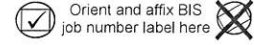




PW2: Work Permit Application

Must be typewritten.



BIS Document No., required:

1 Reason For Filing Required for all applications.

- ☒ Initial Permit Complete all sections. Expected work start date: _____ ☐ Renewal Permit with changes Complete all sections.
- ☐ No Work Permit ☐ Renewal Permit without changes 1, 3, 4, 7 - 12

2 Location Information Required for all applications.

House No(s) 232

Street Name Atkins Avenue

Borough 3

Block 4022

Lot 139

BIN 3258751

C.B. No. 305

Work on Floor(s) Roof

Apt. / Condo No(s)

3 Type of Permit Choose one and complete any appropriate sub-choices or other information.

- ☒ Alteration ☐ Curb Cut ☐ Fuel Burning ☐ Plumbing 3C 3A Electrical application no. for shed lighting:
- ☐ Filed as NB (28-101.4-5) ☐ Demolition and Removal ☐ Gas ☐ Sign
- ☐ Boiler ☐ Fire Alarm ☐ Oil ☐ Sprinkler 3C 3B Related fence job no.
- ☐ Construction Equipment ☐ Fire Suppression System ☐ Fuel Storage ☐ Standpipe 3C 3C Secondary permit description (if applies):
- ☐ Chute ☐ Fence ☐ Foundation / Earthwork ☐ Mechanical / HVAC
- ☐ Sidewalk Shed 3A Area of site (sq. ft): ☐ New Building 3B
- ☐ Supported Scaffold
- ☐ Other: _____ ☐ Earthwork Only

- 3D ☐ Yes ☒ No Are you adding more than three stories? ☐ Yes ☒ No Are you removing one or more stories? If yes, 8
- ☐ Yes ☒ No Are you performing work in 50% or more of the area of the building? ☐ Yes ☒ No Are you demolishing 50% or more of the area of the building? If yes, 8
- ☐ Yes ☒ No Are you performing a vertical or horizontal enlargement adding more than 25% of the area of the building? ☐ Yes ☒ No Does your approved work include concrete? If yes, is your concrete work completed? ☐ Yes ☐ No complete section 9
- ☐ Yes ☒ No Are mechanical means to be used?

4 Applicant / Contractor Required for all applications. (* Indicates optional.)

Last Name Stout

First Name James

Middle Initial J

Business Name James J Stout Architect & Associates

Business Telephone (631) 858-9388

Business Address 2 Greg Lane

*Business Fax

City East Northport

State NY

Zip 11731

*Mobile Telephone

*E-Mail nycsubmissions@jamesstoutarch.com

Taxpayer

- ☐ General Contractor 4A, 4B 4A Provide registration or tracking number:
- ☐ Fire Suppression Contractor 4C, 4D 4B Does work require a HIC license? ☐ Yes ☐ No If yes, HIC license
- ☐ Master Plumber 4C, 4D 4C License Number: 021633
- ☐ Oil Burner Installer 4C, 4D 4D Is applicant responsible for all work on this application? ☐ Yes ☐ No
- ☐ Sign Hanger 4D If no, describe work responsibility:
- ☐ Professional Engineer 4C, 6
- ☒ Registered Architect 4C, 6
- ☐ Homeowner

DOB approval required.



Mechanical equipment other than handheld devices to be used for demolition or removal of debris (BC §3306.4).

5 Filing Representative *Complete if different from applicant specified in section 3. (* Indicates optional.)*

Last Name		First Name		Middle Initial
Business Name			Business Telephone	
Business Address			*Business Fax	
City	State	Zip	*Mobile Telephone	
*E-Mail			Registration Number	

6 Insurance *P.E. / R.A. only (* indicates required for all permits)*

☒ Liability Insurance *(NB permits only)* ☒ Workers' Compensation Insurance* ☒ Disability Insurance *

7 Construction Superintendent, Site Safety Coordinator, Site Safety Manager *Required if applicable. (* Indicates optional.)*

I, the applicant / contractor, hereby declare the scope of work filed under this permit application requires: *(choose one)*

☐ Construction Superintendent	☐ Site Safety Coordinator	☐ Site Safety Manager
Last Name		Middle Initial
First Name		Telephone
Business Name		
Address		*Fax
City	State	Zip
*E-Mail		*Mobile Telephone
		Registration Number

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Construction Superintendent, or Site Safety Coordinator, or Site Safety Manager (identified above) as set forth in the Department of Buildings rules and regulations.

