Permit to Operate
Renewal Application

State of New York Department of Health

Business / Location Information (Please modify only if information has changed.)

Business Name: CAMP SARADAC SARATOGA SUMMER REC PRG — **Code: 45-B146**

Address: 15 VANDERBILT AVENUE
SARATOGA SPRINGS, NY 12866

Business Phone: (518) 587-3550 x 2300
Business Fax: (518) 584-1748
Business Website: www.saratoga-springs.org

Location: City of SARATOGA SPGS.
County: SARATOGA

Mail To:
CITY OF SARATOGA SPRINGS
RECREATION DEPARTMENT
15 VANDERBILT AVENUE
SARATOGA SPRINGS, NY 12866-4914

Permit Number *45-B146*

Permit Expiration Date
August 17, 2013

Fee Exempt

Permitted Operation

CAMP SARADAC SARATOGA SUMMER REC PROGRAM — **Operation ID: 329421**
Children's Camp - Day Camp

In Operation: ○ Year-Round ● Seasonal — If Seasonal: Expected Opening Date 6/30 (Month/Day) Expected Closing Date 8/16 (Month/Day)

Capacity: 350 Persons — Days/Hours of Operation: 7:30 Am - 6:00 pm

Permit Applicant Information (Please modify only if information has changed.)

Legal Operator or Operating Corporation: CITY OF SARATOGA SPRINGS

Person in Charge: Title — JOHN (First) — M.I. — HIRLIMAN (Last)
Address: RECREATION DEPARTMENT — 15 VANDERBILT AVENUE
City, State, Zip: SARATOGA SPRINGS — NY — 12866-4914
Primary Phone: (518) 587-3550 Ext 2306 ☐ Cell — Fax (518) 584-1748 — Emergency Contact ☐
Other Phone: ( ) - Ext ☐ Cell — E-mail john.hirliman@saratoga-springs.org

Location Owner: CITY OF SARATOGA SPRINGS

Address: RECREATION DEPARTMENT — 15 VANDERBILT AVENUE
City, State, Zip: SARATOGA SPRINGS — NY — 12866-4914
Primary Phone: (518) 587-3550 Ext 2306 ☐ Cell — Fax (518) 584-1748 — Emergency Contact ☐
Other Phone: ( ) - Ext ☐ Cell — E-mail john.hirliman@saratoga-springs.org

Migrant Labor Camps and Children's Camps
Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH

As required by Article 6, PHL, effective 1/1/88

Fee Exemption Requested? ☑ Yes If Yes, complete sections A, C and D below and return. ☐ No

FOR OFFICE USE ONLY
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

SECTION A

1a. Name of Establishment
Camp Saradac Saratoga Summer Rec. Program

b. Address (No. & Street, City, State, Zip)
15 Vanderbilt Avenue, Saratoga Springs NY 12866

2. Name of Operator City of Saratoga Springs Title Mayor

SECTION B

Check the appropriate category.

☐ MIGRANT LABOR CAMP

Occupancy - check the correct number to determine fee.

☐ 5 - 50 = $50.00

☐ 51 or more = $100.00

☒ CHILDREN'S CAMPS = $200.00

TOTAL FEE DUE: $_____

SECTION C: Exemption Request

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☑ No

2. Is this facility operated by a municipality (city, town, village)? ☑ Yes ☐ No

3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)_____

SECTION D: Certification False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(f) 10/88

Permit to Operate
Renewal Application

State of New York Department of Health

Workers' Compensation and Disability Insurance

Submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law:

A. Workers Compensation and Disability Insurance Coverage is PROVIDED

Workers Compensation

Form C-105.2 – Certificate of Worker's Compensation Insurance **OR**

Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

AND

Disability Benefits

DB-120.1 - Certificate of Disability Benefits **OR**

Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage is NOT PROVIDED

Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

Return Completed Application

Please return completed application to:

Checks should be made payable to "State of New York Department of Health" and include the permit number.

State of New York Department of Health
Glens Falls District Office
77 Mohican Street
Glens Falls NY 12801-4429

(518) 793-3893 Fax: (518) 793-0427
gdfocal@notes.health.state.ny.us

Signature of Individual Operator or Authorized Official (Entire section must be completed by all applicants.)

