

Fort Ann Rescue Squad Inc.

Application for Expansion of Primary Operating Territory

**ENCLOSURES**

**Application for EMS Operating Certificate, Form DOH-206**

**Affirmation of Compliance, Form DOH-1881**

**Application to Expand Operating Authority, Form DOH-3777**

- Certificate of Liability Insurance - USI

**EMS Agency Personnel Roster, Form DOH-2828**

- Licenses & EMT certificates
- Detailed Narrative
- Map of Proposed Expanded Territory

**Additional Materials:**

- Affirmations of Fitness & Competency
- Budget
- Certificate of Incorporation
- Bylaws

**Public Notice:**

- Letters to Public
- Certificates of Mailing/Return Receipts
- Letters in Support and Opposition

RECEIVED  
June 18  
2025

@ 15:18

# Application for EMS Operating Certificate

Current Expiration Date 3 / 31 / 2027

☒ Ambulance Service

☐ ALS First Response Service (non-transporting)

**Name of Service**

FORT ANN RESCUE SQUAD INC

Federal Employer ID No.

43-1757115

NYS EMS Agency Code

5714

Physical Address of Principal Business Location Street and Number

11287 STATE ROUTE 149

City, Town, Village

FORT ANN

State

NY

Zip Code

12827

County

WASHINGTON

Mailing Address (PO Box)

PO BOX 37

Business Phone Number

( 518 ) 639-4406

Fax Number

( 518 ) 639-8725

911 Center 10 Digit Phone Number

( 518 ) 746-2127

Agency E-mail Address

Agency Website

**Organizational Structure** (check only one)

☐ Commercial

☐ Hospital Based

☒ Independent

☐ Industrial

☐ Fire Department

☐ Municipal/Government

☐ College (State or Private Campus/University)

**Type of Ownership**

☐ Individual

☒ Corporation (☐ for profit ☒ not for profit)

☐ Municipal Fire

☐ Ambulance District

☐ Partnership

☐ Municipal (☐ village ☐ town ☐ city ☐ county)

☐ Government (☐ State ☐ Federal)

**Name of Individual Owner, Partners or Government/Municipal entity**

FORT ANN RESCUE SQUAD INC

If a corporation, give official corporate name. Also indicate all DBAs on file with NYS Department of State. Attach separate list if more than one DBA on file. (initial applications must provide certified copies of all DOS filings both corporation and DBA)

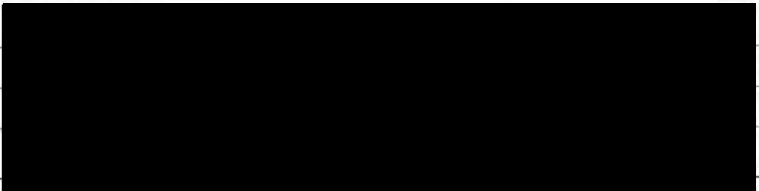
Corporation Name

FORT ANN RESCUE SQUAD INC

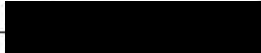
DBA/Assumed Name

FORT ANN EMS

For Profit and Not for Profit Corporations must provide names/addresses of current corporation officers

|                | Name             | Home Address                                                                         | Home Phone                                                                            |
|----------------|------------------|--------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|
| President      | REGINA LADD      |  |  |
| Vice President | KAITLIN MITCHELL |                                                                                      |                                                                                       |
| Secretary      | JANE GRIFFITHS   |                                                                                      |                                                                                       |
| Treasurer      | KELSEY REPERT    |                                                                                      |                                                                                       |

**Chief Operating Officer** (Captain, Operations Manager)

| Name         | Title | Day Phone | Night Phone                                                                           |
|--------------|-------|-----------|---------------------------------------------------------------------------------------|
| THOMAS NOBLE | CHIEF | ( ) -     |  |

**Tax District**

Is this organization funded by a tax district?

☐ Yes

☒ No

Name of District

**Name of Operator** (if different from owner)

Business Phone

( ) -

Address City State Zip

Highest Level of Care Currently Authorized by REMAC (check only one)

☐ EMT

☐ AEMT

☐ Critical Care

☒ Paramedic

Agency Participates in CME Program

☒ Yes

☐ No

**Billing for Service**

☒ Yes

☐ No

If yes, Name of Service Bureau

PROFESSIONAL AMBULANCE BILLING

Service Bureau Number (if not agency)

Medicaid Number

Service Physician Medical Director (please list all others on separate sheet)

THOMAS WILLIAMS, MD

Address

100 PARK ST GLENS FALLS NY 12801

Phone

NYS Physician License Number

List the address of each location where any certified EMS response vehicle is garaged if not the same as your principal location.

Provide list if more than 3

Location 1

Number of vehicles assigned

Location 2

Number of vehicles assigned

Location 3

Number of vehicles assigned

Total Number of Vehicles operated by certificate holder

Ambulances 4 EASV's (ambulance service only) 4 First Response (ALSFR) 0

Description of operating territory boundaries etc.:

PROPOSED EXPANDED TERRITORY - ALL OF THAT TERRITORY IN WARREN COUNTY, GLENS FALLS, NEW YORK, WITHIN THE FOUR CORNERS OF GLEN STREET, MOHEGAN STREET, MURRAY STREET, SOUTH AVENUE AND HUDSON AVENUE.

Total Employees/Members: 55 Number Volunteer 29 Number Paid (on payroll) 26

Provide number of individuals currently certified at each level

CFR 0 EMT 20 AEMT 4 Critical Care 4 Paramedic 6

#### Communications/Dispatch Information

Principal Dispatch Method: ☐ Two-way ☐ Cellular Phone ☒ Pager ☐ Other

Frequency on which you are dispatched 154.1600 MHz

Agency that dispatches your service WASHINGTON COUNTY DPS ☒ Local 911/PSAP ☐ Self

Identify radio systems for hospital calling/medical direction ☐ VHF ☐ UHF ☒ Cellular ☐ Other

UHF MED 1-8 capacity ☐ Yes ☒ No Do your vehicles have Cellular Phones ☐ Yes ☐ No

155.340 capability ☒ Yes ☐ No Call sign if service has FCC License

#### Attachments Required

- Affirmation of Compliance (DOH-1881, Affirmation Side 1 MUST BE NOTARIZED)
- List of all vehicle operated by the service (DOH-1881 Affirmation side 2)
- List of all agency personnel - Use DOH-2828
- List of all owners with 10% of more share of ownership
- Map of current operating territory

#### Agency Certification

I have received and read and understand the contents of the following documents and will comply with all requirements:

- Article 30/30A, NYS Public Health Law
- Part 800, 10NYCRR, State EMS Code
- Applicable DOH EMS Policy Statements and SEMAC Advisories

In addition, I certify that all the information contained in this application is true and correct, and that neither the corporation nor any of the owners, principals, or stockholders have been convicted of Medicaid or Medicare fraud, and I understand that under Section 3012(a) or PHL Article 30 that the ambulance service or ALSFR service certificate for this agency may be revoked, suspended, limited or annulled if this application includes willful misrepresentation.

Name of Owner, CEO or COO

THOMAS NOBLE

Title

CHIEF

Signature

Date

6/16/25

Notary Public affirmation and acknowledgment

NOTARY PUBLIC, STATE OF NEW YORK

Registration No. 01MA4630132

Qualified in Washington County

My Commission Expires: 11/30/26

DOH-206 (4/14) p 2 of 2

#### For DOH Use Only

Date Application Received

New Expiration Date

BEMS review and approval

Date

**ADDENDUM TO DOH-206 FORM**

Please use this form to list additional Corporate Officers not listed on DOH-206 Form.  
See General Instructions for Renewal Form Completion.

[illegible]



## Affirmation of Compliance for Agency Recertification

If you are **adding** new vehicle(s) to your fleet or **removing** vehicles, please use:  
DOH-1881 Affirmation of Compliance Submission Portal | Survey Builder (ny.gov)

Check one ☒ Ambulance Service ☐ ALS First Response Service

Current Operating Certificate Expiration Date

03 / 31 / 2027

Name of Service

FORT ANN RESCUE SQUAD INC

NYS EMS Agency Code

5714

Address

11287 STATE ROUTE 149

City

FORT ANN

State

NY

ZIP

12827

Contact Person

THOMAS NOBLE

Email

FAEMS2661@GMAIL.COM

Work Phone Number

Additional Phone Number

By completing and signing this affirmation, I certify that the vehicles listed are compliant with all requirements of the State EMS Code, Part 800. Title: CERTIFIED AMBULANCE SERVICES | New York Codes, Rules and Regulations (ny.gov)

The records and documentation of the agency have also been reviewed for compliance with all applicable requirements.

The ambulance vehicles listed are registered with the NYS Department of Motor Vehicles (DMV) and the appropriate DMV inspection has been conducted. Those vehicles which are not ambulances have appropriate DMV registration, DMV inspection, and/or any safety inspection as required by the NYS Department of Transportation, The United States Coast Guard, or the Federal Aviation Administration.

I understand that under the authority of the Public Health Law, any deficiencies that result in violations being issued, are subject to the penalties of the Public Health Law, including fines, suspension, revocation or annulment of the operating certificate. I attest that I am an authorized officer of this NYS Certified EMS agency with authority to sign.

Name

THOMAS NOBLE

Title

CHIEF

Signature



Date

6 / 16 / 25

### FOR OFFICE USE ONLY

\_\_\_\_\_ # of stickers

Sent to \_\_\_\_\_

Date

/ /

Rep \_\_\_\_\_

DOH-1881 Affirmation of Compliance Submission Portal | Survey Builder (ny.gov)

☒ Yes, # of stickers 3

## Vehicle Information

Provide the following information for all EMS vehicles to be certified by this affirmation. A computer listing containing the required information is acceptable.

[illegible]

\*All ambulance vehicles are required by New York State Motor Vehicle and Traffic Law to possess a valid motor vehicle registration. If the vehicle(s) listed are not registered with NYS DMV, you must provide the statutory exemption.

\*\*Such as: **AMBULANCES** - Type I, Type II, Type III, Helicopter, Boat, Fixed Wing Aircraft  
**EMERGENCY AMBULANCE SERVICE Vehicle (EASV)** - Agency Fire Car, Van, Truck; or Personal Car, Van, Truck  
**ALS FIRST RESPONSE VEHICLE (ALSFR)** - Agency Fire Apparatus, Car, Van, Truck; or Personal Car, Van, Truck

Add More Pages

Add More Pages

## Application for New Service, Expansion of Primary Operating Territory or Transfer of Ownership

Application for (check one)

- ☐ New service (Sections A,B,C,D,F)  
☒ Expansion of Primary Operating Territory for existing service (Sections A,B,C,D,F)  
☐ Transfer of existing service operating authority (Sections A,D,E,F)

Type of Service (check one)

- ☒ Ambulance  
☐ ALS First Responder

### Section A Organizational Structure

For a corporation, attach a copy of certificate of incorporation, any DBAs and a listing of all owners' stockholders, principals, investors and/or parent corporations or sub-corporations. For LLC attach a copy of NYS DOS Application For Authority.

|                                                    |                                               |                                                |                                                 |                              |
|----------------------------------------------------|-----------------------------------------------|------------------------------------------------|-------------------------------------------------|------------------------------|
| Name of Service                                    | DOH Agency Code                               | Federal Employer Identification Number         |                                                 |                              |
| FORT ANN RESCUE SQUAD INC                          | 5714                                          | 43-1757115                                     |                                                 |                              |
| Address                                            | City                                          | State                                          | Zip                                             | County                       |
| 11287 STATE ROUTE 149                              | FORT ANN                                      | NY                                             | 12827                                           | WASHINGTON                   |
| Contact Person                                     | Title                                         |                                                |                                                 |                              |
| THOMAS NOBLE                                       | CHIEF                                         |                                                |                                                 |                              |
| Business Phone<br>( 518 ) 639- 4406                | Home Phone<br>( ) -                           | Cell Phone<br>[REDACTED]                       | E-mail<br>FAEMS2661@GMAIL.COM                   |                              |
| Current Organizational Sponsor Type                |                                               |                                                |                                                 |                              |
| <input type="checkbox"/> Proprietary               | <input type="checkbox"/> Hospital Based       | <input type="checkbox"/> Volunteer Independent | <input type="checkbox"/> Industrial             |                              |
| <input type="checkbox"/> Volunteer Fire Department | <input type="checkbox"/> Municipal/Government | <input checked="" type="checkbox"/> Other      | INDEPENDENT                                     |                              |
| Type of Ownership                                  |                                               |                                                |                                                 |                              |
| <input type="checkbox"/> Individual                | <input type="checkbox"/> Partnership          | <input type="checkbox"/> Government            | <input checked="" type="checkbox"/> Corporation | <input type="checkbox"/> LLC |

Name of Individual Owner, Partners, Corporation or Government Entity (attach a listing of any/all owners of 10% or more stock)

FORT ANN RESCUE SQUAD INC

### Section B Primary Operating Territory

Specify geographic area requested using municipal, political or other identifiable Boundaries. Attach a detailed map of the primary service area. Statements such as "surrounding, adjacent, vicinity, proximity, contiguous, adjoining, or portions of, etc." are not acceptable when defining a primary operating territory.

Proposed new or expanded primary operating territory

ALL OF THAT TERRITORY IN WARREN COUNTY, GLENS FALLS, NEW YORK, WITHIN THE FOUR CORNERS OF GLEN STREET, MOHEGAN STREET, MURRAY STREET, SOUTH AVENUE AND HUDSON AVENUE.

For expansion list existing primary operating territory

THE TOWN AND VILLAGE OF FORT ANN TO INCLUDE STATE ROUTE 4 SOUTH TO 4294 STATE ROUTE 4 KINGSBURY, THE HAMLET OF PILOT KNOB, A PORTION OF COUNTY ROUTE 17 IN THE TOWN OF HARTFORD, STATE ROUTE 22 EAST FROM STATE ROUTE 4 TO THE FORT ANN GRANVILLE TOWN LINE.

### Section C Financial Responsibility

Applicant is required to attach detailed fiscal and budgetary information as specified in the current DOH Policy Statement. An initial start-up or continuation budget and sufficient financial information as well as the source of such must be provided to insure the fiscal responsibility and stability of the ownership for the territory served.

Insurance Carrier

USI INSURANCE SERVICES LLC - \$1 MILLION/\$2 MILLION

Agent

STEVE SAWN

Business Phone

( 518 ) 260 - 8429

Types and Limits of Coverage

☒ General Liability

☐ Other

## Section D Description of Proposed Services

For a corporation attach a certificate of incorporation, any DBAs and a listing of all owners, stockholders or principals.

Level of Service (check only one)

☐ EMT

☐ AEMT

☐ Critical Care

☒ Paramedic

Agency Medical Director  
THOMAS WILLIAMS, MD

Address  
100 PARK STREET

City  
GLENS FALLS

State  
NY

Phone Number  
( 518 ) 926 - 1000

Agency Providing Medical Control  
GLENS FALLS HOSPITAL

Phone Number  
( 518 ) 926 - 1000

System Medical Director  
THOMAS WILLIAMS, MD

Address  
100 PARK STREET

City  
GLENS FALLS

State  
NY

Phone Number  
( 518 ) 926 - 1000

Size of Population to be Served  
6484

Days of operation  
JANUARY 1 - DECEMBER 31

Hours of operation  
24 HOUR

Projected Call Volume

Total 1830

Emergency 369

Non-Emergency 1461

Source of Statistics for Call volume

☐ PCR

☐ Dispatch Center

☐ Agency Call Record

☒ Other GLENS FALLS HOSPITAL

Total no. of ambulances  
4

Total no. of emergency ambulance service vehicles (EASV'S)  
4

Total no. of ALS First Response vehicles  
0

## Section E Proposed Organizational Structure

For a corporation attach a copy of certificate of incorporation for any DBAs listing of all owners' stockholders, principals, investors and/or parent corporations or sub-corporations. For LLC attach a copy of NYS DOS Application For Authority.

Proposed Name of Service

Federal Employer Identification Number

Address

City

State

Zip

County

Contact Person

Title

Business Phone  
( ) -

Home Phone  
( ) -

Cell Phone  
( ) -

E-mail

Proposed Organizational Sponsor Type

☐ Proprietary

☐ Hospital Based

☐ Volunteer Independent

☐ Industrial

☐ Volunteer Fire Department

☐ Municipal/Government

☐ Other

Proposed Type of Ownership

☐ Individual

☐ Partnership

☐ Government

☐ Corporation

☐ LLC

Name of Proposed Individual Owner, Partners, Corporation or Government Entity (attach any/all owners of 10% or more stock)

## Section F Certification of Accuracy and Ownership Competency

As owner/CEO/operator of the ambulance service described herein I attest to the accuracy of the information contained in this application and its attachments and to having received and read Public Health Law Article 30 and State EMS Code Part 800. I also state that neither the corporation nor any of the owners, principals or stockholders in the corporation, or LLC members, have been convicted of Medicare or Medicaid fraud. I understand that under Section 3012(a) of the PHL Article 30 that the ambulance service or ALS FR service certificate for this agency may be revoked, suspended limited or annulled if this application includes willful misrepresentation.

Attachments Required

- Detailed narrative to support need or statement of purpose and intent for transfer
- Affirmation of Fitness and Competence (DOH-3778)
- DOS Certificate of Incorporation or Authority, DBA's, owners, partners, shareholders or members listing
- Financial information including funding budget and insurance
- Primary operating territory map

Name of Owner or CEO  
THOMAS NOBLE

Title  
CHIEF

Signature

Date

6/16/25

Notary Public affirmation and acknowledgement

Bruce K. Mason

NOTARY PUBLIC, STATE OF NEW YORK

Registration No. 01MA4630132

Qualified in Washington County

My Commission Expires: 11/30/26

### FOR REGIONAL EMS COUNCIL USE ONLY

Date Application Received

Date of Council Decision

☐ Approved ☐ Denied ☐ Rejected - Incomplete

Council Chair Signature



Client#: 975334

FORTANN1

ACORD<sub>TM</sub>

## CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

06/04/2025

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 any rights to the certificate holder in lieu of such endorsement(s).

| <b>PRODUCER</b><br><b>USI Insurance Services LLC</b><br><b>12 Gill Street, #5500</b><br><b>Woburn, MA 01801</b><br><b>855 874-0123</b> | <b>CONTACT NAME:</b> Steven Sawn<br><b>PHONE (A/C, No, Ext):</b><br><b>FAX (A/C, No):</b> 877-775-0110<br><b>E-MAIL ADDRESS:</b> Steve.Sawn@usi.com                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
|----------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------|-------------------------------------------|--------------|--------------------|--|--------------------|--|--------------------|--|--------------------|--|--------------------|--|
| <b>INSURED</b><br><b>Fort Ann Rescue Squad Inc</b><br><b>PO Box 237</b><br><b>Fort Ann, NY 12827</b>                                   | <table border="1"> <tr> <th data-bbox="803 451 1404 483">INSURER(S) AFFORDING COVERAGE</th> <th data-bbox="1404 451 1544 483">NAIC #</th> </tr> <tr> <td data-bbox="803 483 1404 514"><b>INSURER A : Arch Insurance Company</b></td> <td data-bbox="1404 483 1544 514"><b>11150</b></td> </tr> <tr> <td data-bbox="803 514 1404 546"><b>INSURER B :</b></td> <td data-bbox="1404 514 1544 546"></td> </tr> <tr> <td data-bbox="803 546 1404 577"><b>INSURER C :</b></td> <td data-bbox="1404 546 1544 577"></td> </tr> <tr> <td data-bbox="803 577 1404 609"><b>INSURER D :</b></td> <td data-bbox="1404 577 1544 609"></td> </tr> <tr> <td data-bbox="803 609 1404 640"><b>INSURER E :</b></td> <td data-bbox="1404 609 1544 640"></td> </tr> <tr> <td data-bbox="803 640 1404 657"><b>INSURER F :</b></td> <td data-bbox="1404 640 1544 657"></td> </tr> </table> | INSURER(S) AFFORDING COVERAGE | NAIC # | <b>INSURER A : Arch Insurance Company</b> | <b>11150</b> | <b>INSURER B :</b> |  | <b>INSURER C :</b> |  | <b>INSURER D :</b> |  | <b>INSURER E :</b> |  | <b>INSURER F :</b> |  |
| INSURER(S) AFFORDING COVERAGE                                                                                                          | NAIC #                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER A : Arch Insurance Company</b>                                                                                              | <b>11150</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER B :</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER C :</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER D :</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER E :</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |
| <b>INSURER F :</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                               |        |                                           |              |                    |  |                    |  |                    |  |                    |  |                    |  |

## 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 INSR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS                                                                                                                                                                                                                                     |
|----------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------|-------------------------|-------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A        | <input checked="" type="checkbox"/> <b>COMMERCIAL GENERAL LIABILITY</b><br><input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR<br><input checked="" type="checkbox"/> <b>Medical Malpractice</b><br>GEN'L AGGREGATE LIMIT APPLIES PER:<br><input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC<br><input type="checkbox"/> OTHER:                                                                                             |                    | MEPK10463102  | 07/07/2025              | 07/07/2026              | EACH OCCURRENCE \$1,000,000<br>DAMAGE TO RENTED PREMISES (Ea occurrence) \$100,000<br>MED EXP (Any one person) \$5,000<br>PERSONAL & ADV INJURY \$1,000,000<br>GENERAL AGGREGATE \$10,000,000<br>PRODUCTS - COMP/OP AGG \$10,000,000<br>\$ |
| A        | <input checked="" type="checkbox"/> <b>AUTOMOBILE LIABILITY</b><br><input checked="" type="checkbox"/> ANY AUTO OWNED AUTOS ONLY<br><input checked="" type="checkbox"/> HIRED AUTOS ONLY<br><input type="checkbox"/> SCHEDULED AUTOS NON-OWNED AUTOS ONLY                                                                                                                                                                                                                                          |                    | MEPK10463102  | 07/07/2025              | 07/07/2026              | COMBINED SINGLE LIMIT (Ea accident) \$1,000,000<br>BODILY INJURY (Per person) \$<br>BODILY INJURY (Per accident) \$<br>PROPERTY DAMAGE (Per accident) \$<br>\$                                                                             |
| A        | <input checked="" type="checkbox"/> <b>UMBRELLA LIAB</b> <input checked="" type="checkbox"/> OCCUR<br><input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE<br><input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$0<br><b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b><br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N<br>(Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below | N/A                | MEUM09357301  | 07/07/2024              | 07/07/2025              | EACH OCCURRENCE \$2,000,000<br>AGGREGATE \$6,000,000<br>\$<br>PER STATUTE <input type="checkbox"/> OTH-ER <input type="checkbox"/><br>E.L. EACH ACCIDENT \$<br>E.L. DISEASE - EA EMPLOYEE \$<br>E.L. DISEASE - POLICY LIMIT \$             |

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

## Evidence of Coverage

## CERTIFICATE HOLDER

## CANCELLATION

**Mountain Lakes Regional EMS**  
**Council c/o Ft. Frum Regional Health**  
**Org. 120 Washington St**  
**Watertown, NY 13601**

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

*Steve Sawn*

© 1988-2015 ACORD CORPORATION. All rights reserved.

## EMS Agency Personnel Roster

Agency Name  
FORT ANN RESCUE SQUAD INC

Agency Code  
5714

Date Submitted

Page 1 of 3

| List All Personnel Alphabetically |            | DOH-Certified Personnel |              | Level of Certification (Check One) |                                     |                                     |                                     |                                     | Check Other Levels                  |                          |
|-----------------------------------|------------|-------------------------|--------------|------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Last Name                         | First Name | DOH-Issued ID Number    | Expires      | CFR                                | EMT                                 | AEMT                                | CC                                  | P                                   | CPR/AED                             | First Aid                |
| AMELL                             | EDWARD     |                         | 05 / 30 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| AMIDON                            | BRYAN      |                         | 07 / 31 / 27 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| BECKWITH                          | ALYSSA     |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| BLANCHARD                         | JOHN       |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| BREAULT                           | ALBERT     |                         | 03 / 31 / 27 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| BROWN                             | ETHAN      |                         | 07 / 31 / 25 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| CALL                              | ANDREW     |                         | 01 / 31 / 27 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| CAMPBELL                          | KYLE       |                         | 07 / 31 / 25 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| CLARK                             | MELISSA    |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| DUGAN                             | BRENDON    |                         | 08 / 30 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| GRIFFITHS                         | JANE       |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| GRIFFITHS                         | ROBERT     |                         | 07 / 30 / 25 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| HANNA                             | KEITH      |                         | 04 / 30 / 29 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| HILLICOSS                         | KENNETH    |                         | 01 / 31 / 27 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| JONES                             | SCOTT      |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| LADD                              | REGINA     |                         | 04 / 30 / 29 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| LADD                              | ROBERT     |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| LASHINSKY                         | JON        |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| LOVELY                            | JORDAN     |                         | 05 / 31 / 27 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |



## EMS Agency Personnel Roster

Agency Name \_\_\_\_\_ Agency Code \_\_\_\_\_ Date Submitted \_\_\_\_\_ Page 2 of 3

| List All Personnel Alphabetically |            | DOH-Certified Personnel |              | Level of Certification (Check One) |                                     |                                     |                                     |                                     | Check Other Levels                  |                          |
|-----------------------------------|------------|-------------------------|--------------|------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|-------------------------------------|--------------------------|
| Last Name                         | First Name | DOH-Issued ID Number    | Expires      | CFR                                | EMT                                 | AEMT                                | CC                                  | P                                   | CPR/AED                             | First Aid                |
| MARCHESE                          | NICOLE     |                         | 11 / 30 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MASON                             | BRUCE      |                         | 08 / 31 / 25 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MCPHERSON                         | ROBERT     |                         | 01 / 31 / 27 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MEHNERT                           | MACKENZIE  |                         | 10 / 31 / 28 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MITCHELL                          | KAITLIN    |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MITCHELL                          | KENNETH    |                         | 01 / 29 / 29 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| MURRAY                            | SCOTT      |                         | 07 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| NOBLE                             | HALEY      |                         | 08 / 31 / 29 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| NOBLE                             | THOMAS     |                         | 01 / 31 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| RALSTON                           | GLENN      |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| REPPERT                           | KELSEY     |                         | 11 / 30 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| SIMMONS                           | SEAN       |                         | 07 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| SWALD                             | RACHEL     |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| SWEENOR                           | CAITLIN    |                         | 07 / 31 / 25 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| TIEG                              | ANDREW     |                         | 05 / 31 / 27 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| TROMBLEY                          | ASHLEY     |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| VANSYCKLE                         | KYLE       |                         | 05 / 31 / 26 | <input type="checkbox"/>           | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| WALLACE                           | CHANCEY    |                         | 10 / 31 / 25 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| WAITE                             | ZACH       |                         | 08 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/>            | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

## EMS Agency Personnel Roster

Agency Name \_\_\_\_\_ Agency Code \_\_\_\_\_ Date Submitted \_\_\_\_\_ Page 3 of 3

| List All Personnel Alphabetically |            | DOH-Certified Personnel |              | Level of Certification (Check One) |                                     |                          |                          |                          | Check Other Levels                  |                          |
|-----------------------------------|------------|-------------------------|--------------|------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|-------------------------------------|--------------------------|
| Last Name                         | First Name | DOH-Issued ID Number    | Expires      | CFR                                | EMT                                 | AEMT                     | CC                       | P                        | CPR/AED                             | First Aid                |
| WILLARD                           | MIKENZIE   |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| WILLIAMS                          | STEPHANIE  |                         | 10 / 31 / 25 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| WOJCIK                            | KIMBERLY   |                         | 10 / 01 / 27 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| YOUNGER                           | DILON      |                         | 10 / 31 / 26 | <input type="checkbox"/>           | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
|                                   |            |                         | / /          | <input type="checkbox"/>           | <input type="checkbox"/>            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |

Agency Code Number: 5714

Issued: 2/11/2025

Expires: 3/31/2027

NEW YORK STATE DEPARTMENT OF HEALTH  
**Ambulance Service Certificate**



Fort Ann Rescue Squad, Inc.  
DBA: Fort Ann EMS



*is hereby certified as a New York State ambulance service in  
accordance with the provisions of Article 30 of the  
Public Health Law*