Name (print)	Notarization State of New York, County of:	Notary Seal
Signature	Sworn to or affirmed under penalty of perjury day of 20	
Date	Notary Signature	

8 Demolition Subcontractor *Required if applicable. (* Indicates optional.)*

☐ Yes ☐ No Is the applicant/contractor named in section four performing the demolition work for this permit? If no, complete this section.

Last Name		First Name		Middle Initial
Business Name			Telephone	
Address			*Fax	
City	State	Zip	*Mobile Telephone	
*E-Mail			Registration Number	

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Demolition Subcontractor as set forth in the Department of Buildings rules and regulations.

Name (print)	Notarization State of New York, County of:	Notary Seal
Signature	Sworn to or affirmed under penalty of perjury day of 20	
Date	Notary Signature	

9 Concrete Information Choose and complete any appropriate sub-choices.

9A ☐ Yes ☐ No Are you requesting to exclude concrete work at this time from this permit? If no, 9B

9B ☐ Yes ☐ No Does your approved work include 2,000 cubic yards or more of concrete? If yes, 10 and 11

10 Concrete Subcontractor Required if applicable. (* Indicates optional.)

☐ Yes ☐ No Is the applicant/contractor named in section four performing the concrete work for this permit? If no, complete this section.

Last Name	First Name	Middle Initial
Business Name	Telephone	
Address	*Fax	
City	State	Zip
*E-Mail	*Mobile Telephone	
Registration Number		

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Concrete Subcontractor as set forth in the Department of Buildings rules and regulations.

Name (print)	Notarization State of New York, County of:	Notary Seal
Signature	Sworn to or affirmed under penalty of perjury day of 20	
Date	Notary Signature	

11 Concrete Safety Manager Required if applicable. (* Indicates optional.)

Last Name	First Name	Middle Initial
Business Name	Telephone	
Address	*Fax	
City	State	Zip
*E-Mail	*Mobile Telephone	
Registration Number		

I, the undersigned, will perform, on behalf of the Contractor, all of the functions required of a Concrete Safety Manager (identified above) as set forth in the Department of Buildings rules and regulations.

Name (print)	Notarization State of New York, County of:	Notary Seal
Signature	Sworn to or affirmed under penalty of perjury day of 20	
Date	Notary Signature	

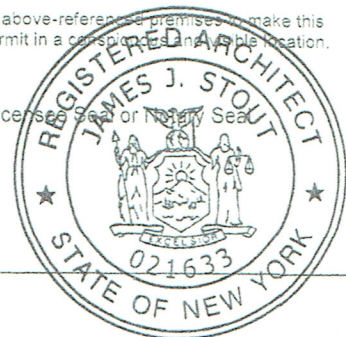
12 Applicant / Contractor Statements and Signatures Required for all applications.

The information in this application is correct and complete to the best of my knowledge and I assume responsibility for all statements on this form. I understand that if I am found after hearing to have knowingly or negligently made a false statement on this or any other document submitted to the Department, I may be subject to fine, imprisonment, and/or barred from filing further documents with the Department. I also understand it is unlawful to give to a city employee, or for a city employee to accept, any benefit, monetary or otherwise, either as a gratuity for properly performing the job or in exchange for special consideration.

I will comply with all applicable laws, rules and regulations including all insurance requirements, and, in addition,

- I hereby state if a Construction Superintendent, Site Safety Coordinator, Site Safety Manager, Demolition Subcontractor, Concrete Subcontractor, or Concrete Safety Manager is required for this application I have hereby advised the individual listed herein he or she is designated as such and hereby certify he or she is registered and in good standing with the NYC Department of Buildings.
- I hereby state this renewal application with no change to Applicant, Filing Representative, Construction Superintendent, Site Safety Coordinator, Site Safety Manager, Subcontractors, Concrete Safety Manager or insurance is for the work as originally filed or as officially amended.
- In accordance with §28-104.8 of the Administrative Code, I hereby declare I am authorized by the owner of the above-referenced premises to make this application for a permit to perform the work described herein. In accordance with Rule 101-16, I will post the permit in a conspicuous and visible location.
- ☒ Check here if the work authorized by this permit does NOT require adjacent property insurance.