I would like to receive information and official correspondence related to this permit at the email address below: (Yes _ No _)

_____ @_____

Failure to completely fill out and sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code. False statements made on this application are punishable under the penal law.

Signature _____

Print Name Joanne D. Yepsen Title Mayor Date _____

FOR OFFICE USE ONLY

Permit Issuance recommended? ☐ Yes ☐ No Permit Effective Date _____ Permit Expiration Date _____

Conditions of approval _____

Signature _____ Title _____ Date _____

STATE OF NEW YORK
WORKER'S 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)
CITY OF SARATOGA SPRINGS

ATTN: THE HUMAN RESOURCE DEPARTMENT
474 BROADWAY
SARATOGA SPRINGS, NY 12866

1b. Business Telephone Number of Insured
518-587-3550

1c. NYS Unemployment Insurance Employer Registration Number of Insured
0460110

1d. Federal Employer Identification Number of Insured or Social Security Number
146002423

2. Name and Address of the Entity requesting Proof of Coverage (Entity being listed as the Certificate Holder)
NYS DEPARTMENT OF HEALTH

GLENS FALLS DISTRICT OFFICE

77 MOHICAN STREET

GLENS FALLS, NY 12801

3a. Name of Insurance Carrier
The First Rehabilitation Life Insurance Company of America

3b. Policy Number of Entity listed in box "1a":
DBL275951

3c. Policy effective period:
06/01/2013 to 05/31/2015

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 3/28/2014 **By** _____
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 516-829-8100 **Title** Chief Executive Officer

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 the purposes of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Worker's Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, NY 12207.

PART 2. To be completed by NYS Worker's Compensation Board (Only if box "4b" of Part 1 has been checked)

State of New York
Worker's Compensation Board

According to information maintained by the NYS Worker's 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 Worker's 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.

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in Box "3" on this form is certifying that it is insuring the business referenced in Box "1a" for disability benefits under the New York State Disability Benefits Law. The insurance carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in Box "2". **This certificate is valid for the earlier of one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in Box "3c".**

Please Note: Upon the cancellation of the disability benefits 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 NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

Section 220. Subd. 8

(a) The head of 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 employment as defined in this article, 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 the payment of disability benefits for all employees has been secured as provided by this article. 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 disability benefits to any such employee if so employed.

(b) The head of 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 employment as defined in this article, and 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 the payment of disability benefits for all employees has been secured as provided by this article.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION COUNTY SELF-INSURANCE PLAN

1a. Legal name and address of participant in County Self-Insurance Plan City of Saratoga Springs 474 Broadway Saratoga Springs, NY 12866 **1b. Effective date of membership in the Plan** 1/1/1967	**1c. Telephone number of participant** 518-587-3550 Ext. 2612 **1d. NYS Unemployment Insurance Employer Registration Number of participant** 04-60110 **1e. Federal Employer Identification Number of participant** 14-6002423
2. Name and address of the entity requesting proof of coverage NYS DOH Glens Falls District Office 77 Mohican Street Glens Falls, NY 12801	**3. Name and address of County Self-Insurer** Saratoga County Self-Insurance Plan 40 McMaster Street Ballston Spa, NY 12020

This certifies that the participant referenced above is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law as a participating member of the County Self-Insurance Plan listed above and participation in such County Self-Insurance Plan is still in force. The County Self-Insurer's Administrator will send this Certificate of Participation to the certificate holder listed in box 2.

If the membership of the participant listed in box 1a is terminated, the County Self-Insurer's Administrator will notify the certificate holder within 10 days of termination. (These notices may be sent by regular mail.) Otherwise, this certificate is valid for a maximum of one year from the date certified by the county self-insurer.

If this certificate is no longer valid according to the above guidelines and the participant referenced in box "1a" continues to be named on a permit, license or contract issued by the certificate holder, the participant must provide the certificate holder either with a new certificate or other authorized proof the participant is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

The County Self-Insurer must file this certificate with the Workers' Compensation Board's Self-Insurance Office. (See reverse.)

