTLE
WESTCHESTER COUNTY, NEW YORK

SCALE: 1" = 30'
GRAPHIC SCALE



Project Agreement
10-20-21
Date Surveyed
06-23-22
Survey by
T.M.P. 2022
Drawn by
DN

TC MERRITTS LAND SURVEYORS
394 BEDFORD ROAD • PLEASANTVILLE • NY 10587
(914) 788-8885 • (202) 632-5899



Conducted by:
Chief of Operations
Field Supervisor/Mapmaker Title Examiner/Computer
Manager/Secretary/Planner/Recorder, Computer
Administrator, (914) 788-8885
T.M.P. #02202020

Surveyed October 1, 2021
New York State Office for General Services
Map Approved: October 18, 2022 by State Office for General Services
Map Approved: February 22, 2022 by State Office for General Services

Tina Merritts
Tina Merritts, Licensed Professional Surveyor



TOWN OF NORTH CASTLE

WESTCHESTER COUNTY
17 Bedford Road
Armonk, New York 10504-1898

Telephone: (914) 273-3000 x 43
Fax: (914) 273-3554
www.nortcastleny.com

RESIDENTIAL PROJECT
REVIEW COMMITTEE
Adam R. Kaufman AICP, Chair

RESIDENTIAL PROJECT REVIEW COMMITTEE (RPRC) APPLICATION

Section I- PROJECT

ADDRESS: 16 Birch Grove Drive Armonk NY 10504

Section III- DESCRIPTION OF WORK:

Section III- CONTACT INFORMATION:

APPLICANT: John Boyle
ADDRESS: 16 Birch Grove Drive Armonk NY 10504
PHONE: _____ MOBILE: 570-460-3623 EMAIL: Johnny.boyle@gmail.com.

PROPERTY OWNER: John Boyle
ADDRESS: 16 Birch Grove Drive Armonk NY 10504
PHONE: _____ MOBILE: 570 460 3623 EMAIL: Johnny.boyle@gmail.com.

PROFESSIONAL: _____

ADDRESS: _____

PHONE: _____ MOBILE: _____

EMAIL: _____

Section IV- PROPERTY INFORMATION:

Zone: _____ Tax ID (lot designation) _____



Town of North Castle Building Department

17 Bedford Road

Armonk, New York 10504-1898

Telephone: (914) 273-3000 ext. 44 Fax: (914) 273-3554

www.northcastleny.com

Tree Removal Application

NOTE: TWO (2) SETS OF ALL REQUIRED DOCUMENTS MUST BE SUBMITTED WITH THIS APPLICATION

Section I- PROJECT ADDRESS: 16 Birch Grove Drive, Armonk, NY 10504 **DATE:** 08/26/2021

Section II- CONTACT INFORMATION: (Please print clearly. All information must be current)

APPLICANT: Mr. John Boyle

ADDRESS: 16 Birch Grove Drive, Armonk, NY 10504

PHONE: _____ **MOBILE:** (570) 460-3623 **EMAIL:** johnny.boyle@gmail.com

PROPERTY OWNER: Same as above

ADDRESS: _____

PHONE: _____ **MOBILE:** _____ **EMAIL:** _____

Tree Company: Rosamilia Brothers, Inc. dba Bizee Bee Tree Service

ADDRESS: PO Box 716, Mahopac, NY 10541

PHONE: (845) 621-4350 **MOBILE:** _____ **EMAIL:** team@bizeebeetree.com

Section III- REGULATED ACTIVITY: (Check all that apply)

- Removal of a tree within a property's regulated setback zone or landscaped buffer zone.
- Removal of a significant tree.
- Removal of any tree in the wetlands, within clearing lines, or conservation easements.
- Clearing/Thinning.
- Removal of any tree within the right of way.
- Removal in any calendar year of more than ten (10) trees on any lot.

Section IV- DESCRIPTION OF WORK: (Please include how many trees will be removed)

Remove (1) 46" dia Tulip tree in front of the house showing signs of rotting throughout the base of the tree Remove (1) 24" dia. Maple tree and (1) 34" dia. Tulip tree behind the basketball hoop on left side of property which are both rotting and have a severe lean toward the garage Remove (1) 36" dia. double trunk Tulip tree in the rear property to the left of the shed which is showing signs of rotting and decay throughout the tree Remove (1) 40" dia. Tulip tree to the right of the shed which has a rotting hole at the base of the tree

Section V- FUTURE PLANS:

Do you have any intention of tearing down the house to build a new house within the next six (6) months. Yes No

Town of North Castle Building Department

Section V- FUTURE PLANS: (Continued)

Do you have any intention to expand the house over 1500 square feet within the next six (6) months? Yes No

Section VI- RESTRICTION:

Is there any conservation easements on your deed? Yes No

Section VII- PERMIT FEES: (\$50 application fee and a \$25 Certificate of Compliance fee)

Section VIII- APPLICANT CERTIFICATION

I hereby certify that I have read the instructions & examined this application and know the same to be true & correct. All provisions of laws & ordinances covering this type of work will be complied with whether specified herein or not. The granting of a permit does not presume to give authority to violate or cancel the provisions of any other state or local law regulating construction or land use or the performance of construction.

