SHERWIN-WILLIAMS.

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Short-Term Disability Instructions

1. If you have not already done so, you must immediately notify your manager or supervisor of your absence from work and / or comply with any local requirements regarding reporting of absences.

2. If you have not already done so, go to the Organizational Solutions Inc. (OSI) Portal at https://portal.orgsoln.com [Username: Sherwin/ Password: Williams (this is case sensitive)] or call OSI toll free at 1-877-674-2567 to report your absence.

3. You can obtain the Short Term Disability forms from the OSI portal or OSI can email you the forms. Please fill out the employee portion and consent of the Attending Physician's Statement (APS) then take the physician portion of the APS to your doctor and have him / her fill it out. Return it directly to at confidential Fax # 1-866-511-0008 or email OSI4Sherwin-Williams@orgsoln.com.

4. After submitting a claim, a Disability Management Specialist from OSI will call you to offer you support during your absence and return to work.

5. You are required to comply with the treatment plan prescribed by your physician in order to return to your regular job.

6. Sherwin-Williams will consider whether transitional modified work is available. You may be asked to have your doctor complete a Functional Abilities Form (FAF) to describe your capabilities.

7. OSI will request updated medical documentation and / or a return to work note when required. Please follow-up with your physician for completion whenever you are asked to do so. This will assist Sherwin-Williams and Organizational Solutions Inc. in arranging appropriate work for you.

8. Return to regular work.

Encl.: Employee Letter
Letter to Physician
Attending Physician's Statement

Dear _____,

Re: **Short Term Disability Claim (STD)**

We know this can be a difficult time from a personal and health perspective. We hope that the information in this packet provides you with a clear understanding of the process during your disability leave. Sherwin-Williams employs Organizational Solutions Inc. to assist with your disability claim. Organizational Solutions Inc. is a leading care management company that provides confidential support during your absence.

Organizational Solutions Inc. will contact you when you are ill or injured to assist you in your recovery and return to work. The Care Management program also facilitates the provision of *"the **RIGHT** care, at the **RIGHT** time, for the **RIGHT** outcome©."*

If you are not able to work due to a non-occupational injury or illness, you must obtain an Attending Physician's Statement (APS) form. This form must be completed by your doctor and should be returned directly to Organizational Solutions Inc.'s confidential fax number **1-866-511-0008** or electronically at OSI4Sherwin-Williams@orgsoln.com

An Organizational Solutions Inc. Disability Management Specialist will work with you to support and help you during your recovery. The Organizational Solutions Inc. Disability Management Specialist works by telephone with you, your healthcare providers, and your employer, respecting confidentiality at all times.

All medical information will remain confidential and only non-medical and return to work capabilities will be shared with your site or area HR Professional.

Should you wish to initiate contact with your Organizational Solutions Inc. Disability Management Specialist, she / he can be reached at 1-877-674-2567 to answer any questions you may have.

Sherwin-Williams

Encl.: Letter to Physician
Attending Physician's Statement

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Dear Physician:

Sherwin-Williams is committed to assisting employees in their recovery and providing safe return to work. Sherwin-Williams will consider providing transitional modified duties and / or modified hours of work, if required.

Employees must provide sufficient objective medical documentation to support their absence and to assist in the development of a return to work plan appropriate to the employee's abilities and limitations.

Please complete and return the enclosed Attending Physician's Statement (APS) to OSI's confidential fax 1-866-511-0008. This APS is also available on-line for your completion at https://portal.orgsoln.com Enter the following:

Username: Physician
Password: APS#4523

The employee must still submit (fax or scan) the consent to OSI.

A Disability Management Specialist from Organizational Solutions Inc. will work with, support and help your patient during their recovery and return to work.

Confidentiality of medical information will be respected at all times. The employee's non-medical and functional capabilities and / or restrictions will be shared with Sherwin-Williams.

We thank you in advance for your assistance and invite you to contact us at 1-877-674-2567 with any questions.

Sincerely,

Disability Management Specialist
1-877-674-2567
Email: OSI4Sherwin-Williams@orgsoln.com

Encl.: Attending Physician's Statement

Please Note:

"The treating physician's role in helping a patient return to work has the following main elements: providing to the patient medical necessary services related to the injury or illness to achieve optimum health and functionality; providing objective, accurate and timely medical information for the consideration of eligibility of insurance benefits; and providing objective, accurate and timely medical information as part of the timely return-to-work program."

CMA – The Treating Physician's Role in Helping Patients Return to Work After an Illness or Injury (Update 2013).

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Attending Physician Statement (APS)

t: 1-866-674-7656; **f:** 1-866-511-0008; **e:** info@orgsoln.com

In order for an absence to qualify under the Employer's Short Term Disability plan, the medical documentation must contain objective clinical findings and detailed medical information which establishes the presence of a medical condition and treatment including objective evidence of an impairment severe enough to prevent your patient / client from participating in work.
This employee is applying for Short Term Disability under the Employer's Short Term Disability / Sick Leave plan.