Under penalty of perjury, I certify that I am an authorized representative of the County Self-Insurer referenced above and that the participant has the coverage as depicted on this form.

Certified by: Wendy Tennant
(~~Print name of~~ authorized representative of County Self-Insurer)

Certified by: _____ 1/2/14
(Signature) (Date)

Title: Self-Insurance Specialist

Telephone Number: 518-885-2234

SI-105.2P (1-13)

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

Children's Camp Facility and Staff Description

Instructions

Complete the items that are applicable to the camp's operation; use additional sheets if necessary. Submit the completed form and other required application materials to the local health department (LHD) at least 60 days prior to camp operation. Information that is not available should be identified as "Pending." For expired certifications, the date of scheduled re-certification courses may be listed when staff are registered to attend. Pending information and confirmation of staff re-certification must be sent to the LHD when available.

Facility

Facility Name: Camp Saradac Saratoga Summer Rec. Prog.

Facility Code: 45-B146 Date Open: 6 / 30/14 Date Close: 8 / 16/ 14 Are 20% or more of the campers developmentally disabled? ☐ Yes ☒ No

Activities available to campers

For activities identified with a "*", please further specify the activity in the space provided.

☒ Amusement Parks	☒ Classroom Instruction	☒ Ice Skating	☐ Roller Skating/Blading	☐ Other Water Activities*
☐ Aquatic Theme Parks	☐ Cooking	☒ Martial Arts	☐ Ropes/Challenge Course	☒ Other*
☐ Archery	☒ Dancing/Acting	☐ Mountain Boarding	☐ Skate Boarding	* Saratoga County Fair
☐ Arts and Crafts	☐ Gymnastics	☒ Nature Study	☒ Sports	
☐ Bicycling	☐ High Adventure*	☒ Organized Games (Play)	☐ Swimming – On-Site	
☐ Boating/Canoeing/Rafting	☐ Hiking	☐ Petting Zoo	☒ Swimming – Off-Site	
☒ Camp Trips	☐ Horseback Riding	☐ Riflery	☐ Swimming – Wilderness	

Camper Capacity

For each session, select the camp type, specify the number of days in the session and provide camper capacity information. Use separate session rows if both a day camp and overnight camp operate at the same time. **Use actual attendance data from last season.** If the camp did not operate last season, use estimates and check this box ☐. Attach additional sheets if needed.

	Camp Type			Age Group											
				1 to 5		6 & 7		8 to 12		13 to 15		16 & 17		CITs **	
	Day	Overnight	Number of Days	male	female	male	female	male	female	male	female	male	female	male	female
Session 1	☒	☐	34	5	10	20	15	50	50						
Session 2	☐	☐													
Session 3	☐	☐													
Session 4	☐	☐													
Session 5	☐	☐													
Session 6	☐	☐													
Session 7	☐	☐													
Session 8	☐	☐													
Session 9	☐	☐													
Session 10	☐	☐													

** A counselor-in-training (CIT) must be 15 years old at a day camp and 16 or 17 years old at an overnight camp. CITs that do not meet the minimum age requirements must be accounted for as a camper.

Camp Director

Name of Camp Director: Lindsey Cote Date of Birth: 12 / 26 / 87

Education: Masters in Special Education & BS in Childhood Education

Qualifying Experience: Assistant Director 2 years; Camp Saradac -Summer 2007 - Present

A "State Central Register Database Check" form (LDSS-3370) and a "Prospective Children's Camp Director Certified Statement" form (DOH-2271) must be completed by the Camp Director and submitted to the LHD with this form.

Camp Health Director

Name of Camp Health Director(s): Mary Egan

Attach additional sheets if more than one Health Director is used.