PRIMARY TERRITORY:  
Village & Town of Fort Ann

Emergency Medical Services Program

Commissioner of Health

This certificate may be revoked, suspended, limited or annulled for violation of the Public Health Law

**THIS CERTIFICATE IS NOT TRANSFERABLE**  
Keep conspicuously posted

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Vansyckle, Kyle M  
Level: Advanced-EMT  
State #: [REDACTED]  
EXP: 05/31/2026

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**ADVANCED-EMT VANSYCKLE**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Mcpherson, Robert  
Level: Paramedic  
State #: [REDACTED]  
EXP: 01/31/2027

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**PARAMEDIC MCPHERSON**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Clark, Melissa  
Level: EMT  
State #: [REDACTED]  
EXP: 10/31/2026

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**EMT CLARK**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Noble, Thomas  
Level: Paramedic  
State #: [REDACTED]  
EXP: 01/31/2026

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**PARAMEDIC NOBLE**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

New York State Department of Health  
Bureau of Emergency Medical Services

Certificate No.: [REDACTED] Expiration: 8/31/2024

**BRUCE K. MASON**  
is hereby certified as an  
**AEMT**

*Howard A. Zucker, M.D., J.D.* *Ryan P. Greenberg*  
Commissioner of Health Director

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Griffiths, Robert  
Level: EMT  
State #: [REDACTED]  
EXP: 06/30/2029

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**EMT GRIFFITHS**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Ladd, Regina  
Level: Advanced-EMT  
State #: [REDACTED]  
EXP: 04/30/2029

*James V. McDonald, MD, MPH* *Ryan P. Greenberg, NRP*  
Commissioner of Health Director, Bureau of EMS

**ADVANCED-EMT LADD**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Mehnert, Mackenzie  
Level: EMT  
State #: [REDACTED]  
EXP: 10/31/2028

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT MEHNERT**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Hanna, Keith  
Level: EMT  
State #: [REDACTED]  
EXP: 04/30/2029

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT HANNA**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Teig, Andrew  
Level: Paramedic  
State #: [REDACTED]  
EXP: 05/31/2026

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**PARAMEDIC TEIG**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Ralston, Glenn  
Level: EMT-Critical Care  
State #: [REDACTED]  
EXP: 10/31/2026

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT-CRITICAL CARE RALSTON**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Simmons, Sean  
Level: EMT  
State #: [REDACTED]  
EXP: 07/31/2026

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT SIMMONS**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Noble, Haley  
Level: Paramedic  
State #: [REDACTED]  
EXP: 08/31/2029

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**PARAMEDIC NOBLE**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Brown, John  
Level: EMT  
State #: [REDACTED]  
EXP: 07/31/2026

Mary T. Bassett, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT BROWN**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW YORK STATE Department of Health Bureau of EMS and Trauma Systems EMS Provider Certification

Provider: Blanchard Jr, John  
Level: EMT-Critical Care  
State #: [REDACTED]  
EXP: 10/31/2026

James V. McDonald, MD, MPH  
Commissioner of Health

Ryan P. Greenberg, NRP  
Director, Bureau of EMS

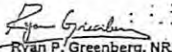
**EMT-CRITICAL CARE BLANCHARD JR**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)



 Provider: Breault, Albert  
Level: EMT  
State #: [REDACTED]  
EXP: 03/31/2027

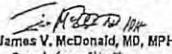
  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT BREAUT**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

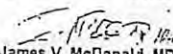
 Provider: Wojcik, Kimberly  
Level: EMT  
State #: [REDACTED]  
EXP: 01/31/2029

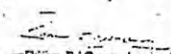
  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT WOJCIK**

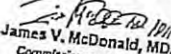
 Provider: Murray, Scott  
Level: EMT  
State #: [REDACTED]  
EXP: 07/31/2026

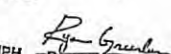
  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT MURRAY**

 Provider: Amidon, Bryan Eric  
Level: EMT  
State #: [REDACTED]  
EXP: 07/31/2027

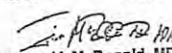
  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT AMIDON**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

 Provider: Younger, Dilen  
Level: EMT  
State #: [REDACTED]  
EXP: 10/31/2026

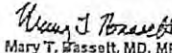
  
James V. McDonald, MD, MPH  
Commissioner of Health

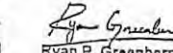
  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT YOUNGER**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

 Provider: Wallace, Chauncey E  
Level: EMT  
State #: [REDACTED]  
EXP: 10/31/2025

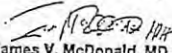
  
Mary T. Bassett, MD, MPH  
Commissioner of Health

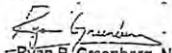
  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT WALLACE**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

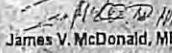
 Provider: Amell, Edward  
Level: EMT  
State #: [REDACTED]  
EXP: 06/30/2026

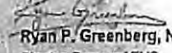
  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT AMELL**

 Provider: Reppert, Kelsey  
Level: EMT-Critical Care  
State #: [REDACTED]  
EXP: 11/30/2026

  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT-CRITICAL CARE REPERT**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

NEW  
YORK  
STATE

Department  
of Health

Bureau of EMS and Trauma Systems  
EMS Provider Certification

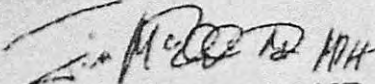


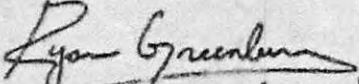
Provider: Mitchell, Kaitlin

Level: EMT

State #: [REDACTED]

EXP: 10/31/2026

  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT MITCHELL**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

Department of Health

Bureau of EMS and Trauma Systems  
EMS Provider Certification

Provider: Dugan, Brandon M

Level: EMT

State #: [REDACTED]

EXP: 08/31/2026



*James V. McDonald*  
James V. McDonald, MD, MPH  
Commissioner of Health

*Ryan P. Greenberg*  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

EMT DUGAN





Department  
of Health

Bureau of EMS and Trauma Systems  
EMS Provider Certification



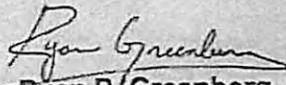
Provider: Mitchell, Kenneth

Level: Paramedic

State #: [REDACTED]

EXP: 01/31/2029

  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**PARAMEDIC MITCHELL**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

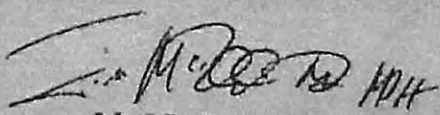


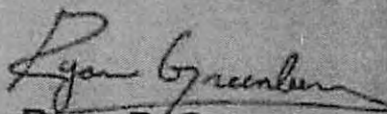
Department  
of Health

Bureau of Emergency and Trauma Systems  
EMS Provider Certification



Provider: Sweenor, Caitlin  
Level: Advanced-EMT  
State #: [REDACTED]  
EXP: 07/31/2025

  
James V. McDonald, MD, MPH  
Commissioner of Health

  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**ADVANCED-EMT SWEENOR**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)



YORK  
STATE

Department  
of Health

## EMS Provider Certification



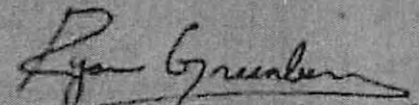
Provider: **Swald, Rachel**

Level: **EMT**

State #: [REDACTED]

EXP: **10/31/2026**

  
**James V. McDonald, MD, MPH**  
Commissioner of Health

  
**Ryan P. Greenberg, NRP**  
Director, Bureau of EMS

### EMT SWALD

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

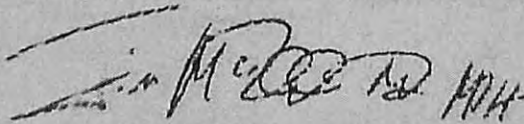
NEW  
YORK  
STATE

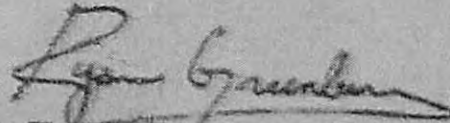
Department  
of Health

Bureau of EMS and Trauma Systems  
EMS Provider Certification



**Provider:** Hillicoss, Kenneth  
**Level:** Paramedic  
**State #:** [REDACTED]  
**EXP:** 01/31/2027

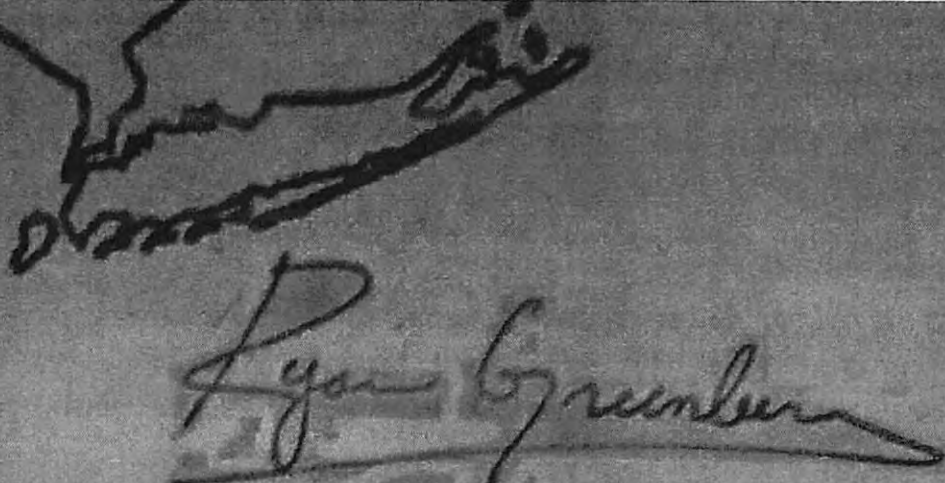
  
**James V. McDonald, MD, MPH**  
Commissioner of Health

  
**Ryan P. Greenberg, NRP**  
Director, Bureau of EMS

**PARAMEDIC HILLILOSS**

This is a copy of the original certification. The original certification is the only one that is valid. If you need a replacement, you must apply for a new certification.



  
Ryan P. Greenberg, Director  
Bureau of Emergency Medical Services

New York State Department of Health  
Bureau of Emergency Medical Services

Certificate No.

Expiration 7/31/2024

**KYLE R. CAMPBELL**

is hereby certified as an

**EMT - BASIC**

Howard A. Zucker, M.D., J.D.

Commissioner of Health

Ryan P. Greenberg

Director

Greenberg  
Bureau of EMS

 **Department of Health** **Bureau of EMS and Trauma Systems**  
**EMS Provider Certification**



**Provider:** Williams, Stephanie  
**Level:** EMT  
**State #:** [REDACTED]  
**EXP:** 10/31/2024

*Howard Zucker M.D.*  
Howard Zucker, MD, JD  
Commissioner of Health

*Ryan P. Greenberg*  
Ryan P. Greenberg, NRP  
Director, Bureau of EMS

**EMT WILLIAMS**

This card is only valid with a government issued ID and should be validated at [health.ny.gov/ems/validation](http://health.ny.gov/ems/validation)

Williams  
Route 4  
d, NY 12828



## DETAILED NARRATIVE

Fort Ann Rescue Squad desires to provide Basic and Advanced Life Support transporting ambulance services for discharged and transferred patients from Glens Falls Hospital, Warren County, New York. The Public Health Law requires that Fort Ann Rescue Squad apply to expand its operating authority, and request letters from stakeholders.

Presently, the Ambulance Service Certificate for the Fort Ann Rescue Squad includes the following territory:

The Town and Village of Fort Ann to include State Route 4 South to 4294 State Route 4 Kingsbury, the Hamlet of Pilot Knob, a portion of County Route 17 in the Town of Hartford, State Route 22 East from State Route 4 to the Fort Ann Granville town line.

Fort Anne operates four (4) ambulances and four (4) fly cars. We have twenty-nine (29) volunteers and twenty-six (26) employees. Among them are nine (9) paramedics, four (4) advanced EMTs, and nineteen (19) EMT-Basics. We respond annually to 1461 BLS calls each year and 369 ALS calls in our present territory, exclusive of the hospital transports. We have an average respond time of 2.0 minutes and an average response rate of over ninety-nine (99%) percent.

We look to add the following territory: “All of that territory in Warren County, Glens Falls, New York, within the four corners of Glen Street, Mohegan Street, Murray Street, South Avenue and Hudson Avenue.” We refer to this as the “Expansion Territory”.



The goal of this application is for Fort Ann Rescue Squad to be authorized to continue to provide a reliable non-emergency transporting ambulance service to Glens Falls Hospital in order to permit the timely discharge and/or transfer of the Hospital's patients, and specifically in order to transport patients out of Glens Falls Hospital to their homes, to other hospitals, to nursing homes and other treatment and diagnostic facilities. Our application will support but will not negatively affect any other ambulance service in the area.

As will be demonstrated below, Fort Ann Rescue Squad has been actively transporting the Hospital’s patients and can demonstrate need for such services.

Public Need

Fort Ann Rescue Squad is required to provide the definition of need and to demonstrate that need exists for Fort Ann Rescue Squad’s ambulance services in Warren County. The State EMS Council and the Department of Health defined public need as follows:

“The Demonstrated absence, reduced availability or an inadequate level of care in ambulance or emergency medical service availability to a geographical area which is not readily correctable through the reallocation or improvement of existing resources.” Variables in considering “public need” include: geography, population (size, density, projections), level of care (existing, available), quality, reliability and response patters of existing services, type of service (emergency, non-emergency), special needs, service effectiveness, cost and operation, and other local factors.

This letter is intended to address these issues.

**LACK OF AVAILABLE AMBULANCES CREATES NEED**

The primary role of any emergency ambulance service is to serve the emergency medical needs of the public. Unfortunately, Warren County if not the entire state, is in short supply of emergency ambulance services. Therefore, the needs of patients who require discharges from and transports between facilities such as hospitals, nursing homes, physician offices and diagnostic facilities must take a back seat.

Hospitals are having a serious issue whereby patients in need of ambulance level care cannot get timely discharged and beds remain unavailable for those who need them.

Need exists

The following reflects the number of transports from Glens Falls Hospital.

2025 (January – June 1)

| YEAR         | Total Transports | ALS | BLS  |
|--------------|------------------|-----|------|
| 2025 to date | 785              | 66  | 719  |
| 2024         | 1830             | 369 | 1461 |

Present and Proposed Territory

Fort Ann Rescue Squad’s proposed territory is described as follows: “All of that territory in Warren County, Glens Falls, New York, within the four corners of Glen Street, Mohegan Street, Murray Street, South Avenue and Hudson Avenue.”.

## **I. Impact upon existing ambulance and or emergency medical services in the proposed area**

### ***Positive impact on the community***

Fort Ann Rescue Squad's ambulance service will have a positive impact throughout Warren County by providing a reliable transporting ambulance service from Glens Falls Hospital in a reasonable amount of time considering the vast area covered.

### ***Present providers***

There are several transporting (emergency) ambulance providers serving Warren County, including:

Bolton Emergency Medical Services, Inc.  
Glens Falls Fire Department Ambulance  
Hague Volunteer Fire Department, Inc.  
Johnsburg Emergency Squad, Inc.  
Lake George EMS  
North Warren Emergency Squad, Inc  
Queensbury EMS, Inc.  
Rockwell Falls Ambulance Service, Inc.  
Stony Creek Volunteer Fire Company, Inc  
Warrensburg Emergency Medical Services, Inc  
West Glens Falls Emergency Squad, Inc.  
Ambulanz  
Mohwak Ambulance

### ***No negative impact on other providers***

There will be no negative impact on any other providers which hold operating authority in all or some of Warren County. Fort Ann Rescue Squad is not looking to displace any of the private services, fire departments or volunteer ambulance services which serve this small territory. It is hard to imagine that any other ambulance service will lose income, members, or employees from Fort Ann Rescue Squad's provision of interfacility transports and non-911 ambulance services. No other ambulance service will be negatively impacted.

### ***Response Time***

Response time metrics for our type of proposed services are different than 911 service response times. The hospital must be able to discharge its patients in a timely manner, but mere minutes are not likely critical. We typically will be scheduled to arrive at various times. Therefore, response times are not as important. However, the present ambulance providers are unable to guarantee reliable response times even with pre-scheduled times, as they are overwhelmed with 911 calls which must take priority. Our statistics dictate that most transports occur between 2pm and 12am.

### ***Staffing/Contracting***

Fort Ann Rescue Squad will staff a total of four (4) ambulances available to respond to the Expansion Territory (the Hospital) with at least one basic EMT and a driver on each, or for advanced life support transports, with at least one paramedic.

### ***Call volume for past 12 months and anticipated for next 12 months***

We will operate 24/7. We project that we will transport on average, 1200-1300 patients per year in this Expansion Territory. We expect about 3-4 transports per day in this territory. This is based upon our present statistics for 2024 and 2025.

### ***Mutual Aid***

We will participate in the mutual aid system for Warren County.

### ***Quality Assurance***

We will maintain our own Quality Assurance Program. However, all calls that meet mandatory reporting to the Regional EMS Council will be sent in a timely fashion. All calls requiring review by the Medical Director are also done at the earliest possible time.

### ***Protocols***

Fort Ann Rescue Squad adopts and adheres to all state and regional basic life support and advanced life support protocols. Fort Ann Rescue Squad maintains all required policies by the Department of Health, Bureau of Emergency Medical Services. Fort Ann Rescue Squad frequently reviews its best practices in an effort to continuously improve its already high quality of services.

### ***Ability and quality of existing services***

This application does not seek to displace any other service. Fort Ann Rescue Squad will fill significant gaps in ambulance service for interfacility transports, hospital discharges and patient appointments which require ambulance transport. It does not displace any other service from responding to their primary territories for 911 emergencies.

We have spoken with other available ambulance services and they are either not capable of providing these transports and/or are not interested in doing so.

### ***No Financial Impact or any adverse impact on existing services***

Fort Ann Rescue Squad will not stop any other service from operating in their primary operating territories for 911 calls and will not attempt to interfere with existing transport contracts being reliably served by any other ambulance service.



## **II. EMS System in the Area**

*These entities are listed above.*

*The following hospital is affected:*

- Glen Falls Hospital

*Fort Ann Rescue Squad participates in the Fort Ann Rescue Squad Mutual Aid Plan.*

Fort Ann Rescue Squad will participate in 911 response services and will not provide or receive mutual aid support services.

*Projected Response Times for the next 12 months*

Response time is based upon the schedule required by the hospital, but is on average, less than two (2) minutes.

*Communication System Interface*

Fort Ann Rescue Squad will utilize 911 services and will communicate with 911 on frequency 154.1600 and has 155.340 capability. We will have the ability to speak with the hospital via phone and radio.

*The positive and negative impact on the community*

There will only be a positive impact on emergency medical services, the hospital and the community through the effective and efficient discharge and/or transport of patients out of Glens Falls Hospital. There will be no negative impact on patient care, and no other ambulance service will be negatively impacted in the area. Without Fort Ann Rescue Squad providing services, response time for patient transports and discharges will suffer.

*Economic improvements from Fort Ann Rescue Squad's operation in the proposed territory*

The primary benefit will be the availability of an ambulance service to remove patients from a hospital, thereby opening much needed bed space in Glens Falls Hospital.

### **Appendix 1 – Guidelines for Establishing Ambulance Services**

*Population of jurisdiction requesting the ambulance service, including tourism and traffic flow.*

- Glens Falls Hospital has 391 beds.

*Does each area have a large enough population base to support a new ambulance service?*

Yes, Glens Falls Hospital has a significant patient population and a significant number of discharges each day to justify the provision of these transporting, non-911 ambulance service.

*How many calls for service and how many emergency calls are made in the proposed area?*

Approximately 3-4 per day

***Average response time for calls and emergency calls***

Likely about two (2) minutes, but all transports will be scheduled in advance when possible.

***Quality of existing services and how to present conditions affect public convenience***

In the absence of the Fort Ann Rescue Squad, existing services would not be adequate for the purpose of serving Glens Falls Hospital with a prompt response time. The mere fact that we are presently transporting 3-4 patients per day must establish need.

***Mutual aid ambulance agreements exist***

Mutual aid does not cover our types of non-911 transport services. Our services will cover these calls.

***Would the employees of the proposed service have a sufficient level of clinical experience for maintaining emergency care?***

Yes, all employees presently have adequate experience to perform these transport services.

***Would opportunities exist for personnel to maintain their level of skill. If an additional ambulance service were added, would the dilution of service calls between the ambulance services cause decay in skills due to inactivity?***

Providers of other services would not see a decrease in their skills as there are more than enough calls to be handled outside of Glens Falls Hospital. However, these calls are primarily basic life support calls which require less skill than the average 911 emergency, though certainly some skill.

***Are the existing communications capabilities adequate for maintaining medical control and directing paramedics?***

Yes. We have radio and phone communications.

***How will the ambulance service be financed? Are the financial resources available to the proposed service sufficient for maintaining a full time service?***

Private contracts with the hospital and patient billing will be the primary source of funding.

***How will the ambulance service be organized and administered? Is management capable of performing its duties?***

Fort Ann Rescue Squad is a not for profit corporation, which is managed by a Board of Directors and an internal administrative staff, with oversight from its Medical Director. The corporation has more than adequate experience operating a business as it has provided ambulance services since 1961.

***What will be the total cost of the new ambulance service? Are the benefits that the proposed area receive worth the expense?***

We anticipate the cost of this service to be approximately \$500,000 per year for responding to Glens Falls Hospital. This encompasses the need for staffing four (4) ambulances per day for this response.

***Does public opinion in the proposed area favor the establishment of Fort Ann Rescue Squad?***

We have already received letters of support and service requests from skilled nursing facilities, with well more support to come.

***Does local government planning agencies favor establishment of a new ambulance service.***

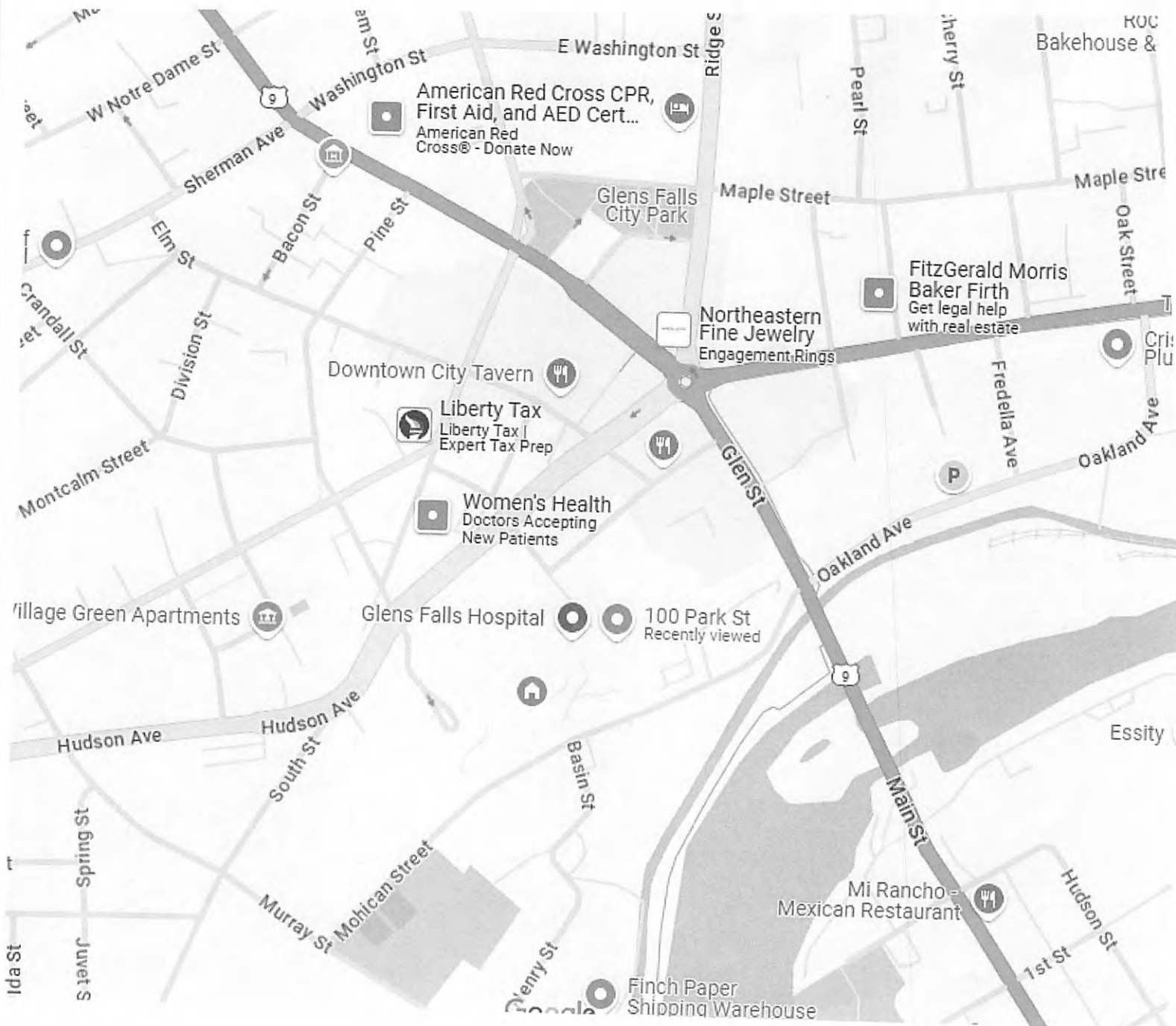
The local governments appear to approve of Fort Ann Rescue Squad's provision of ambulance services as their residents need these services. We hope that this letter will serve to encourage positive responses from the local government leaders in the form of support letters. All opposition and support will be shared with the regional council.

***Are there any viable alternatives other than licensing a new ambulance service.***

The present system is not working, as transport times of non-911 patients between medical and residential care facilities, and patient treatment facilities, are way too long.

Therefore, we believe this application supports need.

We therefore ask that you send a letter of support to our attention on behalf of our client, or feel free to submit a letter of concern or opposition.







## Affirmation of Fitness and Competency

By completing this form, you are aware that the NYS Department of Health will be conducting a detailed background review in order to determine fitness and competency in accordance with Article 30 of the NYS Public Health Law.

Fort Ann Rescue Squad Inc

5714

Name of EMS Agency

NYS EMS Agency Code

Fort Ann Rescue Squad Inc

Full Name of Corporate Entity requiring F&C review as a new owner/operator

Thomas Noble

Chief

Full Name of Individual

Title

Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator

Social Security Number (this is not releasable under the provisions of FOIL)

Date of Birth

As the proposed new owner/operator of an EMS agency, I hereby certify that I am or have been a director, sponsor, principal, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES NO

- ☒ ☐ Emergency Medical Service certified by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Hospital, long term care facility or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Invalid coach (Ambulette) Service authorized by the NYS Department of Transportation or equivalent in any other state.
- ☐ ☒ Home or residence licensed by NYS or equivalent in any other state.
- ☐ ☒ Halfway house, hostel or residential facility or institution licensed by, or subject to the rules of the NYS Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD), or equivalent in any other state.

→ If **NO** has been marked for all of the above, it indicates that there is no history of operating an entity identified in NYS Public Health Law; signing this affirmation is informational only and a testimony to the accuracy of the information provided.

→ If **YES** has been marked for any of the above, on an attached page, please provide the following information for each:

- Name of agency or facility
- Mailing address of facility or agency
- Name of Certifying or Licensing authority
- If applicable, a copy of license, certificate or identification number
- Individual position(s) held with start and end dates

### REQUIRED ATTACHMENTS TO THIS AFFIRMATION

- Current resume or curriculum vitae
- Copies of any related licenses and certifications
- Listing of address of residence, or if less than 2 years, addresses of prior residences.

## Certification of Competency

By completing and signing this affirmation, I certify that I have operated all of the agencies indicated, in compliance with all applicable statutes, rules, regulations and policies, specifically 10 NYCRR800.