Name (print) James J. Stout	Notarization (required if not licensee) State of New York, County of:	Licensee Signature or Notary Seal
Signature	Sworn to or affirmed under penalty of perjury day of 20	
Date	Notary Signature	





CERTIFICATE OF LIABILITY INSURANCE

SRX
R045DATE (MM/DD/YYYY)
2/11/2016

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 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:	
BIN INSURANCE HOLDINGS LLC/PHS		PHONE (A/C, No, Ext): (866) 467-8730	
505500 P:(866) 467-8730 F:(888) 443-6112		FAX (A/C, No): (888) 443-6112	
PO BOX 33015		E-MAIL ADDRESS:	
SAN ANTONIO TX 78265		INSURER(S) AFFORDING COVERAGE	
		INSURER A: Sentinel Ins Co LTD	
		INSURER B: Property & Casualty Co of Hartford	
		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 INSR	SUBR WTD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	COMMERCIAL GENERAL LIABILITY			46 SBM UJ0636	02/10/2016	02/10/2017	EACH OCCURRENCE	\$1,000,000
	CLAIMS-MADE ☒ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$1,000,000
	General Liab						MED EXP (Any one person)	\$10,000
							PERSONAL & ADV INJURY	\$1,000,000
							GENERAL AGGREGATE	\$2,000,000
							PRODUCTS - COMP/OP AGG	\$2,000,000
A	AUTOMOBILE LIABILITY			46 SBM UJ0636	02/10/2016	02/10/2017	COMBINED SINGLE LIMIT (Ea accident)	\$1,000,000
	ANY AUTO						BODILY INJURY (Per person)	\$
	ALL OWNED AUTOS						BODILY INJURY (Per accident)	\$
	X HIRED AUTOS	X					PROPERTY DAMAGE (Per accident)	\$
								\$
	UMBRELLA LIAB						EACH OCCURRENCE	\$
	EXCESS LIAB						AGGREGATE	\$
								\$
	DED	RETENTION \$						\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			46 WEC AK0257	02/10/2016	02/10/2017	X PER STATUTE	OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N	N/A				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)

Those usual to the Insured's Operations.

CERTIFICATE HOLDER	CANCELLATION
NYC Department of Buildings 280 BROADWAY NEW YORK, NY 10007	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

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name and address of Insured (Use street address only) JAMES J STOUT & ASSOCIATES PC 2 GREG LN EAST NORTHPORT NY 11731 Work Location of Insured <i>(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 (631) 513-0133 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 364773766
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NYC DEPARTMENT OF BUILDINGS 280 BROADWAY NEW YORK, NY 10007	3a. Name of Insurance Carrier Property & Casualty Co of Hartford 3b. Policy Number of entity listed in box "1a": 46 WEC AK0257 3c. Policy effective period: 02/10/2016 to 02/10/2017 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 will also notify the above certificate holder 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.

Please Note: Upon the 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: Danielle Clausen
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: Danielle Clausen 2/11/2016
(Signature) (Date)

Title: Operations Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: (866) 467-8730

Please Note: Only insurance carriers and their licensed agents are authorized to issue the C-105.2 form. Insurance brokers are **NOT** authorized to issue it.

Workers' Compensation Law

Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. 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 a hazardous employment defined by this chapter, and notwithstanding 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 compensation for all employees has been secured as provided by this chapter. 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 compensation to any such employee if so employed.

2. 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 a hazardous employment defined by this chapter, 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 compensation for all employees has been secured as provided by this chapter.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address only) JAMES STOUT ARCHITECT & ASSOCIATES PC 2 GREG LANE EAST NORTHPORT, NY 11731	1b. Business Telephone Number of Insured 631-858-9388 1c. NYS Unemployment Insurance Employer Registration Number of Insured 0872375 1d. Federal Employer Identification Number of Insured or Social Security Number 364773766
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) NYC Department of Buildings 280 Broadway, New York NY 10007	3a. Name of Insurance Carrier HARTFORD LIFE AND ACCIDENT 3b. Policy Number of entity listed in box "1a": LNY646797 3c. Policy effective period: 01-01-2016 to 12-31-2016

4. Policy covers:

- a. ☒ All of the employer's employees eligible under the New York Disability Benefits Law
b. ☐ Only the following class or classes of the 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 Benefits insurance coverage as described above.

Date Signed 02-11-2016

By

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number (800) 454-7020

Title Manager

IMPORTANT: If box "4a" is 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" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers' Compensation Board (Only if box "4b" 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 Benefits Law with respect to all of his/her employees.

Date Signed

By

(Signature of NYS Workers' Compensation Board Employee)

Telephone Number

Title

Please Note: Only insurance carriers licensed to write NYS disability 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.**