



NEW YORK STATE DEPARTMENT OF HEALTH  
Bureau of Emergency Services and Trauma Systems

# 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		
Sylvamo Medical Emergency Response Team	1511	13-0872805		
Address	City	State	Zip	County
568 Shore Airport Road	Ticonderoga	NY	12883	Essex
Contact Person	Title			
Holly Munson	RN, EMT			
Business Phone	Home Phone	Cell Phone	E-mail	
( 518 ) 585- 5709	( ) -	( ) -	holly.munson@sylvamo.com	

Current Organizational Sponsor Type

- Proprietary
- Hospital Based
- Volunteer Independent
- Industrial
- Volunteer Fire Department
- Municipal/Government
- Other

Type of Ownership

- Individual
- Partnership
- Government
- Corporation
- LLC

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

Sylvamo North America, LLC (wholly owned by Sylvamo Corp. - public entity)

## 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

Industrial premises of paper mill

For expansion list existing primary operating territory

N/A

## 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

See attached Certificate of Insurance

Agent

Business Phone  
( ) -

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 Address City State Phone Number  
 Laura Mulvey, MD ( 518 ) 873 - 6377

Agency Providing Medical Control Phone Number  
 ( ) -

System Medical Director Address City State Phone Number  
 ( ) -

Size of Population to be Served Days of operation Hours of operation  
 600 7 days/week 24 hours/day

Projected Call Volume Total 5 - 8/year Emergency Non-Emergency

Source of Statistics for Call volume  PCR  Dispatch Center  Agency Call Record  Other Records

Total no. of ambulances Total no. of emergency ambulance service vehicles (EASV'S) Total no. of ALS First Response vehicles  
 1

**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  
 Sylvamo Medical Emergency Response Team 13-0872805

Address City State Zip County  
 568 Shore Airport Road Ticonderoga NY 12883 Essex

Contact Person Title  
 Holly Munson RN

Business Phone Home Phone Cell Phone E-mail  
 ( 518 ) 585 - 5673 ( ) - ( ) - holly.munson@sylvamo.com

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)  
 Sylvamo North America, LLC (wholly owned by Sylvamo Corp. - public entity)

**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 Signature Date Title  
 Christopher Dostie 10/15/2025 Agency CEO (Mill Manager)

Signature Date  
 Sarah Eileen Bush 10/15/2025  
 Notary Public affirmation and acknowledgement

FOR REGIONAL EMS COUNCIL USE ONLY

Date Application Received \_\_\_\_\_  
 Date of Council Decision \_\_\_\_\_  
 Approved  Denied  Rejected - Incomplete  
 Council Chair Signature \_\_\_\_\_



## **APPENDIX TO FORM DOH-3777**

### **Statement of purpose and intent for transfer:**

The Medical Emergency Response Team at the paper mill in Ticonderoga, NY has been authorized and licensed to operate by the New York Department of Health and REMSCO prior to 1985. It provides emergency response services strictly to employees and contractors at its paper mill industrial site. This Medical Emergency Team was under the ownership of the International Paper Company until ownership transferred to Sylvamo North America, LLC in a spin-off on October 1, 2022.

Since 2022, the Medical Emergency Response Team continued to renew its license through New York's DOH and REMESCO believing a name change was all that was necessary. It has since been brought to our attention that this application to Transfer Ownership is necessary.

**Certification of Incorporation** (attached)

**Affirmation of Fitness and Competence** (Form DOH-3778 attached)

**Financial Information** (Form DOH-5131 attached)

**Certificate of Insurance** (attached)

**Primary Operating Territory Map** (attached)

## **APPENDIX TO FORM DOH-3778**

This Medical Emergency Response Team has been certified and licensed by the NYS Department of Health and REMESCO for the last 2 years. Please see agency records.

# Delaware

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*The First State*

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF FORMATION OF "TIN INTERMEDIATE, LLC", FILED IN THIS OFFICE ON THE TENTH DAY OF NOVEMBER, A.D. 2014, AT 6 O'CLOCK P.M.

5636859 8100

141393051

You may verify this certificate online  
at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)



  
Jeffrey W. Bullock, Secretary of State  
AUTHENTICATION: 1854890

DATE: 11-12-14

**CERTIFICATE OF FORMATION**

**OF**

**TIN INTERMEDIATE, LLC**

1. The name of the limited liability company is: TIN INTERMEDIATE, LLC.

2. The address of its registered office in the State of Delaware is: Corporation Trust Center, 1209 Orange Street, in the City of Wilmington, State of Delaware 19801. The name of its registered agent at such address is The Corporation Trust Company.