Further, I certify that there have been no administrative orders issued by any Federal, State or local agency for matters that are or were recurrent or uncorrected, or dealt with patient harm or neglect in accordance with NYS Public Health Law during my tenure as a director, sponsor, principal, stock holder, operator or operations manager.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Thomas Noble

Full Name

*Thomas Noble*

Signature

Date

*6/4/25*

## Certification of Fitness

By completing and signing this affirmation, I certify that I have not been convicted of any crime at anytime, involving murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs, nor have I pleaded nolo contendere to a felony charge relating to any of these offenses.

Further, I certify that, I am not, or was not subject to a state or federal administrative order relating to fraud, embezzlement or patient harm, including, but not limited to actions involving Medicare and or Medicaid.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of fitness.

Thomas Noble

Full Name

*Thomas Noble*

Signature

Date

*6/4/25*

## Notary Public Affirmation and Acknowledgement

*BRUCE K. MASON*

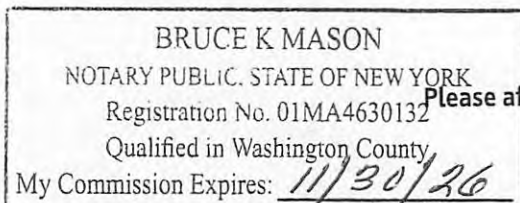
Notary Public Name

*Bruce K. Mason*

Signature

Date

*6/4/25*



Please affix Notary Public Stamp or equivalent.

## Affirmation of Fitness and Competency

By completing this form, you are aware that the NYS Department of Health will be conducting a detailed background review in order to determine fitness and competency in accordance with Article 30 of the NYS Public Health Law.

Fort Ann Rescue Squad Inc

5714

Name of EMS Agency

NYS EMS Agency Code

Fort Ann Rescue Squad Inc

Full Name of Corporate Entity requiring F&C review as a new owner/operator

Regina Ladd

President

Full Name of Individual

Title

Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator

Social Security Number (this is not releasable under the provisions of FOIL)

Date of Birth

As the proposed new owner/operator of an EMS agency, I hereby certify that I am or have been a director, sponsor, principal, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES NO

- ☒ ☐ Emergency Medical Service certified by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Hospital, long term care facility or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Invalid coach (Ambulette) Service authorized by the NYS Department of Transportation or equivalent in any other state.
- ☐ ☒ Home or residence licensed by NYS or equivalent in any other state.
- ☐ ☒ Halfway house, hostel or residential facility or institution licensed by, or subject to the rules of the NYS Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD), or equivalent in any other state.

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- Name of agency or facility
- Mailing address of facility or agency
- Name of Certifying or Licensing authority
- If applicable, a copy of license, certificate or identification number
- Individual position(s) held with start and end dates

### REQUIRED ATTACHMENTS TO THIS AFFIRMATION

- Current resume or curriculum vitae
- Copies of any related licenses and certifications
- Listing of address of residence, or if less than 2 years, addresses of prior residences.



## Certification of Competency

By completing and signing this affirmation, I certify that I have operated all of the agencies indicated, in compliance with all applicable statutes, rules, regulations and policies, specifically 10 NYCRR800.

Further, I certify that there have been no administrative orders issued by any Federal, State or local agency for matters that are or were recurrent or uncorrected, or dealt with patient harm or neglect in accordance with NYS Public Health Law during my tenure as a director, sponsor, principal, stock holder, operator or operations manager.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Regina Ladd

Full Name

*Regina Ladd*

Signature

*6/4/25*

Date

## Certification of Fitness

By completing and signing this affirmation, I certify that I have not been convicted of any crime at anytime, involving murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs, nor have I pleaded nolo contendere to a felony charge relating to any of these offenses.

Further, I certify that, I am not, or was not subject to a state or federal administrative order relating to fraud, embezzlement or patient harm, including, but not limited to actions involving Medicare and or Medicaid.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of fitness.

Regina Ladd

Full Name

*Regina Ladd*

Signature

*6/4/25*

Date

## Notary Public Affirmation and Acknowledgement

*BRUCE K. MASON*

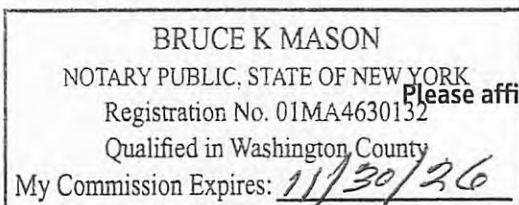
Notary Public Name

*Bruce K. Mason*

Signature

*6/4/25*

Date



Please affix Notary Public Stamp or equivalent.

## Affirmation of Fitness and Competency

By completing this form, you are aware that the NYS Department of Health will be conducting a detailed background review in order to determine fitness and competency in accordance with Article 30 of the NYS Public Health Law.

Fort Ann Rescue Squad Inc

5714

Name of EMS Agency

NYS EMS Agency Code

Fort Ann Rescue Squad Inc

Full Name of Corporate Entity requiring F&C review as a new owner/operator

Robert McPherson

Board of Director

Full Name of Individual

Title

Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator

Social Security Number (this is not releasable under the provisions of FOIL)

Date of Birth

As the proposed new owner/operator of an EMS agency, I hereby certify that I am or have been a director, sponsor, principal, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES NO

- ☒ ☐ Emergency Medical Service certified by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Hospital, long term care facility or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state.
- ☐ ☒ Invalid coach (Ambulette) Service authorized by the NYS Department of Transportation or equivalent in any other state.
- ☐ ☒ Home or residence licensed by NYS or equivalent in any other state.
- ☐ ☒ Halfway house, hostel or residential facility or institution licensed by, or subject to the rules of the NYS Office of Mental Health (OMH) or Office of Mental Retardation and Developmental Disabilities (OMRDD), or equivalent in any other state.

→ If **NO** has been marked for all of the above, it indicates that there is no history of operating an entity identified in NYS Public Health Law; signing this affirmation is informational only and a testimony to the accuracy of the information provided.

→ If **YES** has been marked for any of the above, on an attached page, please provide the following information for each:

- Name of agency or facility
- Mailing address of facility or agency
- Name of Certifying or Licensing authority
- If applicable, a copy of license, certificate or identification number
- Individual position(s) held with start and end dates

### REQUIRED ATTACHMENTS TO THIS AFFIRMATION

- Current resume or curriculum vitae
- Copies of any related licenses and certifications
- Listing of address of residence, or if less than 2 years, addresses of prior residences.

## Certification of Competency

By completing and signing this affirmation, I certify that I have operated all of the agencies indicated, in compliance with all applicable statutes, rules, regulations and policies, specifically 10 NYCRR800.

Further, I certify that there have been no administrative orders issued by any Federal, State or local agency for matters that are or were recurrent or uncorrected, or dealt with patient harm or neglect in accordance with NYS Public Health Law during my tenure as a director, sponsor, principal, stock holder, operator or operations manager.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Robert McPherson

Full Name

Signature

Date

## Certification of Fitness

By completing and signing this affirmation, I certify that I have not been convicted of any crime at anytime, involving murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs, nor have I pleaded nolo contendere to a felony charge relating to any of these offenses.

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If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of fitness.

Robert McPherson

Full Name

Signature

Date

## Notary Public Affirmation and Acknowledgement

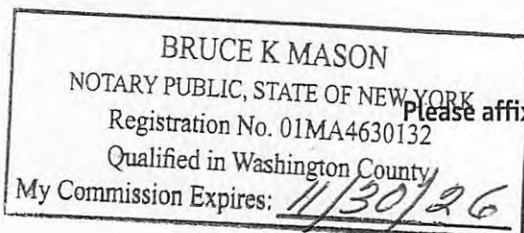
BRUCE K. MASON

Notary Public Name

Bruce K. Mason

Signature

Date



Please affix Notary Public Stamp or equivalent.

## Affirmation of Fitness and Competency

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|                                                                                            |                     |
|--------------------------------------------------------------------------------------------|---------------------|
| Fort Ann Rescue Squad Inc                                                                  | 5714                |
| Name of EMS Agency                                                                         | NYS EMS Agency Code |
| Fort Ann Rescue Squad Inc                                                                  |                     |
| Full Name of Corporate Entity requiring F&C review as a new owner/operator                 |                     |
| Melissa Clark                                                                              | Board of Director   |
| Full Name of Individual                                                                    | Title               |
| [REDACTED]                                                                                 |                     |
| Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator |                     |
| [REDACTED]                                                                                 |                     |
| Social Security Number (this is not releasable under the provisions of FOIL)               | Date of Birth       |
| [REDACTED]                                                                                 |                     |

As the proposed new owner/operator of an EMS agency, I hereby certify that I am or have been a director, sponsor, principal, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES NO

- |                                     |                                     |                                                                                                                                                                                                                                                      |
|-------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | Emergency Medical Service certified by the NYS Department of Health, or equivalent in any other state.                                                                                                                                               |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Hospital, long term care facility or other Article 28 facility licensed by the NYS Department of Health, or equivalent in any other state.                                                                                                           |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Invalid coach (Ambulette) Service authorized by the NYS Department of Transportation or equivalent in any other state.                                                                                                                               |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Home or residence licensed by NYS or equivalent in any other state.                                                                                                                                                                                  |
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- Name of Certifying or Licensing authority
- If applicable, a copy of license, certificate or identification number
- Individual position(s) held with start and end dates

### REQUIRED ATTACHMENTS TO THIS AFFIRMATION

- Current resume or curriculum vitae
- Copies of any related licenses and certifications
- Listing of address of residence, or if less than 2 years, addresses of prior residences.



## Certification of Competency

By completing and signing this affirmation, I certify that I have operated all of the agencies indicated, in compliance with all applicable statutes, rules, regulations and policies, specifically 10 NYCRR800.

Further, I certify that there have been no administrative orders issued by any Federal, State or local agency for matters that are or were recurrent or uncorrected, or dealt with patient harm or neglect in accordance with NYS Public Health Law during my tenure as a director, sponsor, principal, stock holder, operator or operations manager.

If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Melissa Clark

Full Name



Signature

6/4/25  
Date

## Certification of Fitness

By completing and signing this affirmation, I certify that I have not been convicted of any crime at anytime, involving murder, manslaughter, assault, sexual abuse, theft, robbery, drug abuse, or sale of drugs, nor have I pleaded nolo contendere to a felony charge relating to any of these offenses.

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Melissa Clark

Full Name



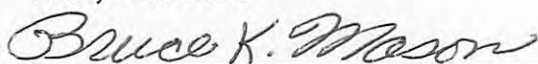
Signature

6/4/25  
Date

## Notary Public Affirmation and Acknowledgement

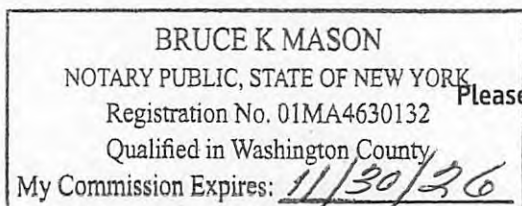
BRUCE K. MASON

Notary Public Name



Signature

6/4/25  
Date



Please affix Notary Public Stamp or equivalent.

## Affirmation of Fitness and Competency

By completing this form, you are aware that the NYS Department of Health will be conducting a detailed background review in order to determine fitness and competency in accordance with Article 30 of the NYS Public Health Law.

Fort Ann Rescue Squad Inc

5714

Name of EMS Agency

NYS EMS Agency Code

Fort Ann Rescue Squad Inc

Full Name of Corporate Entity requiring F&C review as a new owner/operator

Robert Griffiths

Board of Director

Full Name of Individual

Title

Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator

Social Security Number (this is not releasable under the provisions of FOIL)

Date of Birth

As the proposed new owner/operator of an EMS agency, I hereby certify that I am or have been a director, sponsor, principal, stock holder, operator or operations manager of one or more of the following in the past 10 years (Article 30 §3005[5]).

YES NO

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If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Robert Griffiths

Full Name

*Robert Griffiths*

Signature

Date

*6/4/25*

## Certification of Fitness

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Robert Griffiths

Full Name

*Robert Griffiths*

Signature

Date

*6/4/25*

## Notary Public Affirmation and Acknowledgement

*BRUCE K. MASON*

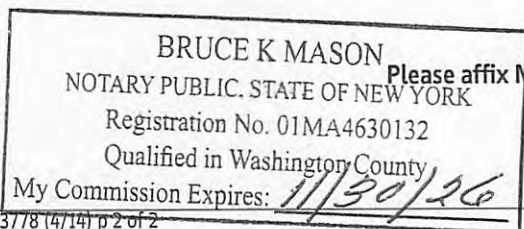
Notary Public Name

*Bruce K. Mason*

Signature

Date

*6/5/25*



Please affix Notary Public Stamp or equivalent.

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| Full Name of Corporate Entity requiring F&C review as a new owner/operator                 |                     |
| Bruce Mason                                                                                | Board of Director   |
| Full Name of Individual                                                                    | Title               |
|                                                                                            |                     |
| Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator |                     |
|                                                                                            |                     |
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YES NO

- |                                     |                                     |                                                                                                                                                                                                                                                      |
|-------------------------------------|-------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
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If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Bruce Mason

Full Name

*Bruce Mason*

Signature

*6/5/25*

Date

## Certification of Fitness

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Bruce Mason

Full Name

*Bruce Mason*

Signature

*6/5/25*

Date

## Notary Public Affirmation and Acknowledgement

*Miranda Herringshaw*

Notary Public Name

*Miranda Herringshaw*

Signature

*6/5/25*

Date

Please affix Notary Public Stamp or equivalent.

MIRANDA LYNN HERRINGSHAW  
Notary Public, State of New York  
Washington County #01HE0016670  
Commission Expires Nov. 19, 2021

## Affirmation of Fitness and Competency

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Fort Ann Rescue Squad Inc

5714

Name of EMS Agency

NYS EMS Agency Code

Fort Ann Rescue Squad Inc

Full Name of Corporate Entity requiring F&C review as a new owner/operator

Chauncey Wallace

Board of Director

Full Name of Individual

Title

Address of the Individual or Corporate Entity requiring F&C review as a new owner/operator

Social Security Number (this is not releasable under the provisions of FOIL)

Date of Birth

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If you are unable to sign this affirmation, attach copies of all background information, Department orders and/or justification to assist in the review and determination of competency.

Chauncey Wallace

Full Name



Signature

6-12-2025

Date

## Certification of Fitness

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Chauncey Wallace

Full Name



Signature

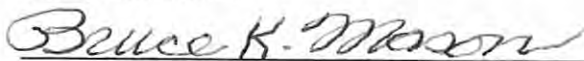
6-12-2025

Date

## Notary Public Affirmation and Acknowledgement

BRUCE K. MASON

Notary Public Name

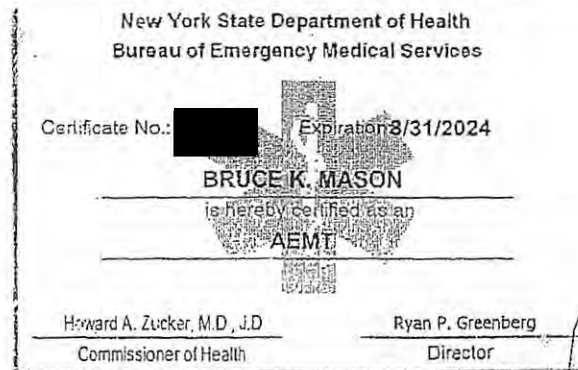
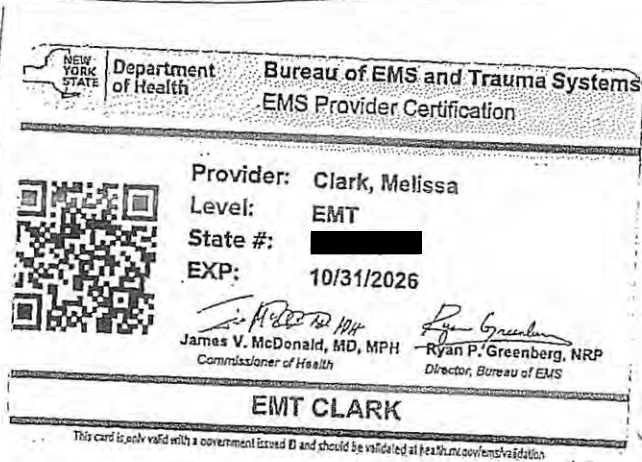
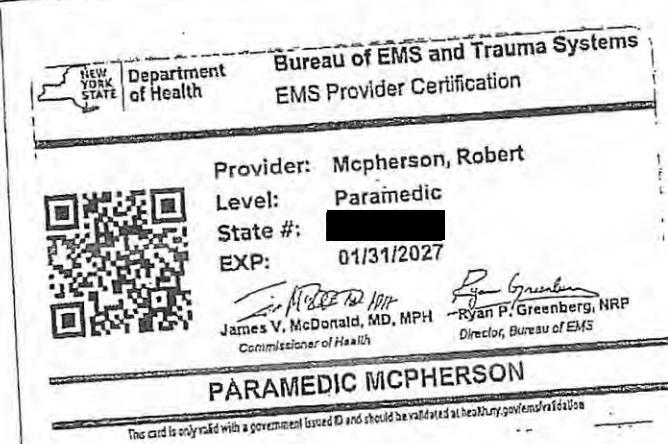
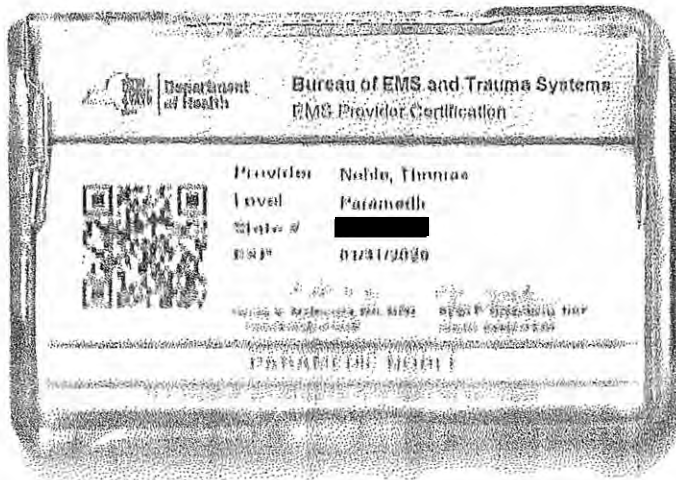


Signature

6-12-2025

Date







**NEW YORK STATE** USA  
DRIVER LICENSE

Class D

NOBLE  
THOMAS, S

Sex M Height 5'-00" Eyes GRN

ENONE  
RNONE

THOMAS NOBLE

Organ Donor

**NEW YORK STATE** USA  
COMMERCIAL DRIVER LICENSE

Class BM

LADD  
REGINA C

Sex F Height 5'-07" Eyes BRO

EP  
RA3 B K

Issued

REGINA LADD

Organ Donor

**NEW YORK STATE** USA  
DRIVER LICENSE

Class D

MCPHERSON  
ROBERT, M

Sex M Height 5'-07" Eyes HAZ

ENONE  
RNONE

ROBERT MCPHERSON

Organ Donor

**NEW YORK STATE** USA  
DRIVER LICENSE

Class DM

GRIFFITHS  
ROBERT, E

Sex M Height 5'-10" Eyes BRO

ENONE  
RNONE

ROBERT GRIFFITHS

**NEW YORK STATE** USA  
DRIVER LICENSE

Class D

MASON  
BRUCE, KENT

Sex M Height 5'-08" Eyes BLU

ENONE  
RNONE

FEB 4

BRUCE MASON

NEW YORK STATE  
DRIVER LICENSE

NOT FOR  
FEDERAL  
PURPOSES

Glass D

CLARK  
MELISSA J

♥  
Organ  
Donor

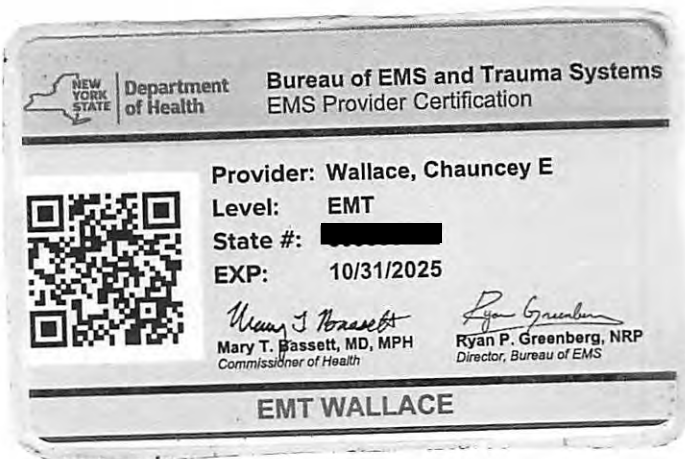
E NONE  
R NONE

Sex F Height 5'03" Eyes BLU

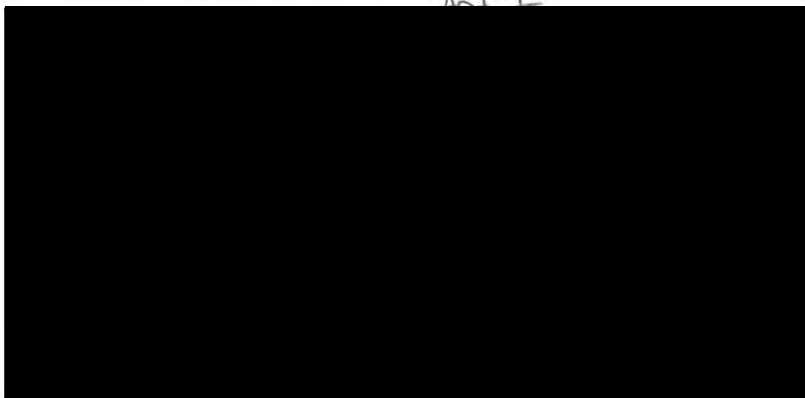
NOV 94

CLARK MELISSA J

NOV 94



Home Address



---

# THOMAS NOBLE

[FAEMS2661@gmail.com](mailto:FAEMS2661@gmail.com)

## Certifications:

### Current:

NYS/NR Paramedic (NYS 459464 expires 1/31/2026) (NR M5119761 expires 3/31/2027)  
NYS AHA ACLS Instructor  
NYS AHA PALS Instructor  
AHA BLS CPR Instructor

### Past Certification:

NYS AEMT (2019-2023)  
NYS EMT (2017-2019)

## Employer:

### Present:

Fort Ann Rescue Squad Inc

- Job Description: In charge of the Day-to-Day Operational needs of the 911 Division and the Interfacility Division. EMS Command for large & small-scale incidents which require management of several resources. Overall responsible for all Paid Staff Employees and there needs.
- Positions Held
  - Chief
    - 2019 till Present
  - Deputy Chief
    - 2018-2019
  - Lieutenant
    - 2018
- 2017-Present

### Past Employer:

United States Army (Active Duty)

- Job: 13FL7 (Joint Fires Observer)
  - Job Description: On the ground close air support for troops in contact. Coordination of Fixed Wing, Rotary Wing, Mortars and Artillery for ground troops in contact. Performed Infantry duties when not conducting close air support.
- Fort Drum (Watertown, NY)
  - 2005-2007
- Fort Carson (Colorado Springs, CO)
  - 2008-2012
- Deployments to Iraq, and Afghanistan
- Highest Rank Obtained: E5 Sergeant (Non-Commissioned Officer)



---

## Education:

Hudson Valley Community College: Paramedic Program

- 2021-2023

Queensbury High School

- 1999-2003

## Present Volunteer Experience

Fort Edward Rescue Squad (2012 till Present) Inactive Life Member

- Positions Held at Fort Edward Rescue Squad:
  - Chief
  - Deputy Chief
  - Lieutenant
  - President

Fort Ann Rescue Squad Inc.

- Positions Held at Fort Ann rescue Squad Inc
  - Chief
  - Deputy Chief
  - Lieutenant

## Past Volunteer or Medical Experience

Hudson Falls Fire Department

Positions Held:

- Lieutenant
- Firefighter

2012-2019

Job Description: In charge of fire mitigation and interior firefighter. Job was to manage people and resources inside of IDLH atmospheres.

West Fort Ann Fire Department

Positions Held:

- Lieutenant
- Firefighter

Job Description: In charge of fire mitigation and interior firefighter. Job was to manage people and resources inside of IDLH atmospheres

2022-2024

Fort Ann Fire Department

Positions Held:

- Firefighter

2024-Present

Past Medical:

- Combat Life Saving Course (United States Army)

---

## **Management Experience**

While a member of the United States Army I was trained to lead troops in combat as well as at peace time. I had extensive training during my time with the military to include Equal Opportunities for members of the military, combat training, management of soldiers, and mental health training.

While serving at President of the Fort Edward Rescue Squad I took several CE Classes on business management and Finance. It was my responsibility to manage all personal of the agency as well as chairperson of all committees. After moving into the Operational Side, I had several mentors guide me and teach day to day operational duties.

While serving with the Fort Ann rescue Squad I have continued to take CE Classes every year such as: Business, Finance, Leadership, and Mental Health. It is my responsibility to manage the day-to-day operational duties of the organization's 911 Division as well as the Interfacility Division. Additional responsibilities are included such as weekly payroll, NYS Paperwork, NYS CON recertifications, and overall responsible for the Narcotics program.



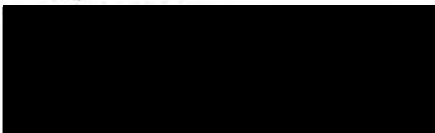
REGINA LADD

---

### Objectives

I have been in emergency services in one form or another since 1992. My goals are to provide the best patient care in a quick efficient manner and to help Fort Ann Rescue Squad and its members and employees to grow. I have been a leader in my prior 911 communications officer job, in EMS and fire in one form or another since 1992, The majority of the time holding leadership positions.

Regina Ladd

  
[presidentfars@gmail.com](mailto:presidentfars@gmail.com)

---

### Experience

911 Communications officer, CTO 2006-2025-Retired 3/25  
CPR Instructor 2006-Current  
Advanced Emergency Medical Technician Fort Ann Rescue Squad  
2019-Current

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### Education

*Queensbury High School Regents Diploma 1980*

Certified First Responder-1992  
Emergency Medical Technician-2001  
Advanced Emergency Medical Technician-2013  
Critical Incident Stress Debriefing for individuals in Crisis as well as the group setting. Washington County Peer Support Team-2017-Current

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### Volunteer Experience or Leadership

Captain of Bay Ridge Rescue Squad for 3 years, Asst Captain Bay Ridge Rescue Squad 2 yrs, Lt Bay Ridge Rescue Squad 2 yrs, Lt Fort Ann Rescue Squad 1 yr, President Fort Ann Rescue Squad total of 14 years. Volunteer Bay Ridge Rescue Squad 8 years, Volunteer with Fort Ann Rescue Squad for over 20 years. Chairman of the Board of Directors West Fort Ann Fire Company 2 years, First Response Captain West Fort Ann Fire Company for 8 years.



# RM

## ROBERT MCPHERSON

FORT ANN RESCUE SQUAD INC  
PARAMEDIC / BOARD OF DIRECTOR

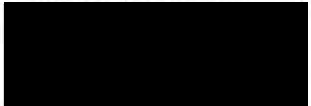
### CERTIFICATION

NYS EMT: 2004-2011  
NYS Paramedic: 2012-Present

### OVERVIEW

I have been in emergency services in one form another from EMS to Fire since graduating High School. I care Deeply about serving the community that I live within and helping people in general. My life experiences have taken me from my hometown in Fabius to the eastern side of NYS to Fort Ann all that time serving in one capability or another in emergency services. My time in emergency services and current employment have taught me a wide range of skills to include Management of personnel and leadership. One is never done learning and or honing their skills in leadership.

Robert McPherson



### CURRENT EMPLOYER

#### CAMP RANGER • TWIN RIVERS COUNCIL • 1/23-PRESENT

Responsible for day-to-day operations of Camp Wakpominee in Fort Ann, NY. Oversee and maintain the grounds and needs of the property. Responsible for the safety and wellbeing of all Scouting of America children who attend camp.

### EDUCATION

#### HIGH SCHOOL DIPLOMIA • 2005 • FABIOUS POMPEY

#### DEGREE • DATE EARNED • SCHOOL

On the Home tab of the ribbon, check out Styles to apply the formatting you need with just a click.