Signature: John B. L. Date: _____

Section IX- AFFIDAVIT OF OWNER AUTHORIZATION: (To be notarized)

STATE OF NEW YORK }
COUNTY OF WESTCHESTER } SS:

The applicant _____ has proper consent from said owner to make this application as submitted and said owner agrees to all terms and conditions placed upon same.

Owner's Name (PRINT) _____ Owner's Signature _____

Sworn to before me this _____ day of _____, 20_____

OFFICE USE ONLY - DO NOT WRITE BELOW THIS LINE

Zone: _____ Section: _____ Block: _____ Lot: _____

Building Department Checklist:

Does this permit require RPRC approval? Yes No

Has a plan delineating all improvements, site grading and disturbance proposed on the subject property. Yes No

GC License Work. Comp. Liability. Ins. Disability Two sets of documents

Permit Fee \$75.00 Payment type: Check #: _____ Cash

Name on check: _____ Received By: _____ Date: _____

Reviewed By: _____ Date: _____

Building Inspector Approval: _____ Date: _____

Conditions: _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

08/26/2021

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 JEFFREY D KAVOVIT FARM FAMILY CASUALTY INSURANCE CO 88 OLD ROUTE 9W, SUITE 100 NEW WINDSOR, NY 12553	CONTACT NAME: PHONE (A/C, No., Ext): 845-562-0701	FAX (A/C, No.): 845-562-0852
	E-MAIL ADDRESS: INSURER(S) AFFORDING COVERAGE	
INSURED ROSAMILIA BROTHERS INC DBA BIZEE BEE LAWN & TREE MAINTENANCE PO BOX 716 MAHOPAC, NY 10541	INSURER A: FARM FAMILY CASUALTY INS. CO.	NAIC # 408-13803
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

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. Y/YD	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"/> SELECT BUSINESS PKG <input checked="" type="checkbox"/> CONTRACTUAL LIABILITY GEN'L AGGREGATE LIMIT APPLIES PER <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC <input type="checkbox"/> OTHER	X	3101X1090	11/19/20	11/19/21	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
A	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		3140C0246	11/19/20	11/19/21	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 RETENTION \$ 10,000		3101E2480	11/19/20	11/19/21	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000
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	3101W9834	11/19/20	11/19/21	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER 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)

TREE REMOVAL- TREE SERVICE, LANDSCAPE/GARDENING (INCL. XCU),

RE: MR. JOHN BOYLE, 16 BIRCH GROVE DRIVE, ARMONK, NY 10504

TOWN OF NORTH CASTLE IS ADDITIONAL INSURED

CERTIFICATE HOLDER**CANCELLATION**

TOWN OF NORTH CASTLE
 15 BEDFORD RD.
 ARMONK, NY 10504

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

Jeffrey D. Kavovit

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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)</p> <p>ROSAMILIA BROTHERS INC DBA BIZEE BEE LAWN & TREE MAINTENANCE 585 UNION VALLEY RD MAHOPAC, NY 10541</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured</p> <p>914-557-6587</p> <p>1c. Federal Employer Identification Number or Social Security Number</p> <p>208300596</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>TOWN OF NORTH CASTLE 15 BEDFORD RD. ARMONK, N.Y. 10504</p>	<p>3a Name of Insurance Carrier</p> <p>HARTFORD LIFE AND ACCIDENT</p> <p>3b Policy Number of Entity Listed in Box "1a"</p> <p>LVNY631821</p> <p>3c Policy effective period</p> <p>10-01-2020 to 09-30-2021</p>
<p>4. Policy provides the following benefits:</p> <p><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.</p> <p>5. Policy covers:</p> <p><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:</p>	

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 05-12-2021 *Elizabeth Tello*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (212) 553-8074 Name and Title: Elizabeth Tello – Assistant Director, Statutory 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 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.





**CERTIFICATE OF
NYS WORKERS' COMPENSATION INSURANCE COVERAGE**

<p>1a. Legal Name & Address of Insured (use street address only)</p> <p>ROSAMILIA BROTHERS INC DBA BIZEE BEE LAWN & TREE MAINTENANCE PO BOX 716 MAHOPAC, NY 10541</p> <p><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></p>	<p>1b. Business Telephone Number of Insured 914-557-6587</p> <p>1c. NYS Unemployment Insurance Employer Registration Number of Insured</p> <p>1d. Federal Employer Identification Number of Insured or Social Security Number 208300596</p>
<p>2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>TOWN OF NORTH CASTLE 15 BEDFORD RD. ARMONK, N.Y. 10504</p>	<p>3a. Name of Insurance Carrier FARM FAMILY CASUALTY INS CO</p> <p>3b. Policy Number of Entity Listed in Box "1a" 3101W9834</p> <p>3c. Policy effective period <u>11-19-20</u> to <u>11-19-21</u></p> <p>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.</p>

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:  05-12-21
(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.

George Latimer
Westchester County Executive

Westchester
gov.com

James Maisano
Director, Consumer Protection

Department of Consumer Protection Home Improvement License

ROSAMILIA BROTHERS, INC.

BIZEE BEE LAWN & TREE MAINTENANCE

585 UNION VALLEY RD.

MAHOPAC, NY-10541

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-19402-H07



Date of Expiration

07/23/2023