IN WITNESS WHEREOF, the undersigned has executed this Certificate of Formation of TIN INTERMEDIATE, LLC, this 10<sup>th</sup> day of November, 2014.

/s/ Michelle R. King  
Michelle R. King, Authorized Person

# Delaware

Page 1

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY THE ATTACHED IS A TRUE AND CORRECT COPY OF THE CERTIFICATE OF AMENDMENT OF "TIN INTERMEDIATE, LLC", CHANGING ITS NAME FROM "TIN INTERMEDIATE, LLC" TO "SYLVAMO NORTH AMERICA, LLC", FILED IN THIS OFFICE ON THE TWENTIETH DAY OF APRIL, A.D. 2021, AT 7:52 O`CLOCK P.M.



A handwritten signature in black ink, appearing to read "JB", is written over a horizontal line. Below the line, the text "Jeffrey W. Bullock, Secretary of State" is printed in a small font.

5636859 8100  
SR# 2021137747

Authentication: 203024199  
Date: 04-21-21

You may verify this certificate online at [corp.delaware.gov/authver.shtml](http://corp.delaware.gov/authver.shtml)

State of Delaware  
Secretary of State  
Division of Corporations  
Delivered 07:52 PM 04/20/2021  
FILED 07:52 PM 04/20/2021  
SR 2021137747 - File Number 5636859

**CERTIFICATE OF AMENDMENT  
OF THE  
CERTIFICATE OF FORMATION  
OF  
TIN Intermediate, LLC**

TIN Intermediate, LLC, a limited liability company (the "Company") organized and existing under and by virtue of the Limited Liability Company Act of the State of Delaware,

DOES HEREBY CERTIFY:

FIRST: That the Board of Managers of said Company, by unanimous written consent, filed with the minutes of the Board, adopted a resolution approving the following amendment to the Certificate of Formation of said Company:

RESOLVED, that the Certificate of Formation of TIN Intermediate, LLC be amended by changing the First Article thereof so that, as amended, said Article shall be and read as follows:

"The name of this limited liability company is Sylvamo North America, LLC."

SECOND: That the aforesaid amendment was duly adopted in accordance with the applicable provisions of Section 18-202(a) of the Limited Liability Company Act of the State of Delaware.

THIRD: That this Certificate of Amendment of the Certificate of Formation shall be effective when filed with the Secretary of State of the State of Delaware.

IN WITNESS WHEREOF, said Company has caused this certificate to be signed by Matthew L. Barron, its Senior Vice President, General Counsel and Secretary this 20th day of April, 2021.

Matthew L. Barron  
Matthew L. Barron (Apr 20, 2021 15:31 CDT)

Matthew L. Barron  
Senior Vice President, General Counsel and  
Secretary



# State of Delaware

SECRETARY OF STATE  
DIVISION OF CORPORATIONS  
P.O. BOX 898  
DOVER, DELAWARE 19903

8052935  
INTERNATIONAL PAPER COMPANY  
6400 POPLAR AVENUE  
MEMPHIS, TN 38197

03-16-2021

ATTN: ECORP

DESCRIPTION	AMOUNT
<b>5515548 - SYLVAMO U.S., LLC - 07/14/2021</b> <b>0100C Name Reserve; Charge</b>	
	<i>Name Reservation Fee</i> <b>\$75.00</b>
<b>5515550 - SYLVAMO CORPORATION - 07/14/2021</b> <b>0100C Name Reserve; Charge</b>	
	<i>Name Reservation Fee</i> <b>\$75.00</b>
<b>5515554 - SYLVAMO NORTH AMERICA, LLC - 07/14/2021</b> <b>0100C Name Reserve; Charge</b>	
	<i>Name Reservation Fee</i> <b>\$75.00</b>
	<b>TOTAL CHARGES</b> <b>\$225.00</b>
	<b>TOTAL PAYMENTS</b> <b>\$225.00</b>
	<b>BALANCE</b> <b>\$0.00</b>

## 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.

Sylvamo Medical Emergency Response Team

1511

Name of EMS Agency

NYS EMS Agency Code

Sylvamo North America, LLC

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

Christopher Dostie

Mill Manager/Agency CEO

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.

Christopher Dostie

Full Name

*Christopher Dostie*

Signature

*10/15/2025*

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.