### VOLUNTEER EXPERIENCE OR LEADERSHIP

#### 2004-2020: Pompey Hill Fire Dept

- Firefighter/Paramedic
- Rescue Captain

#### 2005: Rome Metro Medical Services

- EMT

#### 2008: Peer Support (Critical Incident Stress debriefing) Class

#### 2009: TLC EMS

- EMT

#### 2020: NorthStar EMS

- Chief Operations Officer
- Paramedic

#### 2024- Present: Fort Ann Rescue Squad Inc

- Paramedic / Board of Director





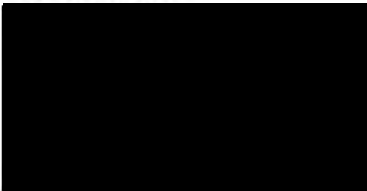
Bruce Mason

### Objectives

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I have been in Fort Ann Rescue Squad since 1972, my goal has always been to be here for the community of Fort Ann. I have always supported the growth of our members and the growth of our agency, offering my years of experience in life and EMS. I have taught hundreds of providers and citizens CPR. I have participated in hundreds of EMT and advanced providers classes with their skills as a CLI. I have loved and supported this agency and community since I moved here in 1972.

Bruce Mason



### Experience

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Funeral Director-1969-1924  
Business Owner Mason's Funeral home 1972-2024  
CPR Instructor 2004-2024  
Emergency Medical Technician-1972-1991  
Advanced Emergency Medical Technician-1991-2025  
Certified Lab Instructor-1999-2024  
CPR Instructor-2001-2024

### Education

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Coxsackie High School-1964  
Dutchess County Community College 2yrs-1966  
Cortland College-1968  
Mortuary School-1969

### Volunteer Experience or Leadership

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Have volunteered at Fort Ann Rescue Squad since 1972. I have held every position operationally and the executive side, with one exception, the position of Captain during my 50 years of service. I held the position of EMS C-3 for Washington County for 5 years. I then moved to the position of EMS C-1 for Washington County from 2003-2024.



MC

**MELISSA CLARK**

FORT ANN RESCUE SQUAD INC  
EMT / BOARD OF DIRECTOR

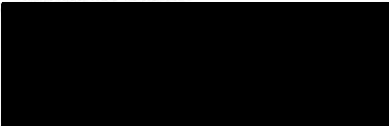
## CERTIFICATION

NYS EMT: 2016-Present  
NYS EMT# 463929

## OVERVIEW

I have always been interested in Emergency Services and helping people, as I grew up in a household where my father was a fire chief. After High School I moved to the Fort Ann area where I had family and joined the Fort Ann Rescue Squad Inc. My life has been centered around helping people as well as currently serving as the health and safety officer for FARS where I have taken on helping members struggling with mental health issues as its near and dear to my heart. I have served as a Board of Director for the Fort Ann Rescue Squad for the last two years helping the agency transition into one of the busiest agencies in Washington County.

Melissa Clark



## CURRENT EMPLOYER

**BANK TELLER • ARROW BANK • 2024 - PRESENT**

Assist customers with bank transactions and other bank related items.

**HOUSE / PATIENT ASSISTANT • ARC • 2016 - PRESENT**

Help take care of disabled patients in need. I stay in house with patients and take care of day to day needs to long term residents of ARC.

## EDUCATION

**HIGH SCHOOL DIPLOMIA • 2012 • LONG LAKE**

Graduated with Regents Diploma

## VOLUNTEER EXPERIENCE OR LEADERSHIP

Fort Ann Rescue Squad Inc: 2014-Present

- EMT
- Board of Director: 2023-Present
- Vice President: 2022-2023
- Health and Safety Officer: 2023 - Present

Fort Edward Rescue Squad: 2019-2021

- EMT

Granville Rescue Squad: 2018-2020

- EMT



## ROBERT GRIFFITHS

FORT ANN RESCUE SQUAD INC  
EMT / BOARD OF DIRECTOR

### CERTIFICATION

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NYS EMT: 2012 – Present  
NYS EMT# 418858

### OVERVIEW

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After spending more than more than twenty years with NYS Department of Health and the Environmental agencies serving the central region in various leadership and staffing positions, I was able to retire to the Fort Ann NY area where I found a new appreciation of serving my community. I joined the Fort Ann Rescue Squad and served in various position such as treasurer, Operational Lieutenant and now as a Board of Director helping shape and lead the agency into the future. My many years with the state along with my education has helped me guide and mentor several new providers who have today turned into Operational leaders currently leading the agency now. One never stops learning and leadership never clocks out.

### CURRENT & PAST EMPLOYER

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#### EMT • FORT ANN RESCUE SQUAD INC • 2017 - PRESENT

Caring for the sick and injured as a New York State EMT for 911 calls, as well as driver and care provider for interfacility transfers.

#### INSPECTOR • NYS DEPT OF HEALTH • 1986 - 2010

Inspection of large-scale business and food establishments, as well as various leadership roles in many projects

#### NYS ENVIROMENTAL CONSERVATION • 1981 – 1986

Program and Research for Child Health Plus

### EDUCATION

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#### HIGH SCHOOL DIPLOMIA • NEW HARTFORD CENTRAL HIGH

#### ASSOCIATE'S DEGREE • SUNY MORRISVILLE

- DEGREE IN ENVIORMENTAL SCIENCE

#### BACHELOR'S DEGREE • EAST TENNESSEE STATE UNIVERSITY

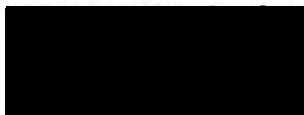
- DEGREE IN PUBLIC HEALTH



**ROBERT GRIFFITHS**

FORT ANN RESCUE SQUAD INC  
EMT / BOARD OF DIRECTOR | LINK TO OTHER ONLINE PROPERTIES:

Robert Griffiths



## **VOLUNTEER EXPERIENCE OR LEADERSHIP**

Fort Ann Rescue Squad Inc: 2012 – Present

- Lieutenant: 2017 – 2019
- Treasurer: 2014-2019
- Board of Director: 2019- Present

Double H Hole in the Woods: 2016- 2023

- Facilities Commission
- Board of Director

Rotary International: 2018-2023



EMAIL



TWITTER HANDLE



TELEPHONE



LINKEDIN URL





# CHAUNCEY WALLACE

FORT ANN RESCUE SQUAD INC  
EMT/ BOARD OF FIRECTOR

## CERTIFICATION

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NYS EMT: 2022 – Present  
NYS EMT #: 509503

## OVERVIEW

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After finishing High School I had a growing nature to want to help the community to which I live in. I first became a firefighter which I still do to this day and then had a growing love to helping people and became an EMT. In my time in emergency services, I have held various leadership positions within the Fire Dept and EMS guiding the next generation of EMTs and Firefighters.

## CURRENT & PAST EMPLOYMENT

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### EMT • FORT ANN RESCUE SQUAD • 2021 – PRESENT

Summarize your key responsibilities, leadership, and most stellar accomplishments. Don't list everything; keep it relevant and include data that shows the impact you made.

### EMT • QUEENSBURY EMS • 2022 - 2025

Think about the size of the team you led, the number of projects you balanced, or the number of articles you wrote.

## EDUCATION

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HIGH SCHOOL DIPLOMA • 2019 • HOME SCHOOLED (FORT ANN CSD)

## VOLUNTEER EXPERIENCE OR LEADERSHIP

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Fort Ann Vol Fire Dept: May 2019 – Present

- NYS Firefighter 1
- EVOC
- Pump Operator Course
- Leadership Classes
- Current Captain: 2603

Fort Ann Rescue Squad Inc: June 2019

- EMT: 2022- Present
- Former Lieutenant: 2022-2023
- Former Captain: 2023 – 2025
- Current Board of Director: 2025 - Present

Argyle EMS: 2023 – Present

- EMT

| 2025 Proposed Budget           |                              |        | 2024<br>Budgeted | 2025<br>Proposed Revenue | Totals / Notes | Difference to 2024 |
|--------------------------------|------------------------------|--------|------------------|--------------------------|----------------|--------------------|
| <b>Revenue</b>                 |                              |        |                  |                          |                |                    |
| 4000                           | Grants                       | (ARPA) | \$30,000.00      | \$34,500.00              | \$0.00         | -\$4,500.00        |
| 4200                           | Donations                    |        | \$13,573.50      | \$8,000.00               | \$8,000.00     | \$5,573.50         |
| 4300                           | Government Contracts         |        | \$159,000.00     | \$108,000.00             | \$108,000.00   | \$51,000.00        |
| 4400                           | Insurance Recovery           |        | \$469,781.08     | \$825,000.00             | \$825,000.00   | -\$355,218.92      |
| 4500                           | Sales                        |        | \$0.00           | \$0.00                   | \$0.00         | \$0.00             |
| Total Revenue                  |                              |        | \$672,354.58     | \$975,500.00             | \$975,500.00   | -\$303,145.42      |
| <b>Expenditures</b>            |                              |        |                  |                          |                |                    |
|                                |                              |        | 2024 Budgeted    | 2025 Proposed            | Totals         | Difference         |
| 6105                           | Bank Charges                 |        | \$250.00         | \$300.00                 | \$300.00       | -\$50.00           |
| 6110                           | Captains Gift                |        | \$1,800.00       | \$1,500.00               | \$1,500.00     | \$300.00           |
| 6115                           | Donations                    |        | \$1,000.00       | \$1,000.00               | \$1,000.00     | \$0.00             |
| 6120                           | Contract Services            |        |                  |                          |                |                    |
| 6121                           | Accounting Fee's             |        | \$3,600.00       | \$5,000.00               |                | -\$1,400.00        |
| 6122                           | Billing Company              |        | \$29,000.00      | \$60,000.00              |                | -\$31,000.00       |
| Total 6121-6122                |                              |        | \$35,650.00      | \$67,800.00              | \$67,800.00    | -\$32,150.00       |
| 6130                           | Contributions                |        | \$250.00         | \$250.00                 |                | \$0.00             |
| 6140                           | EMS Manager                  |        | \$4,200.00       | \$4,500.00               |                | -\$300.00          |
| 6160                           | Interest Expense             |        | \$0.00           | \$0.00                   |                | \$0.00             |
| 6170                           | Legal & Professional         |        | \$3,000.00       | \$3,500.00               |                | -\$500.00          |
| 6180                           | License & Permits            |        | \$200.00         | \$400.00                 |                | -\$200.00          |
| Total Contract Services - 6120 |                              |        | \$7,650.00       | \$8,650.00               | \$8,650.00     | -\$1,000.00        |
| 6190                           | Loans                        |        |                  |                          |                | \$0.00             |
|                                | Building Loan                |        | \$4,900.00       | \$4,900.00               |                | \$0.00             |
|                                | 2652                         |        | \$15,000.00      | \$15,000.00              |                | \$0.00             |
|                                | 2641                         |        | \$0.00           | \$6,000.00               |                | -\$6,000.00        |
| Total 6160 -6161               |                              |        | \$19,900.00      | \$25,900.00              | \$25,900.00    | -\$6,000.00        |
| 6200                           | Med Supplies & Med Direction |        |                  |                          |                |                    |
| 6201                           | Medical Director             |        | \$5,500.00       | \$5,500.00               |                | \$0.00             |

|                                   |             |             |             |             |
|-----------------------------------|-------------|-------------|-------------|-------------|
| 6202 Oxygen                       | \$3,561.60  | \$4,000.00  |             | -\$438.40   |
| 6203 Supplies                     | \$12,000.00 | \$18,000.00 |             | -\$6,000.00 |
| Total Med Suuplies / Med Dir 6200 | \$21,061.60 | \$27,500.00 | \$27,500.00 | -\$6,438.40 |

|                              |             |             |                         |             |
|------------------------------|-------------|-------------|-------------------------|-------------|
| 6210 Equipment               |             |             |                         |             |
| 6211 Cardiac Monitor         | \$19,500.00 | \$19,500.00 | ARPA                    | \$0.00      |
| 6212 Stretchers              | \$0.00      | \$0.00      | 2024 Payments           | \$0.00      |
| 6213 Power Load System       | \$9,600.00  | \$0.00      | 4 items (ARPA) +Install | \$9,600.00  |
| 6214 Equipment Maint         | \$2,500.00  | \$2,500.00  |                         | \$0.00      |
| 6215 Station Alerting System | \$500.00    | \$500.00    |                         | \$0.00      |
| 6216 Fly Car                 | \$6,500.00  | \$0.00      |                         | \$6,500.00  |
| 6217 Stair Chair             | \$0.00      | \$5,000.00  |                         | -\$5,000.00 |
| Total New Equipment 6210     | \$38,600.00 | \$27,500.00 | \$27,500.00             | \$11,100.00 |

|                            |            |            |            |             |
|----------------------------|------------|------------|------------|-------------|
| 6300 Office Supplies       |            |            |            |             |
| 6301 Copy machine          | \$1,500.00 | \$1,000.00 |            | \$500.00    |
| 6302 Postage               | \$500.00   | \$250.00   |            | \$250.00    |
| 6304 Supplie               | \$2,000.00 | \$2,000.00 |            | \$0.00      |
| 6305 Water/Fridge Drinks   | \$1,000.00 | \$2,500.00 |            | -\$1,500.00 |
| 6307 Zoom                  | \$200.00   | \$250.00   |            | -\$50.00    |
| Office Supplies Total 6300 | \$5,200.00 | \$6,000.00 | \$6,000.00 | -\$800.00   |

|                                 |            |            |            |          |
|---------------------------------|------------|------------|------------|----------|
| 6330 Radio Communications       |            |            |            |          |
| 6331 Misc Communications        | \$1,275.00 | \$1,000.00 |            | \$275.00 |
| 6333 Radios                     | \$2,000.00 | \$1,800.00 |            | \$200.00 |
| Total Radio Comminucations 6330 | \$3,275.00 | \$2,800.00 | \$2,800.00 | \$475.00 |

|                                   |            |            |  |            |
|-----------------------------------|------------|------------|--|------------|
| 6350 Repairs and Maint            |            |            |  |            |
| 6351 Building Repairs and Upkeeps | \$3,396.75 | \$2,500.00 |  | \$896.75   |
| Pest Control                      | \$480.00   | \$480.00   |  | \$0.00     |
| Snow Plowing                      | \$3,800.00 | \$3,800.00 |  | \$0.00     |
| 6352 Building Supplies            | \$3,150.00 | \$1,500.00 |  | \$1,650.00 |

|                                    |             |             |             |              |
|------------------------------------|-------------|-------------|-------------|--------------|
| 6355 Landscaping                   | \$800.00    | \$800.00    |             | \$0.00       |
| 6356 Preventive Maintenance        | \$1,500.00  | \$1,000.00  |             | \$500.00     |
| 6357 Repairs & Maint-Other         | \$1,500.00  | \$1,000.00  |             | \$500.00     |
| 6358 Unexpected Repairs            | \$1,500.00  | \$1,500.00  |             | \$0.00       |
| 6360 <i>New Building Fund.</i>     | \$0.00      | \$20,000.00 |             |              |
| Total Repairs and Maintenance 6350 | \$16,126.75 | \$32,580.00 | \$32,580.00 | -\$16,453.25 |

|                         |          |            |            |           |
|-------------------------|----------|------------|------------|-----------|
| 6390 Taxes              |          |            |            | \$0.00    |
| 6391 Real Estate Taxes  | \$480.00 | \$480.00   |            |           |
| 6392 Village Water Bill | \$360.00 | \$600.00   |            | -\$240.00 |
| Total Taxes 6390        | \$840.00 | \$1,080.00 | \$1,080.00 | -\$240.00 |

|                        |             |            |            |            |
|------------------------|-------------|------------|------------|------------|
| 6400 Training          |             |            |            |            |
| 6401 CIC               | \$2,000.00  | \$1,000.00 |            | \$1,000.00 |
| 6402 Classes           | \$3,500.00  | \$3,000.00 |            | \$500.00   |
| 6403 Confrences        | \$2,304.50  | \$2,500.00 |            | -\$195.50  |
| 6404 Trarget Solutions | \$2,500.00  | \$3,000.00 |            | -\$500.00  |
| Total Training 6400    | \$10,304.50 | \$9,500.00 | \$9,500.00 | \$804.50   |

|                                 |            |            |            |           |
|---------------------------------|------------|------------|------------|-----------|
| 6420 Travel and Transport       |            |            |            |           |
| 6421 Meals                      | \$1,275.00 | \$1,500.00 |            | -\$225.00 |
| 6422 Travel-Other               | \$1,000.00 | \$1,500.00 |            | -\$500.00 |
| Total Travel and Transport 6420 | \$2,275.00 | \$3,000.00 | \$3,000.00 | -\$725.00 |

|                     |            |            |            |            |
|---------------------|------------|------------|------------|------------|
| 6450 Uniforms       |            |            |            |            |
| 6451 Jobshirts      | \$1,200.00 | \$1,000.00 |            | \$200.00   |
| 6452 Tee Shirts     | \$2,200.00 | \$1,500.00 |            | \$700.00   |
| 6453 Uniform Shirts | \$1,750.00 | \$1,000.00 |            | \$750.00   |
| Total Uniforms 6450 | \$5,150.00 | \$3,500.00 | \$3,500.00 | \$1,650.00 |

|                             |            |            |  |        |
|-----------------------------|------------|------------|--|--------|
| 6480 Utilities              |            |            |  |        |
| 6481 Cable, Internet, Phone | \$2,500.00 | \$2,500.00 |  | \$0.00 |
| 6482 Electric               | \$3,000.00 | \$3,000.00 |  | \$0.00 |



|      |                                    |              |              |              |               |
|------|------------------------------------|--------------|--------------|--------------|---------------|
| 6483 | Fuel Oil                           | \$5,500.00   | \$5,500.00   |              | \$0.00        |
| 6484 | Tablet/Cell Phone                  | \$100.00     | \$5,500.00   |              | -\$5,400.00   |
|      | Tablets                            | \$0.00       | \$0.00       |              | \$0.00        |
|      | Total Utilities 6480               | \$11,100.00  | \$16,500.00  | \$16,500.00  | -\$5,400.00   |
| 6500 | Vehicles                           |              |              |              |               |
| 6501 | 2651 Repairs                       | \$4,500.00   | \$8,500.00   |              | -\$4,000.00   |
| 6502 | 2652 Repairs                       | \$4,000.00   | \$6,500.00   |              | -\$2,500.00   |
| 6503 | 2653 Repairs                       | \$5,500.00   | \$6,500.00   |              | -\$1,000.00   |
| 6504 | 2654 Repairs                       | \$3,800.00   | \$8,500.00   |              | -\$4,700.00   |
| 6505 | Ambo Down Payment                  | \$30,000.00  | \$0.00       |              | \$30,000.00   |
| 6506 | Unexpected Repairs                 | \$5,500.00   | \$8,000.00   |              | -\$2,500.00   |
| 6507 | Vehicle Fuel                       | \$13,000.00  | \$25,000.00  |              | -\$12,000.00  |
| 6508 | Vehicle Repairs (EASV)             | \$750.00     | \$2,500.00   |              | -\$1,750.00   |
| 6509 | Vehicle Upfitting                  | \$2,500.00   | \$2,500.00   |              | \$0.00        |
| 6510 | Emergency Lighting                 | \$950.00     | \$2,000.00   |              | -\$1,050.00   |
|      | Total Vehicles 6500                | \$70,500.00  | \$70,000.00  | \$70,000.00  | \$500.00      |
| 6600 | Payroll / Labor Cost               |              |              |              |               |
| 6601 | VSI Insurance                      | \$7,500.00   | \$12,000.00  |              | -\$4,500.00   |
| 6602 | Payroll                            | \$378,000.00 | \$560,000.00 |              | -\$182,000.00 |
| 6603 | PFL/Disability Insurance           | \$3,000.00   | \$5,000.00   |              | -\$2,000.00   |
| 6604 | Employee Infurnace Fund (New 2025) | \$0.00       | \$20,000.00  |              | -\$20,000.00  |
| 6605 | NYSIF                              | \$12,768.00  | \$15,000.00  |              | -\$2,232.00   |
| 6606 | Workers Comp                       | \$26,000.00  | \$50,000.00  |              | -\$24,000.00  |
|      | Total Payroll / Labor Cost 6600    | \$427,268.00 | \$662,000.00 | \$662,000.00 | -\$234,732.00 |
|      | Total Expenditures                 | \$667,250.85 | \$967,110.00 | \$967,110.00 | -\$289,159.15 |
|      | Revenue                            | \$672,354.58 | \$975,500.00 |              |               |
|      | Over/Under                         | \$5,103.73   | \$8,390.00   |              |               |

Wm. J. O'Brien  
4-17-61

|                                                                               |                                                         |
|-------------------------------------------------------------------------------|---------------------------------------------------------|
| CERTIFICATE<br>OF<br>INCORPORATION                                            |                                                         |
| "FORT ANN RESCUE SQUAD, INC."                                                 |                                                         |
| Original:                                                                     | STATE OF NEW YORK<br>DEPARTMENT OF STATE<br>MAY 17 1961 |
| TAX                                                                           | 50                                                      |
| FILING FEE                                                                    | 50                                                      |
| By <i>W. J. O'Brien</i><br>Secretary of State                                 |                                                         |
| JOHN J. O'BRIEN<br>ATTORNEY AT LAW<br>1120 MAIN STREET<br>WHITEHALL, NEW YORK |                                                         |
| The Tuttle Law Firm, Publishers, Boston, Vt.                                  |                                                         |

RECEIVED

MAY 9 9 35 AM '61

LIBER OF  
PAGE 123 AND EXAMINED  
WASHINGTON COUNTY, N. Y.  
WILFRED E. PHILION,  
CO. CLERK

FILED

MAY 17 11 05 AM '61

LIBER OF  
PAGE 123 AND EXAMINED  
WASHINGTON COUNTY, N. Y.  
WILFRED E. PHILION,  
CO. CLERK

State of New York }  
Washington County Clerk's Office

I, LEON D. PUTNAM, Clerk of said County, and Clerk of the Supreme and  
County Courts, being Courts of Record held in and for said County, do hereby  
certify that I have compared the annexed copy  
Certificate of Incorporation

with the original and all the endorsements thereon remaining on file in this office,  
and that the same is a correct transcript therefrom, and the whole thereof.

In Testimony Whereof, I have hereunto set my hand and affixed the seal of  
said County and Courts, at Fort Edward, N. Y., this 4th day of  
June 19 81

Form 8

By *Leon D. Putnam* Clerk  
*James W. Remer* Dep. Clerk

CERTIFICATE OF INCORPORATION

of

FORT ANN RESCUE SQUAD, INC.

We, the undersigned, for the purpose of forming a membership corporation pursuant to the Membership Corporations Law of the State of New York, hereby certify:

FIRST: The name of the proposed Corporation shall be FORT ANN RESCUE SQUAD, INC.

SECOND: The purposes for which the said Corporation is to be formed are:

26491  
A. To acquire, equip and maintain an ambulance, and to provide free ambulance and first aid service.

C. To take, hold, invest and re-invest its funds for such purposes, to receive gifts and bequests of personal property, and gifts and devises of real property for the purpose of acquiring new equipment and the upkeep and expense of maintaining free ambulance and first aid service, and to hold, sell and administer the same, together with the proceeds thereof, for such purposes.

In furtherance of the objects and purposes herein, said corporation shall have and exercise all of the powers now or hereafter conferred by the laws of the State of New York upon corporations organized under the laws under which the said corporation is organized, and any and all acts amendatory thereof or supplemental thereto. The enumeration of the foregoing purposes shall not be held or construed to limit or restrict the powers of this corporation, and the corporation shall do all and anything necessary, suitable and proper for the accomplishment of the purposes or objects hereinabove enumerated.

THIRD: The corporation is not organized for pecuniary profits; it shall have no stock or stockholders and none of the

income or surplus assets of the corporation, if any, shall be distributed in dividends to members or for the personal profit of any individual or non-charitable institution or corporation.

FOURTH: The territory in which the operations of the corporation are principally to be conducted is the Town of Fort Ann, County of Washington, State of New York.

FIFTH: The principal office of the corporation shall be located in the Town of Fort Ann, County of Washington, State of New York.

SIXTH: The duration of said corporation shall be perpetual.

SEVENTH: The number of the directors shall not be less than five (5) or more than seven (7) and the exact number shall be fixed by the members from time to time.

EIGHTH: The names and residences of the directors until the first annual meeting are:

| <u>NAME</u>    | <u>RESIDENCE ADDRESS</u> |
|----------------|--------------------------|
| Ernest Granger | Fort Ann, New York       |
| Gary Hayes     | Fort Ann, New York       |
| Lifford Steves | Fort Ann, New York       |
| Donald Smith   | Fort Ann, New York       |
| Walter Rathbun | Fort Ann, New York       |

NINTH: That all of the subscribers to the certificate are of full age; that at least two-thirds of them are citizens of the United States; that at least one of them is a resident of the State of New York, and that of the persons named as directors, at least one of them is a citizen of the United States and a resident of the State of New York.



IN WITNESS WHEREOF, we have made and acknowledged this  
certificate this 28 day of March, 1961.

Ernest Granger  
Ernest Granger

Gary Hayes  
Gary Hayes

Lifford Steves  
Lifford Steves

Donald Smith  
Donald Smith

Walter Rathbun  
Walter Rathbun

STATE OF NEW YORK )  
COUNTY OF WASHINGTON: SS.  
TOWN OF FORT ANN )

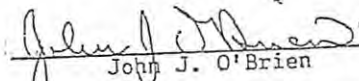
On the 28 day of March, 1961, before me personally  
appeared ERNEST GRANGER, GARY HAYES, LIFFORD STEVES, DONALD SMITH  
and WALTER RATHBUN, to me known and known to me to be the persons  
described in and who executed the foregoing certificate and they  
each severally acknowledged to me that they executed the same.

Lillian B. Allen  
Notary Public, State of New York

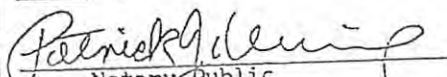
LILLIAN B. ALLEN  
Notary Public, State of New York  
Residing in Washington County  
Commission Expires March 23, 1963

STATE OF NEW YORK )  
COUNTY OF WASHINGTON ) SS.

JOHN J. O'BRIEN, being duly sworn, deposes and says that he is an attorney at law and has been retained for the purpose of securing the incorporation of the above-named FORT ANN RESCUE SQUAD, INC. pursuant to the Membership Corporations Law of the State of New York. No prior application has been made to any Court or judge thereof for the approval of the said corporation.

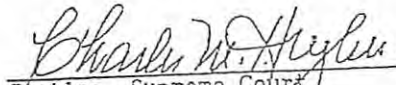
  
John J. O'Brien

Sworn to before me this  
31<sup>st</sup> day of March, 1961.

  
Notary Public

I, CHARLES M. HUGHES, a Justice of the Supreme Court of the Third Judicial Department, hereby approve the foregoing Certificate of Incorporation.

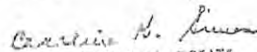
Dated: April 3<sup>rd</sup> 1961

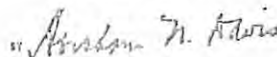
  
Justice, Supreme Court

STATE OF NEW YORK  
DEPARTMENT OF STATE  
A TRUE COPY OF THE ORIGINAL  
FILED IN THIS OFFICE ON

APR 19 1961

WITNESS MY HAND AND OFFICIAL  
SEAL OF THE DEPARTMENT OF  
STATE ON THE DATE ABOVEMENTI-  
TIONED

  
SECRETARY OF STATE

  
Abraham N. Harris



Fort Ann Rescue Squad Inc  
11287 State Route 149  
Po Box 237  
Fort Ann, NY 12827



# BY-LAWS

|             |                                                                                  |
|-------------|----------------------------------------------------------------------------------|
| Established | 1961                                                                             |
| Revised     | Sept 1961                                                                        |
| Revised     | March 2000                                                                       |
| Revised     | Dec 2005                                                                         |
| Re-Written  | April 2020                                                                       |
| Revised     | July 2022                                                                        |
| Revised     | March 2023                                                                       |
| Updated     | April 2023                                                                       |
| Updated     | June 2024                                                                        |
| Authors:    | Jane Griffiths<br>Robert Griffiths<br>Haley Noble<br>Thomas Noble<br>Regina Ladd |

# FORT ANN RESCUE SQUAD INC.

11287 State Route 149

PO Box 237

Fort Ann, NY 12827

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## **ARTICLE I - Name**

**Section 1:** The name of the corporation shall be, Fort Ann Rescue Squad, Inc. or "FARS" for abbreviation.

**Section 2:** Fort Ann Rescue Squad Inc. Shall be located at 11287 State Route 149, Fort Ann New York 12827.

## **ARTICLE II - Objective**

**Section 1:** The objective of this organization shall be: "Preservation of life through caring for our community". This corporation shall not be for pecuniary profit or financial gain, and no part of the corporation assets, income or revenues shall be distributed to, or be directed to the benefit of its members, directors or officers except to the extent permitted under the Not-for-Profit Corporation Law of the State of New York and the laws of the United States of America.