Qualifications (certification, licenses, etc.) ☐ Doctor ☐ Nurse Practitioner ☐ Physician Assistant ☒ RN ☐ LPN ☐ EMT ☐ Other

NYS License Number: 437387-1 *For day camps only:* Will the Health Director be located on-site or off-site? ☒ On-site ☐ Off-site

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Health Director or Designated Assistant. (See Section 7-2.8 for requirements)

Certifications	Staff Possessing Certification		Course Provider	Course Title	Issue Date
CPR	☒ Health Director	☐ Assistant	American Heart Association	Health Care Provider	6 / 27 / 13
First Aid	☒ Health Director	☐ Assistant	American Heart Association	Heart Saver First Aid	6 / 27 / 13

Aquatics Director

Name of Camp Aquatics Director: Mary Kate Moran Date of Birth: 4 / 6 / 93

Certifications

List the Course Provider, Course Title and certification issuance date for each certification held by the Camp Aquatics Director. (See Section 7-2.5(e) for minimum qualifications)

Certifications	Course Provider	Course Title	Issue Date
Lifeguard Supervision and Management*	American Red Cross	Lifeguard Management	6 / 10 / 12
Lifeguarding	American Red Cross	Waterfront Lifeguard	5 / 24 / 11
Progressive Swimming Instructor	American Red Cross	Water Safety Instructor	4 / 28 / 12
CPR*	American Heart Association	Health Care Provider	6 / 17 / 13
First Aid	American Heart Association	Heart Saver First Aid	6 / 17 / 13

* The Camp Aquatics Director must possess these certifications to qualify.

Aquatic Experience (check qualifying experience below)

- [X] One season of previous experience as a camp aquatics director at a New York State children's camp.
- [X] Two seasons of previous experience consisting cumulatively of at least 12 weeks as a children's camp lifeguard, as specified in Section 7-2.5(g), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.
- [ ] At least 18 weeks of previous experience as a lifeguard, as specified in Section 7-2.5(g)(2), at a swimming pool or bathing beach which had more than one lifeguard supervising it at a time.

Other Staff Requirements

Subpart 7-2 of the New York State Sanitary Code (Children's Camps) specifies minimum staff ratios and qualifications for counselors, lifeguards, progressive swimming instructors, riflery instructors, and additional first aid and CPR certified staff. When staff are required to possess special certification, a course standard or criteria is specified in the regulation. Certification courses which have been reviewed and meet or exceed the Children's Camp Code standard/criteria, are listed on New York State Department of Health (NYSDOH) "fact sheets." The fact sheets are available from the LHD and at the NYSDOH's website at www.health.ny.gov. Camp operators are responsible for ensuring that required staff are present and possess acceptable certification. A LHD may require a children's camp operator to document staff ratios and qualifications by submitting a Children's Camp Additional Staff Qualifications form (DOH-367a) and/or copies of certification cards. Copies of all required certifications must be maintained on file at the camp.

Written Safety Plan, Facility Additions/Modifications, and Itinerary of Camp Trips

1. Written Safety Plan as required by Section 7-2.5(n)

- [ ] Plan attached
- [ ] Previously submitted on ____/____/____. This plan remains up to date and complete.
- [X] Update to plan attached

2. Facility Addition/Modifications

Provide a list of additions or modification to the camp that have been made since last season or that are planned prior to this season. Include additions or modifications to buildings (cabins, kitchens, dining halls, infirmary, assembly areas, privies and toilets, etc.), potable water and sewage disposal systems, swimming pools, bathing beaches, activity areas (challenge course, archery and rifle ranges, etc.), emergency access and egress roads and any other camp facilities.

- [X] List attached
- [ ] No Addition/Modifications
- [ ] Not Applicable. Camp did not operate last season.

3. Itinerary of Camp Trips

Attach a list of camp trips. Describe the activities that will take place (swimming, canoeing, hiking, etc.) and include the trip date(s) when known.

- [X] List attached
- [ ] No trips

Section 7-2.5(p) requires a written statement or brochure outlining the rights and responsibilities of campers and camp operators to be provided to parents or guardians of campers by the camp operator with any enrollment application forms and/or enrollment contract forms. Either a statement or brochure prepared by the camp and approved by the permit-issuing official or the Department of Health brochure "Children's Camps in New York State" may be used. Please check the appropriate box below for the brochure sent with your application materials.

- [ ] A statement (brochure) which has been submitted to the DOH and approved
- [X] "Children's Camps in New York State" Brochure (#3601)

I certify that the information given in this form is true.

Signature of Camp Operator: _____

Print Name: Joanne D. Yepsen Title: Mayor Date: ____/____/____