Christopher Dostie

Full Name

*Christopher Dostie*

Signature

*10/15/2025*

Date

## Notary Public Affirmation and Acknowledgement

*Sarah Eileen Bush*

Notary Public Name

*Sarah Eileen Bush*

Signature

*10/15/2025*

Date



Please affix Notary Public Stamp or equivalent.

Please complete the following information regarding the funding of your agency.

**NOTE: Response is mandatory. Failure to complete this form accurately may impact your agency's authority to collect fees for prehospital patient care.**

Name of EMS agency Sylvamo Medical Emergency Response Team DOH agency code 1511

Does your EMS agency bill (collect fees for prehospital transport/patient care)?

Yes  No

If Yes, does your agency process its own billing and filings to Medicare/Medicaid/private insurance for prehospital transport/patient care fees?

Yes  No

If Yes, skip to Funding Sources section below.

If No, indicate the name of the "Service Bureau" or contractor that processes the billing for your EMS agency

EMS Agency NYS Medicaid provider ID number N/A

Service Bureau NYS Medicaid ID number N/A

Note: if your contractor also provides EMS, the Service Bureau is not the same ID used by that EMS agency for its own billing, or your ID this is a separate ID number issued to the contractor by Medicaid authorizing the contractor to process/submit billing for 3rd party EMS agencies.

**The New York State Department of Health will assume that failure to provide a valid ID number for a Medicaid Service Bureau indicates that your service's billing practices and/or contractor services are unlawful and will report them to the New York State Office of Health Insurance Programs.**

## Funding Sources

Identify ALL of the funding sources received by your EMS agency.

Fire District(s) [NOT fire protection districts] \_\_\_\_\_  
(If more than one district, list additional on back of this page. List Fire Protection Districts below)

Ambulance District [legal name of taxing district] \_\_\_\_\_  
(If more than one district, list additional on page 2)

Municipal Contracts [other than fire districts] \_\_\_\_\_  
(List all municipalities your agency holds EMS contracts with including County, City, Town, Village, and Fire Protection Districts.  
List additional municipalities on page 2)

Donations or fund-raisers \_\_\_\_\_

Not-for-profit status  
 501(c)(3)  Other NFP \_\_\_\_\_

Other funding sources not identified above \_\_\_\_\_  
(Include agreements/contracts with service fees to provide ALS to other certified services. i.e., ALS assists)

Service's approximate total annual EMS operating budget \_\_\_\_\_

Is your service an operator for another service that bills?

Yes  No

If Yes, service name \_\_\_\_\_ Agency code \_\_\_\_\_

Name of person completing this form Holly Munson

Title of person completing form (print) RN

Signature of person completing this form (print) Holly J Munson

Date completed 10/15/2025

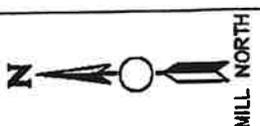
Date 10/15/2025





# AMBULANCE DOORS

# EMERGENCY RESPONSE MAP (MILL PERSONNEL TO MEET AMBULANCE)



1. FIRST-AID
2. ADMIN. BASEMENT
3. WAREHOUSE NORTHWEST CORNER
4. WAREHOUSE LOADING DOCK
5. FINISHING ROOM EXTENSION
6. FINISHING ROOM AIR COMPRESSOR
7. MACHINE ROOM BASEMENT - DRY END
8. AIR/WATER
9. MACHINE ROOM BASEMENT - WET END
10. POWER PLANT - NORTH
11. POWER PLANT - SOUTH
12. RECAUST
13. PULP MILL REPAIRS
14. PULP MILL - SOUTH
15. PFIZER
16. WOODROOM
17. ADDITIVE BLDG.
18. MAINTENANCE CLASS ROOM
19. OUTDOOR MISC.
20. SHOP/STORES AREA
21. BAILER ROOM DOCK
22. WAREHOUSE LOADING AREA - SOUTH
23. CRANE BLDG.
24. ROSS FARM - PRESS BLDG.



- GATE #5
- ▲ RESPONSE PERSONNEL INGRESS & EGRESS
- RESPONSE EQUIPMENT TRANSPORTATION ROUTES
- ☀ MILL WIDE EVACUATION ALARM

## LEGEND

- ▨ - ELEVATORS
- ① - No. 1 thru 24 AMBULANCE DOORS
- ②④ ROSS FARM
- EMERGENCY RESPONSE EQUIPMENT STORAGE