## **ARTICLE III - Purpose**

**Section 1:** The Fort Ann Rescue Squad Inc., will provide Emergency Medical service primarily as defined by its contractual relationship with the Town and Village of Fort Ann, and surrounding communities when requested as shown on a map now on file or subsequently revised and re-filed with the County of Washington and State of New York; and as may be amended from time to time.

**Section 2:** To provide a non-profit Emergency Medical service for individuals within the Village and Town of Fort Ann, and Mutual Aid districts as requested.

**Section 3:** To acquire and own, or lease, ambulance, emergency or rescue apparatus for use by the corporation and its members in pursuant of corporate tasks, for the protection of individuals within the Town and Village of Fort Ann and mutual aid districts as requested.

**Section 4:** To lease, purchase, mortgage or otherwise acquire or dispose of such real or personal property as may be necessary to the purpose of this corporation.

#### **ARTICLE IV – Board of Directors**

**Section 1:** The Executive Board of Directors of the corporation shall consist of eight (8) individuals namely, President, Vice President, Secretary, Treasurer, Four (4) elected Board members all holding one vote.

- a. Quorum of the Board Meeting to held shall be five (5) voting members of the Board of Directors
- b. When quorum is met, and the President is present at the Board Meeting, the Vice President does not hold a vote.
- c. If the President is not present at the Board Meeting, the Vice President shall be chairperson of the meeting and hold a vote.

**Section 2:** The Chief of FARS shall be present at all board of directors meeting, holding a voice but not vote.

#### **ARTICLE V – Corporate Profit**

**Section 1:** No part of any revenue received by the corporation shall inure to the individual benefit of any member, trustee, director, officer of the corporation, or any private individual (except that reasonable compensation may be paid for services rendered to or for the corporation), and no member, trustee, officer of the corporation, director, or any private individual shall be entitled to share in the distribution of any of the corporate assets on dissolution of the corporation.

#### **ARTICLE VI - Dissolution**

**Section 1:** In the event of dissolution of the corporation, all remaining assets and property of the corporation shall be disposed of in accordance with existing Federal, State, and local Statutes rules and regulations.

## **ARTICLE VII - Membership**

**Section 1: Qualifications of membership,** all members shall meet the requirements of this section.

a. Applicant must be 18 years of age by the date of the meeting during which his/her application for probationary membership will be considered and voted on.

b. Applicant must complete the current, written application for membership. The application is to be submitted to the Investigation Committee for review and then turned over to the Board of Directors within thirty days (30).

c. After reviewing the application and interview notes the Board of Directors must submit a recommendation to the membership at the next regular monthly meeting. A majority vote, by secret ballot, will be necessary to approve or deny an individual's application.

### **Section 2. Junior Membership-add**

A. To Qualify for Junior membership, he/she must be between the age of fifteen and eighteen years of age.

a. Consent form must be signed by legal guardian.

B. Junior members are required to complete eight (8) hours of squad duty a month.

a. Junior members must schedule duty, they are not allowed to just show up to the building without prior approval of the Chief or his designee. The exception to this rule will be if the Junior member is going to a call with a parent or legal guardian and is a member.

C. Junior members must obtain a valid CPR Card within 120 days of membership.

a. It is the responsibility of the junior member to keep a valid CPR Card.

D. Junior members shall be always in proper squad uniform while on duty.

- E. During Calendar school year junior members are not permitted to pull duty on a weekday after 9pm
  - a. Every Quarter during the calendar school year junior members are required to produce to the captain or his/ her designee a Report card.
    - i. If a junior member is falling below school minimum requirements a meeting will be held with the junior members legal guardian and the Junior member advisor to discuss membership status until passing grades can be obtained.
- F. Junior members will be required to attend at minimum four (4) monthly meetings each year.
  - a. If Junior members revert to their own bylaws reaching more than 5 members, they will hold their own meetings with the captain or his designee present following their by-laws.
  - b. If the Fort Ann Rescue Squad has more than five (5) junior members, the Junior members will revert to the Junior By-Laws Set Forth by the Bylaw Committee and approved by the BOD and the membership.
  - c. A Juniors Captain will be elected from within the junior ranks who will then in return be the point of contact to the Junior member advisor.

**Section 3. Probationary Period:** All Members must complete their probationary period listed below, before full membership can be voted upon.

- A. The probationary period begins the day after acceptance into FARS and will continue for a period of six months.
  - a. Probationary member(s) will be re-evaluated every 30 days up to the first three months by the Board of Directors, with a recommendation each month to the Membership.
    - i. After each recommendation of the probationary period the membership guided by a recommendation from the board of directors will vote to either proceed the probationary member to the next 30 days or to end the Probationary member(s) membership.
- B. A new member who has not attained certification as an on-line Agency provider, (EVO or EMS) will be classified as an Ambulance Attendant

- C. Probationary members will be assigned a change to Field Training Officer (FTO).
- D. A review by the Board of Directors is required and a recommendation will be made to determine membership status at the end of member's probationary period. The Board of Directors has the authority to set review period and make recommendations to the membership concerning extensions or shortenings of the probationary period as outlined in Article 10, Section 3.
  - a. Probationary members may not hold but will be allowed to vote for any elected position. Change to: Probationary Members may not hold an elected position unless voted upon by the membership with a 2/3 vote of present quorum if no one else is interested or qualified for said position. Probationary members if elected to a position then hold a vote. Probationary members do not hold a vote on elected positions until they have surpassed their first 90 days.
  - b. Any probationary member, who resigns in good standing, may request reinstatement by the membership within one year (12 Months) of resignation.

**Section 3. Types of Membership** All members will be assigned by the Chief one of these positions listed below once probationary period has ended. Except for Ancillary membership which is determined only by the chief(s)

- a. Emergency Vehicle Operator (EVO)
- b. Emergency Medical Service Provider (EMT, AEMT, CCT, Paramedic)
- c. Attendant (Observer)
- d. Life Member (Active or Inactive)
- e. Ancillary Member
- f. Administrative
- g. Junior Member

**Section 4: Emergency Vehicle Operator:** Must be 18 Years of age and hold a valid NYS Driver's License. Must be cleared to drive by the Chief or change to his/her designee of FARS, Emergency Vehicle Operator course recommended. Shall not have had a DWI or DWAI Conviction within the last 5 years. He/she must have the



approval to drive by either the Agency's insurance carrier or the Chief. He or she shall have a valid CPR Qualification.

**Section 5: EMS Provider:** - He/She must maintain EMS certification to maintain EMS provider status. All online providers are subject to Chiefs approval.

**Section 6: Attendant:** Must be 18 Years of age and possess a valid CPR Qualification. Can ride the ambulance as a third but cannot complete a duty crew. Not able to drive an ambulance.

**Section 7: Life Member:** After ten (10) years of accrued service, except for an approved personal leave, a member may apply for Life Member status. The personal leave will be subtracted from said member's years of service. A member granted this status may be carried on the membership roster until his/her death or resignation. He/she must have met the requirements of membership needed to remain in good standing during the previous calendar year prior to submitting his/her written request for status change, unless that member has suffered a disability which has kept him/her from performing (said) duties. Life members will also be granted the same privileges as active members. Life Member status must be voted on by the membership and accepted by a simple majority vote.

- a. Active Life: Active Life members have all the same privileges as an active member.
- b. Inactive Life: Inactive life member have no vote and are not allowed to ride the ambulance but may attend meetings.
- c. Life members may go inactive at any time with a written letter to either the President or the Chief with final approval.
- d. Life members may become active only with the approval of the Chief or President or Board of Directors.
- e. Life members must be active for ninety (90) days to hold a vote.
- f. Active Life members shall meet duty requirements to hold a line officers' position.

## **Section 8: Ancillary Membership:**

A. This type of membership does not require a membership vote or a probationary period. These members are not required to meet the agency duty requirements.

- a. Ancillary members are required to meet the requirements of the Ancillary SOP set forth each year by the captains.

**Section 9: Administrative Membership:** This type of membership is for Executive positions only. Administrative members may not be Ancillary members but are still required to hold a valid CPR card. Administrative members may ride the ambulance as observers only.

## **Article VIII – Membership Requirements**

**Section 1: EVO/EMS Provider:** Members must meet the following requirements during each calendar year to retain active membership and remain in good standing

- a. No suspensions within the previous 12 months.
- b. Must perform a minimum of twelve (12) scheduled duty hours per month, or a minimum of one hundred and forty-four (144) total hours per year.
- c. The required twelve (12) will be evaluated monthly
- d. Members must attend six (6) meetings annually to be able to run for office and vote
- e. All excusals must be approved by the President or his/her designee
- f. All excusals must be in writing to include one of the following: paper copy, text message printed and put in member file, email printed and put in member file Add in d, e, and f
- g. Legal excuses include work, vacation, illness or family illness.
- h. Zoom meeting will count for only 50% of meeting total. While on Zoom if at another agency must be alone in the room and be wearing earbuds for the duration of the meeting. Someone must sign the member on the sign in sheet.

**Section 2: Attendants:** Observers must meet the following requirements during each calendar year to remain in good standing.

- a. Must perform a minimum of change to twelve (12) scheduled duty hours per month, or a minimum of change to one hundred and forty-four (144) total hours per year
- b. The required ninety-six (96) change to twelve hours (12) will be evaluated monthly
- c. No suspensions within the previous 12 months.

**Section 3: Member in good standing to be defined as:**

- a. No suspension in previous 12 months
- b. Maintain duty requirements
- c. Duty Requirements will be evaluated monthly. If not met the following will occur
  - a. First offense: Documented Verbal Counseling
  - b. Second offense: Documented Verbal warning
  - c. Third Offense: Documented written warning
  - d. Fourth Offense: Suspension with Board Review, with possible disciplinary action
  - e. Fifth Offense Membership Review with Possible Termination
- d. Members that have been unable to schedule duty and are now considered "not in good standing", will have the opportunity to return to the status of "member in good standing" by the following criteria:
  - a. Schedule the duty hours missed immediately following the last unscheduled month. The total # of duty hours owed must be completed within 30 days immediately following the last unscheduled month. The captain will review and confirm said duty was scheduled and completed.
- e. A letter will then be put in the members personnel file stating return to good standing. This status change will be allowed one time only per calendar year.

## **Article IX - Training**

**Section 1:** Any member attending training courses that requires funding must be pre-approved by the BOD up to \$1,600.0, anything requiring more shall go to membership for approval. Said member will enter into a contract for training (see Appendix After successfully completing a training course, the member shall provide the Training Officer with a copy of any certificate presented to the member after completing the course. The Training Officer shall keep an updated, written record of training of each member including, but not limited to: First Aid, CPR, Certified First Responder, EMT, AEMT, and instructor ratings. All records for Members must be maintained by the training officer and if the member does not comply with all paperwork, the training officer shall seek assistance from the Chief to prevent the member from participating in patient care.

**Section 2:** Outside training will not count as a squad drill, unless it is pre-approved by the Captain\Training Officer.

## **Article X - Voting**

**Section 1:** Only active member in good standing shall vote in elections for offices or regular meeting.

**Section 2:** During an election of an officer where there are more than three (3) nominees to be voted on, a run-off will occur between the top two (2) nominees. If one candidate has majority vote of all votes cast, run off is not required.

**Section 3:** Probationary members must be past their 90-day period to able to vote.

**Section 4:** Inactive life members are not able to vote.

**Section 5:** Active life members can vote but must be active for 90 days prior to the annual elections.

## ARTICLE XI

### Officers and Their Selection

**Section 1.** The elected executive administrative officers shall consist of: President, Vice President, Secretary, and Treasurer.

**Section 2.** The elected line of operational officers shall consist of: Chief, Deputy Chief, Captain, Lieutenant

**Section 3.** The elected BOD officers shall consist of four (4) at-large members of the Board of Directors along with the Chief and President.

**Section 4.** The term of each executive and line office, except for the office of Chief, President and Board of Director shall be for one (1) year from the date of the Annual meeting. The offices of Chief and President will be for two (2) years from the date of the Annual meeting. Elections for the President and Chief will be on alternating years. The offices of the At-large members of the Board of Director shall be for three (3) years from the date of the Annual Meeting on a rotational basis. In the event of failure to fill an office at the Annual Meeting, the current officer shall remain in office until his/her successor is chosen. A vacancy in any office may be filled by election at any regular meeting. That officer shall serve in that office until the expiration of the term.

**Section 5.** All contested offices shall be filled by paper ballot by a majority vote of members present. Election of line officers shall precede the election of executive officers. Uncontested officers may be filled by an on (1) vote ballot cast by the secretary upon closing of the office nomination.

**Section 6.** Installation of officers: Each officer, either newly elected or re-elected, shall assume the duties of his/her office immediately following the election meeting. Any officer who is not re-elected shall turn in all equipment specific to that position after the close of that meeting or within seven (7) days after the election

Vehicle mounted equipment may be professionally removed but must be scheduled within 7 days of change over.



**Section 7.** Any officer, line or executive who is unable to retain his/her “good standing” status will be removed from their position by the BOD immediately and will be ineligible to run for office at the next election. (see article 8, Section 4). If the vacated position is an elected position, that position will be filled by simple majority vote at the next meeting per Article 12. Appointed positions will be re-appointed after consideration by the administrative CEO or Chief at their discretion.

**Section 8.** If a line, appointed, or administrative officer goes out on a leave of absence for more than to thirty (30) days, they must resign from their current position the day said leave starts. The exception to this will be a medical leave that will be no longer than 3 months in length. A Doctors note must be presented to the Chief or President regarding said leave, stating the length of the leave and any restrictions during the leave or upon returning to active status.

Any officer that goes on leave and must resign their position, will be eligible to run for office at the next election as long as they remain in good standing per (Article 8, section 4) also reference (Article 9 section 7)

## **ARTICLE XII**

### **Duties and Powers of the Board of Directors**

**Section 1.** Review contractual agreements.

**Section 2.** Investigate applications for membership if an Investigation Committee is not present.

**Section 3.** Review probationary membership(s). At the end of the probationary term the Board of Directors will make a recommendation to the membership concerning the status of the member. The Board may also set review periods during the probationary period (including meeting with the probationary member). Recommendations for the extensions, expulsions (dismissal) or early termination of the probationary period before the end of six months are also within the prevue of the Board.

**Section 4.** Review applications for Life Membership and make recommendations to the membership.

**Section 5.** Review individual membership records in November to determine which members (if any) have failed to meet the requirements for active membership. Members in this category will be contacted by the President. A recommendation will be made to the membership, at the next available meeting

**Section 6.** On a quarterly basis, investigate those members who (after having been identified by the Chief) fail to meet the qualifications of "EVO" or "EMS Provider". A recommendation will be made to the membership at the next available meeting.

**Section 7.** Present to the membership, at regular meetings prior to the November regular meeting, a list of those candidates who are willing and qualified to run for elected office positions.

**Section 8.** The senior member, with the most consecutive years of service, as a Board member, out of the three (4) at Large Board of Director members will preside at any meeting for which the President or Vice President are unavailable.

**Section 9.** Provide one member to sit on any appeal hearing in accordance with the disciplinary process.

**Section 10.** Investigate any member who has been identified as a possible candidate for expulsion. A recommendation will then be made to the membership at the next regular or special meeting.

**Section 11.** The Board of Directors is responsible for review of all Administrative policies and guidelines with the final approval by the membership.

**Section 12.** The Board of Directors shall have the power to approve any expense up to (\$500.00) within the approved yearly budget. Any expense above 500 dollars (\$500.00) shall be reviewed by the Board of Directors and shall require approval of the membership except for operational medical supplies and equipment which shall be capped at one thousand dollars (\$1,000.00).

**Section 13.** It is the duty of the Board of Directors to safeguard all property's building and grounds and keep them in working order.

## ARTICLE XIII

### Duties and Powers of Officers

**Section 1. President/Chief Executive Officer (CEO):** The President shall guide the membership in the enforcement of all by-laws, rules, regulations and Administrative SOG's. It is his/her responsibility to oversee all administrative and fiscal operations of the organization. Unless otherwise provided, he/she shall appoint all committees, and positions as defined in the bylaws. The President shall be an ex-officio member of all committees. He/She is responsible for the discharge of the duties of the executive officers. He/She shall be responsible for all building, grounds and all property real or personal of the Rescue Squad.

**Section 2. Vice President:** The Vice President shall assist the President in the discharge of his/her duties of office. In the absence of the President, the Vice President shall assume the duties of the President.

**Section 3. Secretary:** It shall be the duty of the secretary to keep record of attendance and proceedings of all meetings of the squad and its Board of Directors. He/She shall also keep all books, records and correspondence pertaining to the office in accordance with the administrative policy.

**A. Assistant Secretary:** It shall be the duty of the Assistant Secretary to keep a record of attendance and proceedings of all meetings of the squad and its Board of Directors in the absence of the secretary.

- a. This position is filled at the annual elections but may be left open if the membership feels the position is not needed at the time
- b. This position only holds a vote in the absence of the secretary.

**Section 4. Treasurer:** It shall be the duty of the Treasurer to see to the day to day paying of squad bills and accounting records. The treasurer and either the president or Vice President will co-sign all checks from the general account. The treasurer will be responsible for the recording of all squad funds. All functions will be in accordance with the administrative policy.

- a. All duty's listed above shall be the responsibility of the treasurer unless outside parties are not contracted to pay bills and file reports on agency's behalf.

**Section 5. Chief/Chief of Operations (COO):** The (Chief) shall oversee all operational activities, equipment and oversee both the elected and appointed operational officers ensuring they are performing their assigned duties. It shall be his/her duty as Chief Line Officer of the Squad to ensure attendance at all county-based EMS meetings. The Chief shall also be responsible for the distribution and initiation of all operational guidelines. In developing these directives, the Chief shall have the option of utilizing a committee of his/her designation. The Chief shall further be responsible for ensuring that an adequate supply of necessary equipment is always available. The equipment, always, shall be appropriate, duly maintained and functional. All squad vehicles should constantly be kept in proper operating order. The Chief at the first regular meeting following the Annual Meeting shall appoint an

- ALS Coordinator
- BLS Coordinator
- Vehicle Supervisor
- Training officer
- Narcotics Officer
- Assistant Narcotics Officer
- Health and Safety Officer
- Paid Staff Supervisor (Possibly Two)
- Transport Supervisor
- Operational Captain
- Operational Lieutenant
- Operational (Paid Staff Captain & Lieutenant)



- a. The Chief can appoint a Volunteer or Paid Staff to oversee said appointed positions listed above. The Chief can delegate said tasks as needed to line officers if needed.
- b. See Section 12 Of this Article for proper appointment of Operational Lieutenant and Captains by the Chief
- c. It is the responsibility of the Chief to attend required REMAC meetings and report any information as needed to the REMAC Board. It is the responsibility of the Chief to attend required SEMAC, REMAC, County, and any other meeting where our medical director asks/requires

**Section 6. Deputy Chief:** The Deputy Chief will perform all duties assigned by the Chief and shall perform all duties of the Chief in his/her absence. The Deputy Chief is required to attend all meetings that the Chief is required to attend and should understand his/her commitment to his/her position

**Section 7. Captain & Lieutenant:** It shall be the duty of the Captain & Lieutenant to perform all duties assigned by the Chief. The Captain & Lieutenant are required to attend a monthly meeting of the Operational Officers

**Section 8. ALS Coordinator:** It shall be the ALS Coordinators main function, under the direction of the Chief to see that the Squad adheres to all QA/QI policies as directed by the REMAC and Regional Council. He/she will report any deficiencies to the Chief for further actions/training. In addition, the ALS Coordinator shall perform all duties as assigned by the Chief. It is the responsibility of the ALS Coordinator if assigned by the captain to keep a working order of all ALS Supplies, and keep record of all.

**Section 9: BLS Coordinator:** The BLS Coordinator, under the direction of the Chief, shall assist the ALS Coordinator in the performance of his/her duties and oversee that BLS QI is complete. He/she will report any deficiencies to the ALS Coordinator and Chief for further action/training. In addition, the BLS Coordinator shall perform all duties as assigned by the chief. It is the responsibility of the BLS Coordinator if assigned by the chief to keep a working order of all BLS Supplies and keep a record of all.

**Section 10. Health and Safety Officer: (as outlined in new DOH Policy Statement 13-02)** He/She, under the direction of the Chief and President shall oversee the



development of a health and safety program. His/her responsibility may include but not be limited to:

A. Advocate for safe practices and procedures to better protect providers, patients and the public. He/she shall be accountable for keeping abreast of safety issues and trends involving safety and wellness.

B. Stay current with regulatory standards that apply to EMS. They should be well versed with infection control practices and knowledgeable on the hazards of disease and illness. He/she should provide information about workplace hazards and update members on what protective practices and equipment are available to reduce incidents from occurring.

C. the Health and Safety Officer shall investigate any accident, injury or near miss and provide a written report of the findings to the Chief and President so appropriate paperwork can be filed and submitted to insurance carriers, etc.

D. Shall report any incidents, i.e. medical equipment malfunction, vehicle crashes with serious injuries, etc. to the Chief

E. Responsible for following all other guidelines as set forth by DOH Policy Statement 13-02 In order to hold any appointed/elected position, members who are qualified, must be at a minimum an on-line EMT with this agency. If for any reason he/she loses their certification, he/she shall be removed immediately from that position.

**SECTION 11: Narcotics Officer** – The Narcotic's officer will keep an accurate and up to date inventory of all narcotics within sub stock of the Fort Ann Rescue Squad. All SOPS pertaining to Narcotics will be strictly enforced by the Narcotics officer. The Narcotics officer every month will do a monthly inventory of all sub stock. If any deficiencies are found, they are to be reported immediately to the Captain. The Narcotics officer will complete and turn over all NYS required Narcotics reports annually or semiannually. All Records will be kept up to date and in the Officers office at all times, unless permission to remove is granted by the Chief.

**Section 12: Appointment of Officers by Chief-** The Chief of the Fort Ann Rescue Squad may appoint two officers from the ranks of Paid Staff to fill a Captains Position and a Lieutenants Position as needed.

- a. At the First Operational Officers' meeting following the annual meeting, the Chief may make a recommendation to the elected officers for the appointment of one (1) Captain & one (1) lieutenant.
- b. All Elected Operational Line Officers and the President shall cast a vote, there must be a majority vote of those present for each recommended appointment for it to pass.
- c. Paid staff providers holding a Captain or Lieutenants position, will said position for the remainder of the Chiefs term.
  - I. The Chief may remove the Paid Staff provider from the appointed position with a majority vote of the elected line officers and the President.
- d. If a new Chief is elected at the annual meeting, any appointed position will be vacated until a new appointment can be made.
- e. The Paid Staff Operational Position (Captain or Lieutenant) does not have to be filled, and if the Chief chooses, he may leave one or both empty.
- f. The chief may assign Leadership or Position related assignments to Paid Staff Officers that must be completed within the first month of appointment.
  - II. Previous leadership or position related knowledge may count and replace required classes with the Chiefs Approval

## **ARTICLE XIV**

### **Qualifications for Becoming an Elected Officer.**

**Section 1: President:** Must have twelve Months of continuous membership occurring immediately before the date of this election and a member in good standing. Must complete an approved Leadership Course as outlined in Section 12 Add

**Section 2: Vice President:** Must have twelve Months of continuous membership occurring immediately before the date of this election and a member in good standing. Must complete an approved Leadership Course as outlined in section 12 Add

**Section 3: Secretary:** Must have twelve Months of continuous membership occurring immediately before the date of this election and a member in good standing.

**Section 4: Treasurer:** must have twelve months of continuous membership occurring immediately before the date of this election and a member in good standing. Must be willing to become proficient in the financial program currently in use by the Fort Ann Rescue Squad.

**Section 5: BOD:** must have six months of continuous membership occurring immediately before the date of this election, and a member in good standing.

#### **Section 6: Chief**

- A. must have to 36 Months of continuous membership occurring immediately before the date of this election, a member in good standing.
- B. maintain current Cardiopulmonary Resuscitation (CPR) and current Emergency Medical Technician (EMT) certification.
- C. He/she must be at a minimum, an online EMT with this agency and have held a Deputy Chief position at Fort Ann Rescue Squad for a minimum of 12months.
- D. Chief must have completed an approved Leadership Course as outlined in section 12
  - a. Chief must take an additional 4 hours of Leadership courses during term.
- E. Chief must have completed an approved Public Affairs Course as outlined in section 12
  - a. Chief shall annually during his term take an additional six hours of approved course that deals with public relations/finances during term.

#### **Section 7: Deputy Chief**

- A. **Deputy Chief** must have twelve months of continuous membership occurring immediately before the date of this election, and member in good standing. Must have twenty-four (24) months

- a. Maintain current Cardiopulmonary Resuscitation (CPR) and current Emergency Medical Technician (EMT) certification.
  - b. He/she must be at a minimum, and on-line EMT with this agency and have held a Lieutenant position at Fort Ann Rescue Squad for a minimum of 24 months
  - c. Must take an approved leadership course as outlined in section 12
  - d. Must have taken an three additional hours of public relations course while in office
  - e. Assistant Captain shall annually during his/her term take an additional six hours of approved course that deals with public relations/finances during term.
- B. **Captain** Must have twelve months of continuous membership occurring immediately before the date of this election, and a member in good standings.
- a. Maintain a current cardiopulmonary Resuscitation (CPR) and current Emergency Medical Technician (EMT) Certification.
  - b. He/she must be at a minimum, and on-line EMT with this agency and have held a Lieutenant position at Fort Ann Rescue Squad for a minimum of 24 Months
  - c. Must take during office an approved Leadership Course as outlined in Section 12.

#### **Section 8: Lieutenant**

- a. Must have 12 months of continuous membership occurring immediately before the date of this election, a member in good standing.
- b. maintain current Cardiopulmonary Resuscitation (CPR) and current Emergency Medical Technician (EMT) certification.
- c. He/she must be at a minimum have an Emergency Medical Technician (EMT) certification for a minimum 12 months prior to the date of this election and online EMT with this agency.

**Section 9:** In the Absence of any qualified members meeting time requirements for sections 1-7, any member nominated by membership at large may fill a position.

- a. Member(s) wishing to be nominated for line officers' positions under this article and section must have a Valid CPR and EMT Card, and or meet all guidelines pertaining to regional standards.

**Section 10:** Any member holding an Administrative Office shall not hold a Line Office and vice versa. Members holding seats on the Board of Directors will not hold another Administrative or Line Office and vice versa, except for the President and Captain, who are members of the Board of Directors.

- a. If no qualified members available to hold an Executive or Operational Position, then a member may hold two positions of the Administrative or Operational sides.

**Section 11:** Persons Holding Administrative or Line Officer may only hold multiple positions if approved by the membership at a regular or special meeting with a 2/3rds vote thus negating section 9 of this article

**Section 12:** Approved Courses are listed below. Courses are subject to the Training Officers approval if board deemed such if courses are outside Sections listed below.

- a. State, or CIC taught Courses.-BOD approved
- b. Military
- c. Private where Certification if given.
- d. Vector Solutions Courses

## **ARTICLE XV**

### **Meetings and Committees**

**Section 1:** The annual meeting shall be held on Sunday, the second week in December of each year

**Section 2.** All regular monthly and BOD meetings shall be held on the first Sunday of each month in the Fort Ann Rescue Squad, Inc. meeting room, Town of Fort Ann, unless otherwise specified by the President.

**Section 3.** The election of officers shall be held at the Annual Meeting.



- A. At least one month prior to the annual meeting a list of members who are eligible to run for each office will be presented to the BOD, then to the membership at the monthly meeting.

**Section 5.** When a regular meeting falls on a holiday, said meeting shall be held on the same day of the following week.

**Section 6:** All offices shall take effect January 1 of the near year following the annual elections of officers

- a. Unless meeting has been moved due to holiday or situation outside of our control, then effective date shall take effect the following week of the annual election.

#### **Section 7: Nominations Committee**

- A. A nominations committee shall be formed at the regular meeting in October.
- B. The Chief, President or his/her designee, and one member at large will constitute the Nominations Committee.
  - a. It is the responsibility of the committee to generate a list of all qualified persons to hold office for the Fort Ann Rescue Squad
  - b. It is the responsibility of the committee to verify qualifications of Operational and Executive positions.
- C. Once a list of qualified persons is generated all qualified persons will be contacted and given a chance to self-nominate
  - a. Once all members have been called and the listed posted, members shall not self-nominate
- D. The Nominations list once presented at the next regular meeting shall be posted till the annual elections.

**Section 8.** Six members shall constitute a quorum for all special and regular meetings.

**Section 9.** Special meetings shall be subject to the call of the Any member may make a request for a special meeting to the President or his/her designee Notice of the meeting must be emailed as soon as possible prior to the date of said special

meeting. The notice shall state for what purpose the meeting is being called, and no other business shall be transacted there at.

**Section 10.** A standing Auditing Committee and an Investigative Committee shall be appointed by the President during the first meeting after the Annual Meeting.

**Section 11.** The Chief shall appoint a Continuous Quality Improvement Committee during the first meeting following the December Meeting to review and maintain both Basic Life Support (BLS) and Advanced Life Support (ALS) records.

**Section 12.** Meetings will be conducted according to Parliamentary Procedures and Roberts Rules of Order. The following is the standing meeting agenda:

- 1) Roll Call
- 2) Pledge of Allegiance
- 3) Nomination of Candidates for Membership
  - a. Applications (read only)
- 4) New Members/Resignations
  - a. Probationary Members
- 5) Swearing in of probationary members
- 6) Reading of Previous months minutes
- 7) Resignations
  - a. Resignations
  - b. Fillings of vacancies
- 8) Reports of Officers
  - a. Captain
  - b. 1<sup>st</sup> Assistant Captain
  - c. 2<sup>nd</sup> Assistant Captain
  - d. 1<sup>st</sup> Lieutenant
  - e. 2<sup>nd</sup> Lieutenant
  - f. President
  - g. Vice President
  - h. Directors
  - i. Quartermaster/Special Committees
  - j. Auxiliary
- 9) Treasurer
  - a. Accepting of Treasures Report
- 10) Reading of Communications
- 11) Unfinished Business

- 12) New Business
- 13) Good and Welfare/Sickness and Death
- 14) Elections of Officers

## **ARTICLE XVI**

### **Resignations, Disciplinary Action, and Expulsions**

#### **Section 1. Resignations:**

- A. Any member who wishes to resign from the Squad shall give written notice to the Chief or President. Said resignation will then be held for 7 days. If after 7 days said member still wishes to resign and has not contacted the President or Chief, said resignation will then take effect immediately and all squad equipment shall be turned in immediately. Any member in good standing, who has resigned and returns within one year from the date of resignation, will not be required to repeat a probationary period. This reinstatement is contingent upon a simple majority vote of the membership.
- B. If member resigns while in bad standings, member will not be eligible to reapply for membership for at minimum 12 months.
  - a. If member resigned in bad standings and is given membership status back, member is subject to the board of directors for possible extended probationary period or other stipulations as seen fit.

**Section 2.** The following behavior on the part of any member shall be grounds for immediate suspension by an elected officer.

- a. Refusal to obey a direct order given by an elected officer, either while on an emergency run, or while performing duties as a member of the Squad.
- b. Being under the influence of any intoxicating drug or alcohol while on duty or an active call.
- c. Any action or spoken word that would bring embarrassment or have the squad viewed in a negative manner.

**Section 3.** The following behavior on the part of any member may be considered grounds for disciplinary action, suspension, or expulsion.

- a. Gross Misconduct or behavior on the part of any member that may have a deleterious effect on any member of the squad.
- b. Repeated violations of basic Squad practices, procedures or violation of protocols.
- c. Gross Misconduct to be defined as follows:

Misconduct means dereliction of duty or unlawful or improper behavior. Conduct is gross misconduct if it is so outrageous that it shocks the conscience. Gross misconduct refers to behavior that can cause a person to be dismissed immediately from work because it is serious enough and possibly criminal. (Illegal drug use at work, being drunk while on duty, stealing, sexual harassment are all examples of gross misconduct.) Intentional behavior is needed to support a finding of gross misconduct. An act which deliberately or willfully threatens the employer's rules, or shows a repeated disregard for the employee's obligations to the employer or disregards the standard of behavior which an employer has a right to expect of its employee", constitutes gross misconduct.

**Section 4.** The following will serve as progressive disciplinary action plan:

1. The first infraction will consist of a verbal warning with documentation in said member's personnel file for a period of 6 months. If any additional infractions occur during these 6 months, the next step of the disciplinary process will occur.

2. The second infraction will consist of a written warning with documentation in said member's personnel file
3. The third infraction will consist of suspension with documentation in said members personnel file. This suspension will remain in said members personnel file for a period of five years. This documentation may be reviewed and used as evidence of a prior infraction within that five-year time frame only.
4. The fourth infraction will consist of possible recommendation to the Board of Directors and membership for immediate expulsion.
5. Steps 1-4 may be skipped if conduct is severe enough to meet qualifications of sections three of this article.

**Section 5.** Disciplinary action shall be the responsibility of an elected officer.

A member found to be in violation of any of the above designations can be suspended from Squad operations and functions by an elected officer for a period not to exceed thirty (30) days. All allegations against a squad member will be presented to the Chief, President or Board of Directors in writing, no later than ten (10) days after the occurrence. After ten (10) days, no action can be taken. Said member will be notified in writing, by the Chief, President within said ten (10) days of such. The Chief, President must investigate all charges and present them to the Board of Directors within thirty (30) days. Written charges shall be provided to the alleged offender by the elected officer at least five (5) days prior to the regular meeting of the Board of Directors, at which meeting the matter shall be considered and a recommendation made. Once the steps above have been followed a recommendation will be made to the Board of Directors. At such time the Board of Directors will make a final Decision based off the president or chief's recommendation. Any personnel decisions being made shall be done in executive session.

**Section 6.** Any member receiving disciplinary action may appeal in writing, to the Board of Directors within thirty (30) days from the time of the disciplinary action. An appeal hearing will be convened within ten (10) days of notice of appeal.

**A. Members of the Appeal Board shall be:**



1. One-line officer other than the elected officer imposing said suspension.
2. One of the following Executive Committee: President, Vice President, Secretary, Treasurer
3. Any three (3) randomly selected non-probationary members who are willing to serve these members will be chosen by the president, unless said president imposed the suspension. At that time the Chief or next senior officer will choose said members. A simple majority of these five (5) will determine the issue. The standard will be whether the action taken was reasonable. Failure of the hearing panel to meet within fourteen (14) days will result in the dismissal of these charges. The defending Squad member may choose a representative of his/her choice for the appeal process.

## **Section 7.**

### **A. Appeals Board Criteria**

You have been asked to act as a representative of the Appeals Board for the Fort Ann Rescue Squad, Inc, concerning the disciplinary action taken by an elected officer against one of our members in accordance with the by-laws of the Fort Ann Rescue Squad, Inc. (Article 14, Section 5) As a representative you are being tasked with deciding if the suspension given by the elected officer was:

1. Justified or unjustified, given the evidence presented to you
2. Was the disciplinary action reasonable, given the evidence presented to you
3. Was the length of the disciplinary action reasonable, given the evidence presented to you
4. If the length of the disciplinary action was not reasonable, you will by simple majority be allowed to change the length of said action.
5. Your decision will be final.

### **B. Appeals Board Agenda**

The agenda for the meeting will be as follows:

1. The list of charges will be read by the President/Captain/his/her designee.

2. The elected officer imposing the disciplinary action will present his/her case.
3. Charged member will present his/her case
4. Any witnesses or additional documentation will be presented and/or interviewed
5. The Appeals Board will deliberate, and a decision will be made concerning the disciplinary action based on the appeals board criteria.

### **C. Appeals Board Disposition**

#### **Criteria**

1. Was the disciplinary action justified (yes or no), if yes proceed to step (2) if no, action will be erased from accused file
2. Was the length of disciplinary action reasonable (yes or no), if yes action stands. If no, the committee has the option to shorten said action not to exceed 30 days from the date of suspension.
3. A decision will be given to the accused and the initiator of the charges within 24 hours.
4. A written documentation will be completed by the Appeals Board and given to the President and Chief within 5 days. The recording of the meeting will be transferred to an electronic recording media and placed in the safe for a period of 5 years. If the member charged has any disciplinary action placed against them within that 5 year period, the recording of this Appeals Board may be used as evidence of a prior action/hearing. If no further incidents take place, the CD will be destroyed after 5 years.

### **Section 8: Impeachment**

- A. Any member holding Operational or Executive Positions may be impeached from their position for abuse of authority or misconduct in office.
  - a. Abuse of authority or misconduct shall constitute.
    - i. Actions that grossly affect the integrity of the Agency
    - ii. Actions that affect the safety of member(s)
    - iii. Actions that grossly effect the moral of the agency
    - iv. Actions that give personal gain to oneself
    - v. Mutiny
      - 1. Defined as:
        - a. Refusing orders given from superiors
        - b. Open Rebellion for personal gain or advancement within the agency.
- B. Recommendation must be made to the Board of Directors in writing, and a 2/3<sup>rd</sup> vote of the Board of Directors is needed to bring the impeachment article to the membership with findings.
  - a. If 2/3<sup>rd</sup> vote is a yes, two members of the Board of Directors must investigate and present findings to the membership at the next monthly meeting.
  - b. Member accused will have the right to present their case to the BOD Prior to the findings being presented to the membership
    - i. The captain shall be one of the members at large if the article doesn't pertain to his position. If the Captain position is the one in question the President is the one main member at large.
- C. At the next regular schedule monthly meeting the Board of Directors will present the findings, and the membership must vote by secret ballot on the article of impeachment
  - a. 2/3<sup>rd</sup> vote of membership present is needed to pass.
  - b. A special meeting may be held if the next regular monthly meeting is more then 15 days so as to not affect the operations of the agency.
  - c. Impeachments that are founded cannot be appealed.

- d. If impeached, said officer will not be eligible to run for any office for a period of at minimum 18 months.

## ARTICLE XVII

### Leave of Absence Section

1. A leave of absence from the Squad shall be granted under the following categories:

1. Medical Leave
2. Military Leave
3. Personal Leave
4. Academic Leave Section

**2. Medical leave** shall be granted to members until said member can return to active duty or said member is permanently disabled. If at the time of permanent disability, the member is in good standing, the Board of Directors will recommend the membership vote to approve or deny granting the member Life Membership status by a simple majority vote by secret ballot. Any member requesting medical leave must provide a doctor's note at the beginning and end of their medical leave to include a note clearing them to return to full duty. There will be no limited duty or light duty status available to any members for example being a third crew

member or having a lifting restriction. A member on medical leave shall remain in their current status (member in good standing or member not in good standing) until such time they return to active duty or a change of status. All accrued time will be on hold during medical leave. The Board of Directors must be notified of the leave of absence in writing to include e-mail, typed or handwritten letter

**Section 3. Military leave** will be granted to all Active, Reserve and National Guard members according to Federal Law. The Board of Directors must be notified of the leave of absence in writing to include e-mail, typed or handwritten letter.

**Section 4. Personal Leave** Any member may request a personal leave of absence for a time period of up to six (6) months. This request must be made in writing, to include e-mail, typed or hand written letter, to the Board of Directors who shall review it and make a recommendation to the membership where it will be approved or denied by a simple majority vote by secret ballot. Any member on personal leave shall remain a member in good standing until the end date of their approved leave of absence. A member wishing to extend their leave of absence must do so in writing to the Board of Directors prior to the end date of their approved leave. Any member who fails to extend their leave of absence or who fails to return to active duty immediately following the end date of their approved leave of absence will become a member not in good standing. All accrued time will be on hold during personal leaves. Probationary members will not be granted personal leave except in cases of extenuating, unavoidable circumstances, which will be reviewed on a case by case basis.

**Section 5. Academic Leave** Any member may request an academic leave of absence to coincide with the date of their current school semester. This request must be in writing to the Board of Directors who will review and make a recommendation to the membership where it will be approved or denied by a simple majority vote by secret ballot. Any member on academic leave shall remain a member in good standing until the end date of their approved leave of absence and will be required to re-submit their leave of absence request for each new semester. Any member who fails to extend their leave of absence or who fails to return to active duty immediately following the end date of their approved leave of absence will become a member not in good standing. If the member wishes to volunteer their time during an academic break, they may do so. All accrued time will be on hold during



academic leaves. Probationary members will not be granted academic leave except in cases of extenuating, unavoidable circumstances which will be reviewed on a case by case basis.

**Section 6.** The following outlines the process to be followed when a member wishes to request a leave of absence, how the leave will be tracked and the process for ending a leave of absence.

1. A member must submit their request for a leave of absence to the Board of Directors in written form to include typed or handwritten letter, e-mail. If the request is received by paper or e-mail. The request must contain the type of leave requested, the start date and the end date of the leave and a description of why the leave is being requested.
2. When a request is received it will be reviewed at the next Board of Directors meeting. A tracking form will be started for each new leave of absence request. The Board of Directors will make a recommendation to the membership at that month's membership meeting for a vote by secret ballot. The outcome of that vote will be listed on the tracking form. Military and medical leave requests are not voted on by the membership they are approved automatically by the Board of Directors.
3. Once the leave is voted on, the member requesting the leave of absence will be notified of the results within 48 hours in writing, to include a mailed letter AND an e-mail. The communication will cite the approval or denial of the requested leave of absence. If the leave of absence is approved the communication will also include a copy of Article 15 of the By-Law of the Fort Ann Rescue Squad, Inc. which outlines the Leave of Absence policy for the agency.
4. The tracking form will then be placed in the leave of absence tracking file to be reviewed by the Board of Directors the month prior to the end date of the approved leave of absence. If the leave of absence was denied it will be placed in the members personnel file.

5. The leave of absence will be reviewed at the Board of Directors meeting the month prior to the end date of the approved leave of absence.

For example: if the approved leave of absence is to end March 20th, the leave of absence will be reviewed at the February Board of Directors meeting. The Board of Directors will send a letter and an e-mail to the member reminding them that their approved leave of absence is about to expire and outline the process for requesting an extension as well as review how to sign up for duty. This letter and e-mail will also include that the Board of Directors will need to have a response from them by the following month's Board of Directors meeting or by the end date of their approved leave of absence whichever comes first.

6. Should the Board of Directors not hear back from the member by the date of the following month's Board of Directors meeting or by the end date of their approved leave of absence the member will become a member in bad standing and will receive a letter requesting them to appear in front of the Board of Directors at the next month's Board of Directors meeting. At that meeting the member will discuss with the Board of Directors their intentions going forward with the agency and will result in the member scheduling their duty, requesting an extension of their leave of absence or their resignation from the agency.

7. If the member does not appear in front of the Board of Directors as requested or reach out to a member of the Board of Directors to reschedule or make arrangements for another date that will result in the member being removed from the agency. Should this occur the member will receive a letter and e-mail from the agency requesting that all property of Fort Ann Rescue Squad be returned to the agency within thirty (30) days of receipt of the letter.

## **ARTICLE XVIII**

### **Amendments**

**Section 1:** Amendments to these by-laws may be proposed, in writing, at any regular meeting and voted on at the next regular meeting. The Secretary or President will notify members, in writing, twenty eight (28) days prior to the date of the next meeting at which said proposed amendment is to be considered for adoption and mail the proposed changes to each member within three weeks of the next meeting.

- a. Time may be amended by a 2/3<sup>rd</sup> vote based on postponed meetings and other extenuating circumstances. May be no less than 14 days

**Section 2:** All amendments require a two-thirds (2/3) favorable vote of the quorum by secret ballot, of the members in good standing at such meeting.

**Section 3:** In the event of any dispute pertaining to an interpretation of the meaning or application of the By-Laws, the chairperson of the By-law committee shall be responsible to convene the Bylaw committee and resolve the interpretation. The chairperson shall then report back to the general membership at the next general meeting.

**Section 4:** After such amendment is approved by the general membership, the President shall permanently amend the master Corporation By-Laws in order to establish a precedent for the future.

## **ARTICLE XIX**

### **Apparel & Transports**

**Section 1.** Each member is expected to wear Fort Ann Rescue Squad apparel on all calls and while on duty.

- a. Volunteers off duty taking a call shall always be dressed appropriately.
- b. Members are required to sign for any clothing that is issued and paid for by the Fort Ann Rescue Squad.
- c. When a member resigns from the organization, they are required to return any and all squad issued apparel within 7 days.

**Section 2:** Transports

- A. Fort Ann Rescue Squad and their immediate families. Immediate families shall be defined as spouse, mother, father, brother, sister, son or daughter.
- B. Any such run for immediate family, or any other family members, beyond a sixty (60) mile radius must first be authorized by the Squad Captain or his/her designee prior to commencement.
- C. Any transports of patients living outside of the Town of Fort Ann that are not limited to Family members shall be approved by the Transport Officer or Chief.
- D. For Transports, a stipend will be given to all providers if transport is during meal hours.
  - a. Stipend for long distant transport not to exceed twenty-five dollars a person. Long distance to be defined as 80 miles or greater round trip.
  - b. Stipend for short transport not to exceed fifteen dollars.
  - c. No Stipend will be given if transport is less than thirty loaded miles.

## **ARTICLE XX**

### **Conference Attendance Requirements**

**Section 1.** For a member to eligible to attend a conference or training at squad expense (example: Vital Signs, IAC) the following Criteria must be met:

1. Member must be an EMS Provider in good standing as defined by Article 8 section 4.
2. Member must be actively pulling duty and doing pcr's
3. No more than 6 members at any one time may attend a given conference
4. Member must have no prior issues with conference attendance, going to classes while at the conference, returning of receipts and remaining money that was issued to member
5. Must sign an agreement agreeing that no squad money will be spent on alcohol and will also agree to return all receipts and remaining money to the Treasurer within 7 days of conference end.
6. Conference attendance will be based on need and seniority; this decision will be made by the Chief and BOD.

7. Requests are to be made to the Chief in writing.
8. May attend one conference per year
9. \$200 cash will be given to each member to cover meals and fuel to travel to the location of the conference.
10. Final determination of attendance will be made by the BOD
11. For any training attendance to be paid for in advance by the Fort Ann Rescue Squad. Each member shall be approved by the Board of Directors and will sign an agreement regarding all conference or training requirements.
12. Final Conference approval will be granted jointly from the Chief and the President.
  - a. Reason for non-approval
    - i. financial constraints of the organization.

## **Appendix A**

### **TRAINING AGREEMENT**

#### **FORT ANN RESCUE SQUAD, INC**

11287 State Route 149 Fort Ann, NY 12827

I, \_\_\_\_\_, being a member of the Fort Ann Rescue Squad, Inc., do hereby agree to reimburse the Squad all monies paid for training, books or other expenses incurred if I do not complete the training program I have signed up and registered for as noted below. Upon completion any NYS CFR, EMT, AEMT, CC or Paramedic courses paid for by this agency, I will also agree to remain a member in good standing with the agency for a minimum of 12 months after achieving on-line status. Any member failing to pass the NYS Exam after a second attempt will not be eligible for squad funds to repeat the courses again. I understand that if I do not adhere to this agreement that legal action may be undertaken to recover all expenses that I have incurred.

Course \_\_\_\_\_



Dates of Course: \_\_\_\_\_

Course Cost: \_\_\_\_\_

Book Cost: \_\_\_\_\_

Other Expenses: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

# PINSKY

LAW GROUP, PLLC

4311 East Genesee Street  
Syracuse, New York 13214  
(315) 428-8345  
(315) 475-8230 (fax)

April 3, 2025

To Whom It May Concern:

This law firm represents the Fort Ann Rescue Squad, Inc, an applicant for an expansion of its Ambulance Service Certificate (a/k/a Certificate of Need) for the following territory, which encompasses Glens Falls Hospital: "All of that territory in Warren County, Glens Falls, New York, within the four corners of Glen Street, Mohegan Street, Murray Street, South Avenue and Hudson Avenue."

**AFTER READING THIS LETTER, WE ARE ASKING THAT YOU SEND A LETTER OF SUPPORT (OR OPPOSITION) REGARDING THE APPLICATION, TO:**

Pinsky Law Group, PLLC  
Re: Fort Ann Rescue Squad, Inc.  
4311 East Genesee Street  
Syracuse, New York 13214

If you could explain that there is (or is not) need for these services, it would be helpful as well. We will then present that letter with our application.

This letter contains a significant amount of information that is being provided to the Mountain Lakes Regional Emergency Medical Services Council, to the public and to you as an interested provider, interested party or municipality in or serving Warren County. Although this letter contains well more information than Fort Ann Rescue Squad is required to provide to you, we believe that we should provide you as much information as possible.

We thank you for your attention to this most important application.

VERY TRULY YOURS,

PINSKY LAW GROUP, PLLC

By: *Bradley Pinsky*  
Bradley M. Pinsky

## DETAILED NARRATIVE

Fort Ann Rescue Squad desires to provide Basic and Advanced Life Support transporting ambulance services for discharged and transferred patients from Glens Falls Hospital, Warren County, New York. The Public Health Law requires that Fort Ann Rescue Squad apply to expand its operating authority, and request letters from stakeholders.

Presently, the Ambulance Service Certificate for the Fort Ann Rescue Squad includes the following territory:

The Town and Village of Fort Ann to include State Route 4 South to 4294 State Route 4 Kingsbury, the Hamlet of Pilot Knob, a portion of County Route 17 in the Town of Hartford, State Route 22 East from State Route 4 to the Fort Ann Granville town line.

Fort Anne operates four (4) ambulances and four (4) fly cars. We have twenty-nine (29) volunteers and twenty-six (26) employees. Among them are nine (9) paramedics, four (4) advanced EMTs, and nineteen (19) EMT-Basics. We respond annually to 1461 BLS calls each year and 369 ALS calls in our present territory, exclusive of the hospital transports. We have an average respond time of 1.9 minutes and an average response rate of over ninety-nine (99%) percent.

We look to add the following territory: "All of that territory in Warren County, Glens Falls, New York, within the four corners of Glen Street, Mohegan Street, Murray Street, South Avenue and Hudson Avenue." We refer to this as the "Expansion Territory".



The goal of this application is for Fort Ann Rescue Squad to be authorized to continue to provide a reliable non-emergency transporting ambulance service to Glens Falls Hospital in order to permit the timely discharge and/or transfer of the Hospital's patients, and specifically in order to transport patients out of Glens Falls Hospital to their homes, to other hospitals, to nursing homes and other treatment and diagnostic facilities. Our application will support but will not negatively affect any other ambulance service in the area.

As will be demonstrated below, Fort Ann Rescue Squad has been actively transporting the Hospital's patients and can demonstrate need for such services.

#### Public Need

Fort Ann Rescue Squad is required to provide the definition of need and to demonstrate that need exists for Fort Ann Rescue Squad's ambulance services in Warren County. The State EMS Council and the Department of Health defined public need as follows:

"The Demonstrated absence, reduced availability or an inadequate level of care in ambulance or emergency medical service availability to a geographical area which is not readily correctable through the reallocation or improvement of existing resources." Variables in considering "public need" include: geography, population (size, density, projections), level of care (existing, available), quality, reliability and response patterns of existing services, type of service (emergency, non-emergency), special needs, service effectiveness, cost and operation, and other local factors.

This letter is intended to address these issues.

#### **LACK OF AVAILABLE AMBULANCES CREATES NEED**

The primary role of any emergency ambulance service is to serve the emergency medical needs of the public. Unfortunately, Warren County if not the entire state, is in short supply of emergency ambulance services. Therefore, the needs of patients who require discharges from and transports between facilities such as hospitals, nursing homes, physician offices and diagnostic facilities must take a back seat.

Hospitals are having a serious issue whereby patients in need of ambulance level care cannot get timely discharged and beds remain unavailable for those who need them.

#### Need exists

The following reflects the number of transports from Glens Falls Hospital.

2025 (January – March 1)

| YEAR         | Total Transports | ALS | BLS  |
|--------------|------------------|-----|------|
| 2025 to date | 447              | 27  | 420  |
| 2024         | 1830             | 369 | 1461 |

#### Present and Proposed Territory

Fort Ann Rescue Squad's proposed territory is described as follows: "All of that territory in Warren County, Glens Falls, New York, within the four corners of Glen Street, Mohegan Street, Murray Street, South Avenue and Hudson Avenue."

## **I. Impact upon existing ambulance and or emergency medical services in the proposed area**

### ***Positive impact on the community***

Fort Ann Rescue Squad's ambulance service will have a positive impact throughout Warren County by providing a reliable transporting ambulance service from Glens Falls Hospital in a reasonable amount of time considering the vast area covered.

### ***Present providers***

There are several transporting (emergency) ambulance providers serving Warren County, including:

Bolton Emergency Medical Services, Inc.  
Glens Falls Fire Department Ambulance  
Hague Volunteer Fire Department, Inc.  
Johnsburg Emergency Squad, Inc.  
Lake George EMS  
North Warren Emergency Squad, Inc  
Queensbury EMS, Inc.  
Rockwell Falls Ambulance Service, Inc.  
Stony Creek Volunteer Fire Company, Inc  
Warrensburg Emergency Medical Services, Inc  
West Glens Falls Emergency Squad, Inc.  
Ambulanz  
Mohwak Ambulance

### ***No negative impact on other providers***

There will be no negative impact on any other providers which hold operating authority in all or some of Warren County. Fort Ann Rescue Squad is not looking to displace any of the private services, fire departments or volunteer ambulance services which serve this small territory. It is hard to imagine that any other ambulance service will lose income, members, or employees from Fort Ann Rescue Squad's provision of interfacility transports and non-911 ambulance services. No other ambulance service will be negatively impacted.

### ***Response Time***

Response time metrics for our type of proposed services are different than 911 service response times. The hospital must be able to discharge its patients in a timely manner, but mere minutes are not likely critical. We typically will be scheduled to arrive at various times. Therefore, response times are not as important. However, the present ambulance providers are unable to guarantee reliable response times even with pre-scheduled times, as they are overwhelmed with 911 calls which must take priority. Our statistics dictate that most transports occur between 2pm and 12am.



### ***Staffing/Contracting***

Fort Ann Rescue Squad will staff a total of four (4) ambulances available to respond to the Expansion Territory (the Hospital) with at least one basic EMT and a driver on each, or for advanced life support transports, with at least one paramedic.

### ***Call volume for past 12 months and anticipated for next 12 months***

We will operate 24/7. We project that we will transport on average, 1200-1300 patients per year in this Expansion Territory. We expect about 3-4 transports per day in this territory. This is based upon our present statistics for 2024 and 2025.

### ***Mutual Aid***

We will participate in the mutual aid system for Warren County.

### ***Quality Assurance***

We will maintain our own Quality Assurance Program. However, all calls that meet mandatory reporting to the Regional EMS Council will be sent in a timely fashion. All calls requiring review by the Medical Director are also done at the earliest possible time.

### ***Protocols***

Fort Ann Rescue Squad adopts and adheres to all state and regional basic life support and advanced life support protocols. Fort Ann Rescue Squad maintains all required policies by the Department of Health, Bureau of Emergency Medical Services. Fort Ann Rescue Squad frequently reviews its best practices in an effort to continuously improve its already high quality of services.

### ***Ability and quality of existing services***

This application does not seek to displace any other service. Fort Ann Rescue Squad will fill significant gaps in ambulance service for interfacility transports, hospital discharges and patient appointments which require ambulance transport. It does not displace any other service from responding to their primary territories for 911 emergencies.

We have spoken with other available ambulance services and they are either not capable of providing these transports and/or are not interested in doing so.

### ***No Financial Impact or any adverse impact on existing services***

Fort Ann Rescue Squad will not stop any other service from operating in their primary operating territories for 911 calls and will not attempt to interfere with existing transport contracts being reliably served by any other ambulance service.

## **II. EMS System in the Area**

*These entities are listed above.*

*The following hospital is affected:*

- Glen Falls Hospital

*Fort Ann Rescue Squad participates in the Fort Ann Rescue Squad Mutual Aid Plan.*

Fort Ann Rescue Squad will participate in 911 response services and will not provide or receive mutual aid support services.

*Projected Response Times for the next 12 months*

Response time is based upon the schedule required by the hospital, but is on average, less than two (2) minutes.

*Communication System Interface*

Fort Ann Rescue Squad will utilize 911 services and will communicate with 911 on frequency 154.1600 and has 155.340 capability. We will have the ability to speak with the hospital via phone and radio.

*The positive and negative impact on the community*

There will only be a positive impact on emergency medical services, the hospital and the community through the effective and efficient discharge and/or transport of patients out of Glens Falls Hospital. There will be no negative impact on patient care, and no other ambulance service will be negatively impacted in the area. Without Fort Ann Rescue Squad providing services, response time for patient transports and discharges will suffer.

*Economic improvements from Fort Ann Rescue Squad's operation in the proposed territory*

The primary benefit will be the availability of an ambulance service to remove patients from a hospital, thereby opening much needed bed space in Glens Falls Hospital.

### **Appendix 1 – Guidelines for Establishing Ambulance Services**

*Population of jurisdiction requesting the ambulance service, including tourism and traffic flow.*

- Glens Falls Hospital has 391 beds.

*Does each area have a large enough population base to support a new ambulance service?*

Yes, Glens Falls Hospital has a significant patient population and a significant number of discharges each day to justify the provision of these transporting, non-911 ambulance service.

*How many calls for service and how many emergency calls are made in the proposed area?*

Approximately 3-4 per day

*Average response time for calls and emergency calls*

Likely about two (2) minutes, but all transports will be scheduled in advance when possible.

*Quality of existing services and how to present conditions affect public convenience*

In the absence of the Fort Ann Rescue Squad, existing services would not be adequate for the purpose of serving Glens Falls Hospital with a prompt response time. The mere fact that we are presently transporting 3-4 patients per day must establish need.

*Mutual aid ambulance agreements exist*

Mutual aid does not cover our types of non-911 transport services. Our services will cover these calls.

*Would the employees of the proposed service have a sufficient level of clinical experience for maintaining emergency care?*

Yes, all employees presently have adequate experience to perform these transport services.

*Would opportunities exist for personnel to maintain their level of skill. If an additional ambulance service were added, would the dilution of service calls between the ambulance services cause decay in skills due to inactivity?*

Providers of other services would not see a decrease in their skills as there are more than enough calls to be handled outside of Glens Falls Hospital. However, these calls are primarily basic life support calls which require less skill than the average 911 emergency, though certainly some skill.

*Are the existing communications capabilities adequate for maintaining medical control and directing paramedics?*

Yes. We have radio and phone communications.

*How will the ambulance service be financed? Are the financial resources available to the proposed service sufficient for maintaining a full time service?*

Private contracts with the hospital and patient billing will be the primary source of funding.

*How will the ambulance service be organized and administered? Is management capable of performing its duties?*

Fort Ann Rescue Squad is a not for profit corporation, which is managed by a Board of Directors and an internal administrative staff, with oversight from its Medical Director. The corporation has more than adequate experience operating a business as it has provided ambulance services since 1961.

*What will be the total cost of the new ambulance service? Are the benefits that the proposed area receive worth the expense?*

We anticipate the cost of this service to be approximately \$500,000 per year for responding to Glens Falls Hospital. This encompasses the need for staffing four (4) ambulances per day for this response.

***Does public opinion in the proposed area favor the establishment of Fort Ann Rescue Squad?***

We have already received letters of support and service requests from skilled nursing facilities, with well more support to come.

***Does local government planning agencies favor establishment of a new ambulance service.***

The local governments appear to approve of Fort Ann Rescue Squad's provision of ambulance services as their residents need these services. We hope that this letter will serve to encourage positive responses from the local government leaders in the form of support letters. All opposition and support will be shared with the regional council.

***Are there any viable alternatives other than licensing a new ambulance service.***

The present system is not working, as transport times of non-911 patients between medical and residential care facilities, and patient treatment facilities, are way too long.

Therefore, we believe this application supports need.

We therefore ask that you send a letter of support to our attention on behalf of our client, or feel free to submit a letter of concern or opposition.

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☐ Adult Signature Restricted Delivery \$Postmark  
Here

Postage

\$

Village of Argyle  
PO Box 7  
Argyle, NY 12809

See Reverse for Instructions

9589 0710 5270 0483 2092 32

U.S. Postal Service™  
**CERTIFIED MAIL® RECEIPT**  
Domestic Mail OnlyFor delivery information, visit our website at [www.usps.com](http://www.usps.com)™.**OFFICIAL USE**

Certified Mail Fee

\$

Extra Services & Fees (check box, add fee as appropriate)  
☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$Postmark  
Here

Postage

\$

Town of Argyle  
PO Box 38  
Argyle, NY 12809

See Reverse for Instructions

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Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
Glens Falls Fire  
Street and Apt. No., or PO Box No.  
134 Bridge Street  
City, State, ZIP+4®  
Glens Falls, NY 12001

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**OFFICIAL USE**

Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
Queensbury EMS  
Street and Apt. No., or PO Box No.  
1100 Bridge Road  
City, State, ZIP+4®  
Queensbury, NY 12004

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Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
Stenesborough EMS  
Street and Apt. No., or PO Box No.  
34 Stenesborough Drive  
City, State, ZIP+4®  
Whitehall, NY 12087

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Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
Corinth Ambulance  
Street and Apt. No., or PO Box No.  
101 Sherman Avenue  
City, State, ZIP+4®  
Corinth, NY 12027

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Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
West Glens Falls EMS  
Street and Apt. No., or PO Box No.  
600 W. 1st Street  
City, State, ZIP+4®  
Queensbury, NY 12004

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Certified Mail Fee

Extra Services & Fees (check box, add fee as appropriate)

☒ Return Receipt (hardcopy) \$  
☐ Return Receipt (electronic) \$  
☐ Certified Mail Restricted Delivery \$  
☐ Adult Signature Required \$  
☐ Adult Signature Restricted Delivery \$

Postmark  
Here

Total Postage and Fees

\$

Sent To  
Town of Hartford  
Street and Apt. No., or PO Box No.  
PO Box 214  
City, State, ZIP+4®  
Hartford, NY 12030

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**OFFICIAL USE**

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|---------------------------------------------------------------|----|
| Certified Mail Fee                                            |    |
| \$                                                            |    |
| Extra Services & Fees (check box, add fee as appropriate)     |    |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) | \$ |
| <input type="checkbox"/> Return Receipt (electronic)          | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery   | \$ |
| <input type="checkbox"/> Adult Signature Required             | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery  | \$ |

Postmark  
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| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**HOOSICK FALLS EMS**  
Street and Apt. No., or PO Box No.  
**21 1st Street**  
City, State, ZIP+4®  
**HOOSICK FALLS, NY 12090**

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**OFFICIAL USE**

|                                                               |    |
|---------------------------------------------------------------|----|
| Certified Mail Fee                                            |    |
| \$                                                            |    |
| Extra Services & Fees (check box, add fee as appropriate)     |    |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) | \$ |
| <input type="checkbox"/> Return Receipt (electronic)          | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery   | \$ |
| <input type="checkbox"/> Adult Signature Required             | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery  | \$ |

Postmark  
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| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**Maista Stillwater EMS**  
Street and Apt. No., or PO Box No.  
**266 County Route 76**  
City, State, ZIP+4®  
**Stillwater, NY 12170**

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**OFFICIAL USE**

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|---------------------------------------------------------------|----|
| Certified Mail Fee                                            |    |
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| Extra Services & Fees (check box, add fee as appropriate)     |    |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) | \$ |
| <input type="checkbox"/> Return Receipt (electronic)          | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery   | \$ |
| <input type="checkbox"/> Adult Signature Required             | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery  | \$ |

Postmark  
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| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**Bolton EMS**  
Street and Apt. No., or PO Box No.  
**5003 Lake Shore Drive**  
City, State, ZIP+4®  
**Bolton Landing, NY 12814**

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**OFFICIAL USE**

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|--------------------------------------------------------------|----|
| Certified Mail Fee                                           |    |
| \$                                                           |    |
| Extra Services & Fees (check box, add fee as appropriate)    |    |
| <input type="checkbox"/> Return Receipt (hardcopy)           | \$ |
| <input type="checkbox"/> Return Receipt (electronic)         | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery  | \$ |
| <input type="checkbox"/> Adult Signature Required            | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery | \$ |

Postmark  
Here

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| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**Hoosick Valley EMS**  
Street and Apt. No., or PO Box No.  
**1448 NY-40**  
City, State, ZIP+4®  
**Schoharie, NY 12154**

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|                                                               |    |
|---------------------------------------------------------------|----|
| Certified Mail Fee                                            |    |
| \$                                                            |    |
| Extra Services & Fees (check box, add fee as appropriate)     |    |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) | \$ |
| <input type="checkbox"/> Return Receipt (electronic)          | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery   | \$ |
| <input type="checkbox"/> Adult Signature Required             | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery  | \$ |

Postmark  
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| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**Wilton EMS**  
Street and Apt. No., or PO Box No.  
**1 Harran Lane**  
City, State, ZIP+4®  
**Saratoga Springs, NY 12866**

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|---------------------------------------------------------------|----|
| Certified Mail Fee                                            |    |
| \$                                                            |    |
| Extra Services & Fees (check box, add fee as appropriate)     |    |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) | \$ |
| <input type="checkbox"/> Return Receipt (electronic)          | \$ |
| <input type="checkbox"/> Certified Mail Restricted Delivery   | \$ |
| <input type="checkbox"/> Adult Signature Required             | \$ |
| <input type="checkbox"/> Adult Signature Restricted Delivery  | \$ |

Postmark  
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|------------------------|--|
| Postage                |  |
| \$                     |  |
| Total Postage and Fees |  |
| \$                     |  |

Sent To  
**Moreau EMS**  
Street and Apt. No., or PO Box No.  
**1583 US-9**  
City, State, ZIP+4®  
**Fort Edward, NY 12828**

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|                                                                                                                                               |                  |
|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                                      | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                                     |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                              |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$                                                                                       |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                                |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                          |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                               |                  |
| Postage<br>\$                                                                                                                                 |                  |
| Total Postage and Fees<br>\$                                                                                                                  |                  |
| Sent To<br>Cambridge Ems<br>Street and Apt. No., or PO Box No.<br>37 Gilbert Street<br>City, State, ZIP+4 <sup>®</sup><br>Cambridge, NY 12816 |                  |

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|                                                                                                                                              |                  |
|----------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                                     | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                                    |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                             |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$                                                                                      |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                               |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                         |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                              |                  |
| Postage<br>\$                                                                                                                                |                  |
| Total Postage and Fees<br>\$                                                                                                                 |                  |
| Sent To<br>Easton Greenwich Ems<br>Street and Apt. No., or PO Box No.<br>441 NY-29<br>City, State, ZIP+4 <sup>®</sup><br>Greenwich, NY 12834 |                  |

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|                                                                                                                                            |                  |
|--------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                                   | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                                  |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                           |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$                                                                                    |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                             |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                       |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                            |                  |
| Postage<br>\$                                                                                                                              |                  |
| Total Postage and Fees<br>\$                                                                                                               |                  |
| Sent To<br>Fort Edward Ems<br>Street and Apt. No., or PO Box No.<br>PO Box 226<br>City, State, ZIP+4 <sup>®</sup><br>Fort Edward, NY 12828 |                  |

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|                                                                                                                                       |                  |
|---------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                              | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                             |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                      |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$                                                                               |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                        |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                  |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                       |                  |
| Postage<br>\$                                                                                                                         |                  |
| Total Postage and Fees<br>\$                                                                                                          |                  |
| Sent To<br>Salem Ems<br>Street and Apt. No., or PO Box No.<br>192 East Broadway<br>City, State, ZIP+4 <sup>®</sup><br>Salem, NY 12865 |                  |

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|                                                                                                                                                |                  |
|------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                                       | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                                      |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                               |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$                                                                                        |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                                 |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                           |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                                |                  |
| Postage<br>\$                                                                                                                                  |                  |
| Total Postage and Fees<br>\$                                                                                                                   |                  |
| Sent To<br>Granville Ems<br>Street and Apt. No., or PO Box No.<br>14 East Potter Ave<br>City, State, ZIP+4 <sup>®</sup><br>Granville, NY 12832 |                  |

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|                                                                                                                                                          |                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                                                                                                                 | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)                                                                                                |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$                                                                                         |                  |
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| <input type="checkbox"/> Certified Mail Restricted Delivery \$                                                                                           |                  |
| <input type="checkbox"/> Adult Signature Required \$                                                                                                     |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$                                                                                          |                  |
| Postage<br>\$                                                                                                                                            |                  |
| Total Postage and Fees<br>\$                                                                                                                             |                  |
| Sent To<br>Village of Hudson Falls<br>Street and Apt. No., or PO Box No.<br>220 Main Street<br>City, State, ZIP+4 <sup>®</sup><br>Hudson Falls, NY 12839 |                  |

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| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ |                  |
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| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
Monawk Ambulance Service  
Street and Apt. No., or PO Box No.  
292 Duval Street  
City, State, ZIP+4<sup>®</sup>  
Albany, NY 12208  
PS Form 3800, January 2023 PSN 7530-02-000-9047

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| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$          |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
Ambulance Ambulance Semi  
Street and Apt. No., or PO Box No.  
605 3rd Ave. 9th Floor Suite 900  
City, State, ZIP+4<sup>®</sup>  
New York, NY 10017  
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| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
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| <input type="checkbox"/> Return Receipt (electronic) \$          |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
Town of Fort Edward  
118 Broadway  
Fort Edward, NY 12828  
or Instructions

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|                                                                  |                  |
|------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$          |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
Warrensburg EMS  
Street and Apt. No., or PO Box No.  
3 King Street  
City, State, ZIP+4<sup>®</sup>  
Warrensburg, NY 12885  
PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions

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|------------------------------------------------------------------|------------------|
| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$          |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
North Warren EMS  
Street and Apt. No., or PO Box No.  
2 Colgar Lane  
City, State, ZIP+4<sup>®</sup>  
Chesterstown, NY 12917  
PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions

9589 0710 5270 0483 2090 34

U.S. Postal Service<sup>TM</sup>  
**CERTIFIED MAIL<sup>®</sup> RECEIPT**  
Domestic Mail Only

For delivery information, visit our website at [www.usps.com](http://www.usps.com)

**OFFICIAL USE**

|                                                                  |                  |
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| Certified Mail Fee<br>\$                                         | Postmark<br>Here |
| Extra Services & Fees (check box, add fee as appropriate)        |                  |
| <input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ |                  |
| <input type="checkbox"/> Return Receipt (electronic) \$          |                  |
| <input type="checkbox"/> Certified Mail Restricted Delivery \$   |                  |
| <input type="checkbox"/> Adult Signature Required \$             |                  |
| <input type="checkbox"/> Adult Signature Restricted Delivery \$  |                  |
| Postage<br>\$                                                    |                  |
| Total Postage and Fees<br>\$                                     |                  |

Sent To  
Ticonderoga EMS  
Street and Apt. No., or PO Box No.  
118 Champlain Avenue  
City, State, ZIP+4<sup>®</sup>  
Ticonderoga, NY 12883  
PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions

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| <b>U.S. Postal Service™</b><br><b>CERTIFIED MAIL® RECEIPT</b><br><i>Domestic Mail Only</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |
| For delivery information, visit our website at <a href="http://www.usps.com">www.usps.com</a>                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |
| <b>OFFICIAL USE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| Certified Mail Fee<br>\$ _____<br>Extra Services & Fees (check box, add fee as appropriate)<br><input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ _____<br><input type="checkbox"/> Return Receipt (electronic) \$ _____<br><input type="checkbox"/> Certified Mail Restricted Delivery \$ _____<br><input type="checkbox"/> Adult Signature Required \$ _____<br><input type="checkbox"/> Adult Signature Restricted Delivery \$ _____<br>Postage<br>\$ _____<br>Total Postage and Fees<br>\$ _____ | Postmark<br>Here |
| Sent To<br>Lake George EMS<br>Street and Apt. No., or PO Box No.<br>24 Gage Road<br>City, State, ZIP+4®<br>Lake George, NY 12845                                                                                                                                                                                                                                                                                                                                                                                   |                  |
| PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |

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| <b>U.S. Postal Service™</b><br><b>CERTIFIED MAIL® RECEIPT</b><br><i>Domestic Mail Only</i>                                                                                                                                                                                                                                                                                                                                                                                   |                  |
| For delivery information, visit our website at <a href="http://www.usps.com">www.usps.com</a>                                                                                                                                                                                                                                                                                                                                                                                |                  |
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| Certified Mail Fee<br>\$ _____<br>Extra Services & Fees (check box, add fee as appropriate)<br><input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ _____<br><input type="checkbox"/> Return Receipt (electronic) \$ _____<br><input type="checkbox"/> Certified Mail Restricted Delivery \$ _____<br><input type="checkbox"/> Adult Signature Required \$ _____<br><input type="checkbox"/> Adult Signature Restricted Delivery \$ _____<br>Postage<br>\$ _____ | Postmark<br>Here |
| Town of Granville<br>PO Box 177<br>Granville, NY 12865                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |
| or Instructions                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                  |

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| <b>U.S. Postal Service™</b><br><b>CERTIFIED MAIL® RECEIPT</b><br><i>Domestic Mail Only</i>                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |
| For delivery information, visit our website at <a href="http://www.usps.com">www.usps.com</a>                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |
| <b>OFFICIAL USE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
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| Sent To<br>Argyle EMS<br>Street and Apt. No., or PO Box No.<br>15 Sheridan Street<br>City, State, ZIP+4®<br>Argyle, NY 12809                                                                                                                                                                                                                                                                                                                                                                                       |                  |
| PS Form 3800, January 2023 PSN 7530-02-000-9047 See Reverse for Instructions                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |

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| <b>U.S. Postal Service™</b><br><b>CERTIFIED MAIL® RECEIPT</b><br><i>Domestic Mail Only</i>                                                                                                                                                                                                                                                                                                                                                                                   |                  |
| For delivery information, visit our website at <a href="http://www.usps.com">www.usps.com</a>                                                                                                                                                                                                                                                                                                                                                                                |                  |
| <b>OFFICIAL USE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |
| Certified Mail Fee<br>\$ _____<br>Extra Services & Fees (check box, add fee as appropriate)<br><input checked="" type="checkbox"/> Return Receipt (hardcopy) \$ _____<br><input type="checkbox"/> Return Receipt (electronic) \$ _____<br><input type="checkbox"/> Certified Mail Restricted Delivery \$ _____<br><input type="checkbox"/> Adult Signature Required \$ _____<br><input type="checkbox"/> Adult Signature Restricted Delivery \$ _____<br>Postage<br>\$ _____ | Postmark<br>Here |
| Village of Fort Edward<br>PO Box 345<br>Fort Edward, NY 12828                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| See Reverse for Instructions                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                  |

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LAW GROUP, PLLC

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First Name: IV  
ZIP: 13214

04/04/2025  
034B 0081832696

417

RETURN TO SENDER  
UNCLAIMED  
UNABLE TO FORWARD

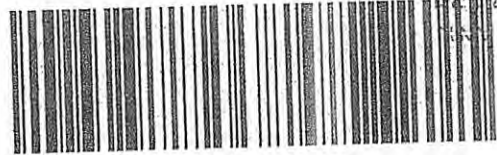
UNC

BC: 13214212111 \*0637-14202-04-45

12345678910

**PINSKY**  
LAW GROUP, PLLC

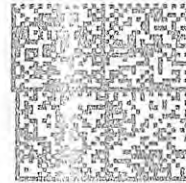
4311 East Genesee Street  
Syracuse, NY 13214



9589 0710 5270 0483 2089 45

1321421211

9.7



**FP** US POSTAGE  
\$ 009.64  
First-Class Mail  
ZIP 13214  
04/04/2025  
034B 0081832696

Lake George EMS

24 Gage Road

Lake George, NY 12845

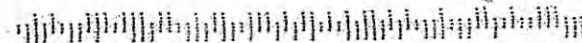
UNCLAIMED

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~~SECOND NOTICE~~  
5-6

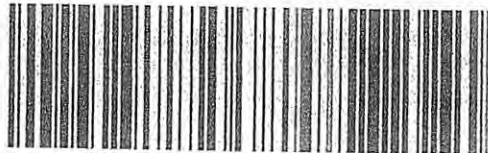
~~FINAL NOTICE~~  
5-20

1284586130 R003

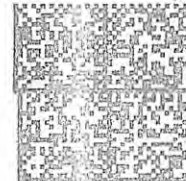


**PINSKY**  
LAW GROUP, PLLC

4311 East Genesee Street  
Syracuse, NY 13214



9589 0710 5270 0483 2090 58



**FP** US POSTAGE  
\$ 009.64  
First-Class Mail  
ZIP 13214  
04/04/2025  
034B 0081832696

Warrensburg EMS

3 King Street

Warrensburg, NY 12885

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RETURN TO SENDER  
UNCLAIMED  
UNABLE TO FORWARD

UNC

BC: 13214212111 \*0637-14180-04-45

1321421211 C



## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Salem, MS  
152 East Broadway  
Salem, NY 12865



9590 9402 9166 4225 5231 59

2. Article Number (Transfer from service label)

9589 0710 5270 2292 8116 68

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

☒ Agent  
☐ Addressee  
*Vicky Campbell*

B. Received by (Printed Name)

Vicky Campbell

C. Date of Delivery

4/16/25

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

☐ Mail  
☐ Mail Restricted Delivery

Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

A. Signature

☒ Agent  
☐ Addressee

B. Received by (Printed Name)

Vicky Campbell

C. Date of Delivery

4/16/25

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

☐ Mail  
☐ Mail Restricted Delivery

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Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Fort Edward, MS  
PO Box 226  
Fort Edward, NY 12828



9590 9402 9166 4225 5230 67

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2089 07

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

☐ Agent  
☐ Addressee  
*Katie Bouey*

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

☐ Mail  
☐ Mail Restricted Delivery

Domestic Return Receipt

COMPLETE THIS SECTION ON DELIVERY

1. Complete items 1, 2, and 3.

- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Queerbury EMS  
1109 Ridge Road  
Queerbury, NY 12804



9590 9402 9166 4225 5230 50

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2089 14

PS Form 3811, July 2020 PSN 7530-02-000-9053



| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                                        | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                                | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| <p><input checked="" type="checkbox"/> Complete items 1, 2, and 3.</p> <p><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.</p> <p><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p>North Warren EMS<br/>2 Cougar Lane<br/>Chester town, NY 12817</p> | <p>A. Signature<br/><i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>K. Modert</i> C. Date of Delivery <i>4-9-25</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/>If YES, enter delivery address below: <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                          | <p><input checked="" type="checkbox"/> Complete items 1, 2, and 3.</p> <p><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.</p> <p><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p>Town of Hampton<br/>2629 NY-22A<br/>Hampton, NY 12837</p> | <p>A. Signature<br/><i>Rebecca S. Jones</i> <input type="checkbox"/> Agent <input type="checkbox"/> Address</p> <p>B. Received by (Printed Name) <i>Rebecca S. Jones</i> C. Date of Delivery</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/>If YES, enter delivery address below: <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                                      |
| <p></p> <p>9590 9402 8180 3030 6442 67</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2090 41</p>                                                                                                                                                                                                                 | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p>Mail Restricted Delivery (00)</p> | <p></p> <p>9590 9402 8180 3030 6443 80</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2092 63</p>                                                                                                                                                                                                      | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p>Mail Restricted Delivery (over \$500)</p> |
| PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                                 | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                              | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input checked="" type="checkbox"/> Complete items 1, 2, and 3.</p> <p><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.</p> <p><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p>Argyle EMS<br/>15 Sheridan Street<br/>Argyle, NY 13809</p> | <p>A. Signature<br/><i>[Signature]</i> <input type="checkbox"/> Agent <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name) <i>Argyle EMS</i> C. Date of Delivery <i>4/10/25</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/>If YES, enter delivery address below: <input type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                        | <p><input checked="" type="checkbox"/> Complete items 1, 2, and 3.</p> <p><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.</p> <p><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>1. Article Addressed to:</p> <p>Town of Dresden<br/>PO Box 16<br/>Clemons, NY 12819</p> | <p>A. Signature<br/><i>Marcinda Wilbur</i> <input type="checkbox"/> Agent <input type="checkbox"/> Address</p> <p>B. Received by (Printed Name) <i>Marcinda Wilbur</i> C. Date of Delivery <i>4-9-25</i></p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/>If YES, enter delivery address below: <input checked="" type="checkbox"/> No</p>                                                                                                                                                                                                                                                                                                                                                           |
| <p></p> <p>9590 9402 9166 4225 5230 74</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 2292 8116 99</p>                                                                                                                                                                                                        | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p>Mail Restricted Delivery (00)</p> | <p></p> <p>9590 9402 8180 3030 6441 82</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2091 26</p>                                                                                                                                                                                                  | <p>3. Service Type</p> <p><input type="checkbox"/> Adult Signature <input type="checkbox"/> Priority Mail Express®</p> <p><input type="checkbox"/> Adult Signature Restricted Delivery <input type="checkbox"/> Registered Mail™</p> <p><input checked="" type="checkbox"/> Certified Mail® <input type="checkbox"/> Registered Mail Restricted Delivery</p> <p><input type="checkbox"/> Certified Mail Restricted Delivery <input type="checkbox"/> Signature Confirmation™</p> <p><input type="checkbox"/> Collect on Delivery <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> <p><input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p>Insured Mail</p> <p>Mail Restricted Delivery (00)</p> |
| PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | PS Form 3811, July 2020 PSN 7530-02-000-9053 Domestic Return Receipt                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

**SENDER: COMPLETE THIS SECTION**

☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Town of ~~Greenwich~~ **Greenwich**

1355 State Route 22

Cambridge, NY 12816



9590 9402 8180 3030 6441 20

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2092 01

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature ☒ Agent ☐ Addressee

*[Signature]*

B. Received by (Printed Name) C. Date of Delivery

*Molly Dixon*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Insured Mail  
☐ Collect on Delivery Restricted Delivery ☐ Mail Restricted Delivery

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Town of ~~Greenwich~~ **Greenwich**

2 Academy Street

Greenwich, NY 12834



9590 9402 8180 3030 6441 13

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2091 95

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature ☐ Agent ☐ Addressee

*Sharon M. Chase*

B. Received by (Printed Name) C. Date of Delivery

*Sharon m chase* *4/7/25*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Insured Mail  
☐ Collect on Delivery Restricted Delivery ☐ Mail Restricted Delivery

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Town of ~~Argyle~~ **Argyle**

PO Box 38

Argyle, NY 12809



9590 9402 8180 3030 6444 10

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2092 32

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature ☐ Agent ☐ Addressee

*Renee Kober*

B. Received by (Printed Name) C. Date of Delivery

*Renee Kober*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Insured Mail  
☐ Collect on Delivery Restricted Delivery ☐ Mail Restricted Delivery

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Granville EMS

64 East Potter Ave

Granville, NY 12842



9590 9402 9166 4225 5231 28

2. Article Number (Transfer from service label)

9589 0710 5270 2292 8116 51

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature ☐ Agent ☐ Addressee

*Steph Zeller*

B. Received by (Printed Name) C. Date of Delivery

*Steph Zeller*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Insured Mail  
☐ Collect on Delivery Restricted Delivery ☐ Mail Restricted Delivery

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Village of Argyle

PO Box 7

Argyle, NY 12809



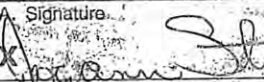
9590 9402 8180 3030 6440 90

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2091 88

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature  ☒ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No



3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery Restricted Delivery  
Mail Restricted Delivery (00)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Skenesborough EMS

37 Skenesborough Drive

Whitehall, NY 12887



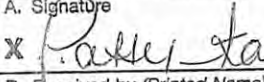
9590 9402 9166 4225 5232 65

2. Article Number (Transfer from service label)

9589 0710 5270 2292 8116 44

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature  ☒ Agent ☐ Address

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

PO Box 333

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
Mail Restricted Delivery (over \$500)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Village of Granville

PO Box 208

Granville, NY 12865



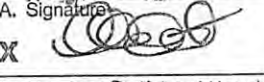
9590 9402 8180 3030 6441 75

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2090 96

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature  ☐ Agent ☐ Addressee

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
Mail Restricted Delivery (00)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Malta Stillwater EMS

266 County Route 76

Stillwater, NY 12170



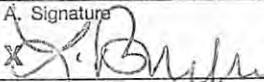
9590 9402 8180 3030 6443 28

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2089 76

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature  ☐ Agent ☐ Address

B. Received by (Printed Name) C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express®  
☐ Adult Signature ☐ Registered Mail™  
☐ Adult Signature Restricted Delivery ☐ Registered Mail Restricted Delivery  
☒ Certified Mail® ☐ Signature Confirmation™  
☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery ☐ Signature Confirmation Restricted Delivery  
☐ Collect on Delivery Restricted Delivery ☐ Signature Confirmation Restricted Delivery  
Mail Restricted Delivery (00)

Domestic Return Receipt



**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

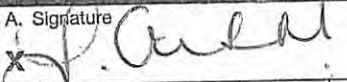
own White Creek  
8 Mountainview Drive  
White Creek, NY 12816

  
9590 9402 8180 3030 6444 03

2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2092 49

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  ☒ Agent ☐ Addressee

B. Received by (Printed Name) Disc. Kelly C. Date of Delivery 4/8/25

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Certified Mail® ☐ Signature Confirmation™ ☒ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Mail Restricted Delivery (over \$500)

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

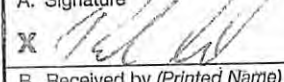
Mohawk Ambulance Service  
292 Queen Street  
Albany, NY 12208

  
9590 9402 8180 3030 6442 43

2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2090 27

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  ☐ Agent ☒ Addressee

B. Received by (Printed Name) D. K. H. H. C. Date of Delivery 10-08-20

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Certified Mail® ☐ Signature Confirmation™ ☐ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Mail Restricted Delivery (over \$500)

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

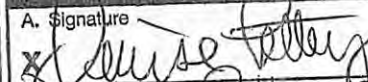
Town of Hartford  
PO Box 221  
Hartford, NY 12838

  
9590 9402 9166 4225 5220 77

2. Article Number (Transfer from service label)  
9589 0710 5270 2292 8116 37

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  ☐ Agent ☐ Addressee

B. Received by (Printed Name) Disc. Kelly C. Date of Delivery 4/8/25

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Certified Mail® ☐ Signature Confirmation™ ☒ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Mail Restricted Delivery (over \$500)

Domestic Return Receipt

**SENDER: COMPLETE THIS SECTION**

- Complete items 1, 2, and 3.
- Print your name and address on the reverse so that we can return the card to you.
- Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

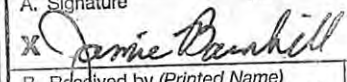
Town of Whitehall  
57 Skenesborough Drive, Suite 1  
Whitehall, NY 12887

  
9590 9402 8180 3030 6440 76

2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2091 19

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  ☐ Agent ☐ Addressee

B. Received by (Printed Name) Jamie Barnhill C. Date of Delivery 4/7/2

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type ☐ Priority Mail Express® ☐ Registered Mail™ ☐ Registered Mail Restricted Delivery ☐ Certified Mail® ☐ Signature Confirmation™ ☒ Certified Mail Restricted Delivery ☐ Signature Confirmation Restricted Delivery ☐ Collect on Delivery ☐ Collect on Delivery Restricted Delivery ☐ Insured Mail ☐ Mail Restricted Delivery (over \$500)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- ☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

town of ~~Tung~~sbury  
 i Michigan Street  
 Hudson Falls, NY 12839



9590 9402 8180 3030 6443 73

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2092 70

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

Paige Zahaba

☐ Agent  
☒ Addressee

B. Received by (Printed Name)

Paige Zahaba

C. Date of Delivery

4/7/25

D. Is delivery address different from item 1? ☐ YesIf YES, enter delivery address below: ☒ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

Mail Restricted Delivery (0)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- ☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Hoosick Falls EMS  
 21 1st Street  
 Hoosick Falls, NY 12090



9590 9402 8180 3030 6443 04

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2089 52

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

James Mahan

☐ Agent  
☐ Addressee

B. Received by (Printed Name)

James Mahan

C. Date of Delivery

4/7/25

D. Is delivery address different from item 1? ☐ YesIf YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

Mail Restricted Delivery (0)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- ☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Glens Falls Fire  
 134 Ridge Street  
 Glens Falls, NY 12801



9590 9402 8180 3030 6443 59

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2090 03

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

Craig Basore

☐ Agent  
☐ Addressee

B. Received by (Printed Name)

Craig Basore

C. Date of Delivery

4-7-25

D. Is delivery address different from item 1? ☐ YesIf YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

Mail Restricted Delivery (0)

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

- ☒ Complete items 1, 2, and 3.  
☒ Print your name and address on the reverse so that we can return the card to you.  
☒ Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Bolton EMS  
 5003 Lake Shore Drive  
 Bolton Landing, NY 12814



9590 9402 8180 3030 6442 81

2. Article Number (Transfer from service label)

9589 0710 5270 0483 2089 38

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature

X

Eal Mahan

☐ Agent  
☐ Addressee

B. Received by (Printed Name)

Eal Mahan

C. Date of Delivery

4-7-25

D. Is delivery address different from item 1? ☐ YesIf YES, enter delivery address below: ☐ No

3. Service Type

- ☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail

- ☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

Mail Restricted Delivery (0)

Domestic Return Receipt



**SENDER: COMPLETE THIS SECTION**

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.  
Article Addressed to:

osick Valley EMS  
48 NY-40  
aghticoke, NY 12154

9590 9402 8180 3030 6443 11

Article Number (Transfer from service label)  
9589 0710 5270 0483 2092 87

Form 3811, July 2020 PSN 75 J2-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
X *Matthew Fusco* ☒ Agent ☐ Addressee

B. Received by (Printed Name)  
*Matthew Fusco*

C. Date of Delivery  
*4/7*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Mail Restricted Delivery (00)

☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

**SENDER: COMPLETE THIS SECTION**

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Village of Hudson Falls  
120 Main Street  
Hudson Falls, NY 12839

9590 9402 9166 4225 5220 84

2. Article Number (Transfer from service label)  
9589 0710 5270 2292 8116 06

PS Form 3811, July 2020 PSN 7530-02-000-9053

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
X *Fawn M. Baum* ☐ Agent ☐ Addressee

B. Received by (Printed Name)  
*Fawn M. Baum*

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Mail Restricted Delivery (00)

☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

**SENDER: COMPLETE THIS SECTION**

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.  
Article Addressed to:

wn of Granville  
Box 177  
anville, NY 12865

9590 9402 8180 3030 6443 66

Article Number (Transfer from service label)  
9589 0710 5270 0483 2092 18

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
X *[Signature]* ☐ Agent ☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery  
*APR - 7 2025*

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Mail Restricted Delivery (00)

☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

**SENDER: COMPLETE THIS SECTION**

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:

Corinth Ambulance  
101 Sherman Avenue  
Corinth, NY 12822

9590 9402 8180 3030 6442 29

2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2091 64

**COMPLETE THIS SECTION ON DELIVERY**

A. Signature  
X *Bab Sirhan* ☐ Agent ☐ Addressee

B. Received by (Printed Name)

C. Date of Delivery

D. Is delivery address different from item 1? ☐ Yes  
If YES, enter delivery address below: ☐ No

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Mail Restricted Delivery (00)

☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery

# SENDER: COMPLETE THIS SECTION

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.  
Article Addressed to:

age of Cambridge  
North Park Street  
Cambridge, NY 12816



Article Number (Transfer from service label)  
9589 0710 5270 0483 2090 89

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature ☒ Agent ☐ Addressee  
*[Signature]*  
B. Received by (Printed Name) *L. Wang* C. Date of Delivery *4/5*  
D. Is delivery address different from item 1? ☐ Yes ☒ No  
If YES, enter delivery address below:

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery  
☐ Priority Mail Express®  
☐ Mail Restricted Delivery

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:  
Town of Putnam  
PO Box 95  
Putnam, NY 12861



2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2091 33

PS Form 3811, July 2020 PSN 7530-02-000-9053

## COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee  
*[Signature]*  
B. Received by (Printed Name) *Darlene Kerr* C. Date of Delivery  
D. Is delivery address different from item 1? ☐ Yes ☐ No  
If YES, enter delivery address below:

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery  
☐ Mail Restricted Delivery

Domestic Return Receipt

# SENDER: COMPLETE THIS SECTION

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.  
Article Addressed to:

ston Greenwich EMS  
1 NY-29  
Greenwich, NY 12834



Article Number (Transfer from service label)  
9589 0710 5270 2292 8116 82

## COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee  
*[Signature]*  
B. Received by (Printed Name) *[Signature]* C. Date of Delivery  
D. Is delivery address different from item 1? ☐ Yes ☐ No  
If YES, enter delivery address below:

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Insured Mail  
☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery  
☐ Mail Restricted Delivery

Domestic Return Receipt

## SENDER: COMPLETE THIS SECTION

Complete items 1, 2, and 3.  
Print your name and address on the reverse so that we can return the card to you.  
Attach this card to the back of the mailpiece, or on the front if space permits.

1. Article Addressed to:  
Town of Salem  
PO Box 575, 14 Main Street  
Salem, NY 12865



2. Article Number (Transfer from service label)  
9589 0710 5270 0483 2092 56

## COMPLETE THIS SECTION ON DELIVERY

A. Signature ☐ Agent ☐ Addressee  
*[Signature]*  
B. Received by (Printed Name) *Patricia A. Gilchrist* C. Date of Delivery  
D. Is delivery address different from item 1? ☐ Yes ☐ No  
If YES, enter delivery address below:

3. Service Type  
☐ Adult Signature  
☐ Adult Signature Restricted Delivery  
☒ Certified Mail®  
☐ Certified Mail Restricted Delivery  
☐ Collect on Delivery  
☐ Collect on Delivery Restricted Delivery  
☐ Priority Mail Express®  
☐ Registered Mail™  
☐ Registered Mail Restricted Delivery  
☐ Signature Confirmation™  
☐ Signature Confirmation Restricted Delivery  
☐ Mail Restricted Delivery

| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                        |  | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>Complete items 1, 2, and 3.</p> <p>Print your name and address on the reverse so that we can return the card to you.</p> <p>Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>Article Addressed to:</p> <p>Mr. of Easton</p> <p>1 State Route 40</p> <p>Enoch, NY 12834</p> |  | <p>A. Signature<br/> <input checked="" type="checkbox"/> Agent<br/> <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name)<br/> A. STONING</p> <p>C. Date of Delivery<br/> 4/7/25</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/> If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type<br/> <input type="checkbox"/> Adult Signature<br/> <input type="checkbox"/> Adult Signature Restricted Delivery<br/> <input checked="" type="checkbox"/> Certified Mail®<br/> <input type="checkbox"/> Certified Mail Restricted Delivery<br/> <input type="checkbox"/> Collect on Delivery<br/> <input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p><input type="checkbox"/> Priority Mail Express®<br/> <input type="checkbox"/> Registered Mail™<br/> <input type="checkbox"/> Registered Mail Restricted Delivery<br/> <input type="checkbox"/> Signature Confirmation™<br/> <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |  |
| <p>Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2090 65</p>                                                                                                                                                                                                                               |  | <p>1. Article Addressed to:</p> <p>Cambridge EMS</p> <p>37 Gilbert Street</p> <p>Cambridge, NY 12816</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 2292 8116 75</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |
| <p>Form 3811, July 2020 PSN 7530-02-000-9053</p>                                                                                                                                                                                                                                                                     |  | <p>Domestic Return Receipt</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |

| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                             |  | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <p>Complete items 1, 2, and 3.</p> <p>Print your name and address on the reverse so that we can return the card to you.</p> <p>Attach this card to the back of the mailpiece, or on the front if space permits.</p> <p>Article Addressed to:</p> <p>Mr. of Greenwich</p> <p>Academy Street</p> <p>Greenwich, NY 12834</p> |  | <p>A. Signature<br/> <input checked="" type="checkbox"/> Agent<br/> <input type="checkbox"/> Addressee</p> <p>B. Received by (Printed Name)<br/> V. S. S.</p> <p>C. Date of Delivery<br/> 4/7/25</p> <p>D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br/> If YES, enter delivery address below: <input type="checkbox"/> No</p> <p>3. Service Type<br/> <input type="checkbox"/> Adult Signature<br/> <input type="checkbox"/> Adult Signature Restricted Delivery<br/> <input checked="" type="checkbox"/> Certified Mail®<br/> <input type="checkbox"/> Certified Mail Restricted Delivery<br/> <input type="checkbox"/> Collect on Delivery<br/> <input type="checkbox"/> Collect on Delivery Restricted Delivery</p> <p><input type="checkbox"/> Priority Mail Express®<br/> <input type="checkbox"/> Registered Mail™<br/> <input type="checkbox"/> Registered Mail Restricted Delivery<br/> <input type="checkbox"/> Signature Confirmation™<br/> <input type="checkbox"/> Signature Confirmation Restricted Delivery</p> |  |
| <p>Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2090 72</p>                                                                                                                                                                                                                                    |  | <p>1. Article Addressed to:</p> <p>Wilton EMS</p> <p>1 Harran Lane</p> <p>Saratoga Springs, NY 12866</p> <p>2. Article Number (Transfer from service label)</p> <p>9589 0710 5270 0483 2089 90</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  |
| <p>Form 3811, July 2020 PSN 7530-02-000-9053</p>                                                                                                                                                                                                                                                                          |  | <p>Domestic Return Receipt</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |



| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                  |  | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                       |                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> Complete items 1, 2, and 3.<br><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.<br><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.                                                                                               |  | A. Signature<br> <input type="checkbox"/> Agent<br><input type="checkbox"/> Addressee                                                                                                                  |                               |
| 1. Article Addressed to:<br><br>Moreau EMS<br>1583 US-9<br>Fort Edward, NY 12828                                                                                                                                                                                                                                                                                                                               |  | B. Received by (Printed Name)<br>Stephen W. Van Buren                                                                                                                                                                                                                                   | C. Date of Delivery<br>4/7/25 |
| 2. Article Number (Transfer from service label)<br>9590 9402 8180 3030 6443 35                                                                                                                                                                                                                                                                                                                                 |  | D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br>If YES, enter delivery address below: <input type="checkbox"/> No                                                                                                                                         |                               |
| 3. Service Type<br><input type="checkbox"/> Adult Signature<br><input type="checkbox"/> Adult Signature Restricted Delivery<br><input checked="" type="checkbox"/> Certified Mail®<br><input type="checkbox"/> Certified Mail Restricted Delivery<br><input type="checkbox"/> Collect on Delivery<br><input type="checkbox"/> Collect on Delivery Restricted Delivery<br><input type="checkbox"/> Insured Mail |  | <input type="checkbox"/> Priority Mail Express®<br><input type="checkbox"/> Registered Mail™<br><input type="checkbox"/> Registered Mail Restricted Delivery<br><input type="checkbox"/> Signature Confirmation™<br><input type="checkbox"/> Signature Confirmation Restricted Delivery |                               |
| PS Form 3811, July 2020 PSN 7530-02-000-9053                                                                                                                                                                                                                                                                                                                                                                   |  | Domestic Return Receipt                                                                                                                                                                                                                                                                 |                               |

| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                                                                  |  | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                       |                               |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> Complete items 1, 2, and 3.<br><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.<br><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.                                                                                               |  | A. Signature<br> <input type="checkbox"/> Agent<br><input type="checkbox"/> Addressee                                                                                                                  |                               |
| 1. Article Addressed to:<br><br>Town of Fort Edward<br>113 Broadway<br>Fort Edward, NY 12828                                                                                                                                                                                                                                                                                                                   |  | B. Received by (Printed Name)<br>Erin Donahue                                                                                                                                                                                                                                           | C. Date of Delivery<br>4/7/25 |
| 2. Article Number (Transfer from service label)<br>9590 9402 8180 3030 6444 27                                                                                                                                                                                                                                                                                                                                 |  | D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br>If YES, enter delivery address below: <input type="checkbox"/> No                                                                                                                                         |                               |
| 3. Service Type<br><input type="checkbox"/> Adult Signature<br><input type="checkbox"/> Adult Signature Restricted Delivery<br><input checked="" type="checkbox"/> Certified Mail®<br><input type="checkbox"/> Certified Mail Restricted Delivery<br><input type="checkbox"/> Collect on Delivery<br><input type="checkbox"/> Collect on Delivery Restricted Delivery<br><input type="checkbox"/> Insured Mail |  | <input type="checkbox"/> Priority Mail Express®<br><input type="checkbox"/> Registered Mail™<br><input type="checkbox"/> Registered Mail Restricted Delivery<br><input type="checkbox"/> Signature Confirmation™<br><input type="checkbox"/> Signature Confirmation Restricted Delivery |                               |
| PS Form 3811, July 2020 PSN 7530-02-000-9053                                                                                                                                                                                                                                                                                                                                                                   |  | Domestic Return Receipt                                                                                                                                                                                                                                                                 |                               |

| SENDER: COMPLETE THIS SECTION                                                                                                                                                                                                                                                                                                                                         |  | COMPLETE THIS SECTION ON DELIVERY                                                                                                                                                                                                                                                       |                               |
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| <input checked="" type="checkbox"/> Complete items 1, 2, and 3.<br><input checked="" type="checkbox"/> Print your name and address on the reverse so that we can return the card to you.<br><input checked="" type="checkbox"/> Attach this card to the back of the mailpiece, or on the front if space permits.                                                      |  | A. Signature<br> <input type="checkbox"/> Agent<br><input type="checkbox"/> Addressee                                                                                                                |                               |
| 1. Article Addressed to:<br><br>Village of Fort Edward<br>PO Box 245<br>Fort Edward, NY 12828                                                                                                                                                                                                                                                                         |  | B. Received by (Printed Name)<br>Erin Donahue                                                                                                                                                                                                                                           | C. Date of Delivery<br>4/7/25 |
| 2. Article Number (Transfer from service label)<br>9590 9402 8180 3030 6441 06                                                                                                                                                                                                                                                                                        |  | D. Is delivery address different from item 1? <input type="checkbox"/> Yes<br>If YES, enter delivery address below: <input type="checkbox"/> No                                                                                                                                         |                               |
| 3. Service Type<br><input type="checkbox"/> Adult Signature<br><input type="checkbox"/> Adult Signature Restricted Delivery<br><input checked="" type="checkbox"/> Certified Mail®<br><input type="checkbox"/> Certified Mail Restricted Delivery<br><input type="checkbox"/> Collect on Delivery<br><input type="checkbox"/> Collect on Delivery Restricted Delivery |  | <input type="checkbox"/> Priority Mail Express®<br><input type="checkbox"/> Registered Mail™<br><input type="checkbox"/> Registered Mail Restricted Delivery<br><input type="checkbox"/> Signature Confirmation™<br><input type="checkbox"/> Signature Confirmation Restricted Delivery |                               |
| PS Form 3811, July 2020 PSN 7530-02-000-9053                                                                                                                                                                                                                                                                                                                          |  | Domestic Return Receipt                                                                                                                                                                                                                                                                 |                               |



8 May 2025

To Whom it May Concern

I serve as the Medical Director for Ft. Ann EMS and have reviewed their application for an expanded CON to include Glens Falls Hospital. I support their application as I feel it will benefit our patient population through improved access to interfacility transport services. I feel Ft. Ann EMS has demonstrated a high standard of performance and dependability with quality oversight through their ongoing work as a transporting agency.

Best Regards

Thomas Williams, MD

Glens Falls Hospital Emergency Medicine Physician



Shelley McKernon  
Town Clerk

Carrie Schermerhorn  
Assessor

Rebecca Brown  
Bookkeeper/Confidential Secretary

# Town of Argyle

41 Main Street/P.O. Box 38  
Argyle, NY 12809  
Phone (518) 638-8681 Fax: (518) 638-6823

<http://townofargyle.ny.com/>

Bob Henke  
Supervisor

Councilmen  
Patrick Sullivan  
Kevin Hayes  
Stephen Bonhote  
Scott Lufkin

Thursday, April 17, 2025

Bradley Pinsky  
Pinsky Law Group  
4311 East Genessee Street  
Syracuse, New York 13214

In Re: Fort Ann Rescue Squad CON

Dear Mr. Pinsky:

Residents of the Town of Argyle would generally be unaffected by activities of the Fort Ann Rescue Squad with regard to non-emergency transports to and from the Glens Falls Hospital. That said, any activities that will help residents anywhere in our rural county get better medical service while minimizing costs is definitely something we would support.

One of the real bars to working out ambulance service, both emergency and non-emergency, in New York State are the redundant and draconian regulations that continue to accrue from the state level. The entire Ambulance Service Certificate program is a prime example and one which adversely effects residents living near a state border even more keenly.

Please consider this a letter in favor of granting the requested CON.

Robert Henke  
Town Supervisor  
Town of Argyle

# TOWN OF HAMPTON

**TOWN CLERK**

Rebecca S. Jones, RMC

**WASHINGTON COUNTY**

PO Box 125  
Hampton, New York 12837  
(518) 282-9830

**TOWN COUNCIL**

Tamme Taran  
Don Sady  
Mike Pietryka  
Andrea Sweeney

**DAVID K. O'BRIEN, SUPERVISOR**  
Dave Obrien@hamptonny.org

April 14, 2025

Pinsky Law Group, PLLC  
Re: Fort Ann Rescue Squad, Inc  
4311 East Genesee Street  
Syracuse, New York 13214

To Whom it May Concern:

The Town of Hampton supports the application of the Fort Ann Rescue Squad for including the referenced area as part of their service area.

With EMS struggling for resources, including financial resources as well as trained and available personnel this increased CON will only serve to strengthen support for the proposed CON area as well as strengthen the financial resources Fort Ann Rescue Squad who to service this area.

We strongly recommend the award of the proposed area as being a win win for the entire area.

Sincerely,



David K. O'Brien

Supervisor

Town of Hampton

518-866-1022

Daveobrien@hamptonny.org

# TOWN OF PUTNAM

14 Putnam Center Road  
P.O. Box 95  
Putnam Station, N.Y. 12861  
(518) 547- 8317 FAX (518) 547- 9705  
www.townofputnamny.com

## PUTNAM TOWN SUPERVISOR

Darrell T. Wilson  
supervisor.wilson@townofputnamny.com

Pinsky Law Group, PLLC  
RE: Fort Ann Rescue Squad, Inc.  
4311 East Genesee Street  
Syracuse, New York 13214

## TOWN CLERK/ TAX COLLECTOR

Darlene Kerr  
townclerk@townofputnamny.com

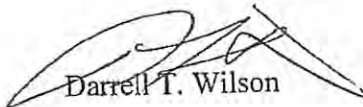
5/01/2025

This letter is an endorsement of the Fort Ann Rescue Squad. The Fort Ann Rescue Squad is instrumental in the safety and well-being of Washington County residents. The Fort Ann Rescue Squad provides reliable non-emergency transport ambulance service to the Glens Falls Hospital, permitting timely discharge and/or transfer of Hospital patients to other hospitals, nursing homes, and other treatment and diagnostic facilities.

The Town of Putnam supports the Fort Ann Rescue Squad's application for an Ambulance Service Certificate. Presently, there are delays hospital discharge and this certificate of need will enable the Fort Ann rescue Squad to better support area residents. This certificate of need should not harm other service providers since everyone is experiencing shortages on certified personnel and ambulances.

Thank you.

Warm regards,

  
Darrell T. Wilson



**TOWN OF WHITEHALL**

**57 Skenesborough Drive**

**Whitehall, NY 12887**

**Phone: (518) 499-1535 Fax: (518) 499-1546**

Councilperson, David Hollister  
Councilperson, Stephanie Safka

Supervisor, John W. Rozell  
Town Assessor, Roberta Stone  
Town Clerk, Patti Gordon

Councilperson, Christopher Dudley Sr  
Councilperson, Francis Wilbur

April 17, 2025

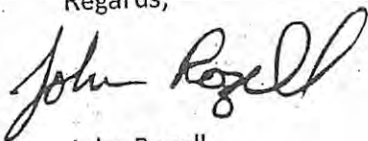
Pinsky Law Group, PLLC  
Re: Fort Ann Rescue Squad, Inc.  
4311 East Genesee Street  
Syracuse, New York 13214

To Whom It May Concern:

Town Supervisor, John Rozell, along with the Town Board members of the Town of Whitehall, NY have discussed and are in agreeance that there is a need for the Fort Ann Rescue Squad, Inc. expansion of its Ambulance Service Certificate.

1. Our local rescue squad, Skenesborough EMS, has a very small rooster of volunteers and has had a difficult time recruiting additional volunteers to join them. This being said, it affects the potential availability of paramedics being able to reach the "individual" in need of emergency care immediately. Having another ambulance available at all times would prevent catrosphy.
2. Also, there are no volunteers qualified in Advanced Life Support currently on staff at Skenesbough; and they have to pay an ALS paramedics from another department to man the station several days a week. When an incident requires this qualification and the paid staff member is not on staff, the ambulance must meet another ambulance at a predetermined location and hand off the patient in order to transport the individual to the hospital. This scenario causes significant delays in patient care which could be "life threatening".

Regards,



John Rozell  
Town Supervisor



April 18, 2025

SENT VIA FEDERAL EXPRESS

Bradley M. Pinsky  
Pinsky Law Group, PLLC  
4311 East Genesee Street  
Syracuse, NY 13214

Re: Fort Ann Rescue Squad, Inc.

Dear Mr. Pinsky:

This letter is in response to your correspondence dated April 3, 2025, regarding the Fort Ann Rescue Squad, Inc.'s Certificate of Need application. Mohawk Ambulance Service unequivocally opposes this request and appreciates this letter being included with the application.

As noted in Fort Ann's "Detailed Narrative", there are currently 13 agencies servicing Glens Falls Hospital; adding another will unnecessarily fragment the market and degrade Basic and Advanced Life Support transport quality and availability.

Glens Falls Hospital and the surrounding community are very well served by Mohawk Ambulance Service and other agencies. The addition of Fort Ann would be redundant and unnecessary.

Thank you for your time and attention. Please contact me by phone ((518) 346-5060) or email (jim@mohawkambulance.com) if there are any questions or comments.

Sincerely,

James P. McPartlon III  
President and CEO

CC: JP McPartlon IV, Vice President and General Counsel

**M E M B E R**



Administrative Office // 357 Kings Road Schenectady, New York 12304 / (518) 346-5060 / FAX (518) 374-8511  
Business Office // 357 Kings Road Schenectady, New York 12304 / (518) 347-4468 / FAX (518) 374-4685  
Dispatch Center // 357 Kings Road Schenectady, New York 12304 / (518) 374-5190 / FAX (518) 374-8368

SCHENECTADY // 793 State Street Schenectady, New York 12307 / Emergency Number (518) 374-4401  
BRUNSWICK // 161 McChesney Ave Troy, New York 12180 / Emergency Number (518) 274-4888  
ALBANY // 290-292 Quail Street Albany, New York 12208 / Emergency Number (518) 434-4151  
ALBANY // 570 Central Avenue Albany, New York 12206 / Emergency Number (518) 434-4151  
GLENNVILLE // 176 Freemans Bridge Road Glenville, New York 12302 / Emergency Number (518) 374-4401