- It is the employee's responsibility to provide medical information to support an absence. The cost incurred in obtaining this information is the responsibility of the employee.
- Failure to submit this information promptly may result in the suspension of income for your patient / client.
- This is not a request for examination, but for information taken from your clinical assessment.

If absence is related to surgery, this form is to be completed after the surgery has been done.
Once completed, please send to Organizational Solutions Inc.'s confidential fax at **1-866-511-0008**. For additional information, please contact us at **1-866-674-7656**.

1 Employee Information - To be Completed by the Employee : Page 1 of 4

Employer Name: SHERWIN-WILLIAMS CANADA			
Employee First Name:	Last Name (Quebec residents include maiden name):		
Employee Number:	Date of Birth: MM / DD / YYYY	Home Telephone:	Work Telephone:
Cell Phone:	Email Address:		
Home Address:	Occupation:		
Immediate Supervisor's Name:	Telephone:		
Please describe the nature of illness or injuries sustained:			

Is your illness or injury due to an accident?: Yes ☐ No ☐
IF YES: 1) Did the accident happen at: Home ☐ Work ☐ Elsewhere ☐
Date and Time of accident: MM / DD / YYYY at _____
2) Have you or will you be applying for Workers' Compensation / CSST? Yes ☐ No ☐
3) Is your illness or injury due to a motor vehicle accident? Yes ☐ No ☐ **If yes, enclose a copy of the accident report.**
4) Date of first absence: MM / DD / YYYY

When did you seek medical attention? MM / DD / YYYY

Date you returned to work or expect to return to work: MM / DD / YYYY

Disability Type: Illness ☐ Injury ☐ Work Injury ☐ Motor Vehicle Accident ☐ Pregnancy ☐

2 Authorization to Release Information

I certify that the statements in this form are true and complete.

I authorize Organizational Solutions Inc., and their respective agents and service providers to use and exchange information needed for providing advice to my employer concerning my absence under my employer's Short Term Disability / Sick-Leave plan, with any person or organization who has relevant information pertaining to my absence, including health professionals, institutions, and insurers.

I hereby authorize health care provider(s), institutions, or the LTD Insurer / WCB involved in my treatment or claim to discuss and provide all information and documents requested by the Employer and / or, Organizational Solutions Inc., their representatives, concerning my current medical or psychological health condition. I authorize Organizational Solutions Inc. to release information to the Insurer, WCB, administrators of government benefits, or health care practitioners. All Information will be treated in a highly confidential manner. Information regarding my return to work capabilities will be shared with my employer.

I agree that a facsimile copy or a photocopy is to be considered as valid as an original signed copy.

Employee Signature : _____ **Date :** MM / DD / YYYY

ORGANIZATIONAL SOLUTIONS INC.
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Attending Physician Statement (APS)

t: 1-866-674-7656; f: 1-866-511-0008; e: info@orgsoln.com

3 Physician Questionnaire

Dear Physician: *The Employer is interested in supporting ill and injured employees in their recovery and a safe, timely return to work. We ask you to complete the few questions below so that the employee can return this form as soon as possible via fax 1-866-511-0008.*

There is an option to complete this form online at : *https://portal.orgsoln.com (**Username**: Physician / **Password**: APS#4523)*

History

Date of 1st visit: MM / DD / YYYY Date most recent visit: MM / DD / YYYY Date last worked: MM / DD / YYYY
When did symptoms first appear or accident first happen?: MM / DD / YYYY

Has your patient ever had the same or similar condition: Yes ☐ No ☐ Unknown ☐
If yes - State when and describe: _____
Frequency of symptoms over the past six months: _____
Physical findings: _____

Names and specialties of other treating physicians **(Please attach copies of consultation reports)** :

Name	Specialty	Frequency of Visits / Treatments	Dates

For PSYCHIATRIC diagnosis please proceed to page 4 and complete. Signature required on Page 3

Diagnosis (including complications)

Primary: _____ Secondary: _____
Co-morbid conditions or complications: _____
If Obstetrical diagnosis: Expected date of confinement: MM / DD / YYYY Is patient confined to bedrest: Yes ☐ No ☐
Signs and Symptoms: _____

Objective and clinical findings – Please be specific – pertinent physical findings (include severity, frequency):

If diagnosis is musculoskeletal in nature, please indicate neurological findings:

				Comments:
Area(s) affected:	Right ☐	Left ☐	Both ☐	
Reflexes:	Right ☐	Left ☐	Both ☐	
Weakness present:		Yes ☐	No ☐	
Muscle wasting noted:		Yes ☐	No ☐	
Decreased sensation or numbness:		Yes ☐	No ☐	
Positive Tinel's or Phalen's sign:		Yes ☐	No ☐	
Radiating Pain?:		Please describe:		

Does your patient exhibit pain focused behaviors?: Yes ☐ No ☐ _____

Treatment Plan

Hospital Admission – Admission Date: MM / DD / YYYY Discharge Date: MM / DD / YYYY
Surgery: Yes ☐ No ☐ Date: MM / DD / YYYY Surgical procedure: _____
Please complete the type of diagnostic testing completed or pending: _____ Date: MM / DD / YYYY
Medication (attach page if required):

Name	Dose	Date Begun	Date Changed and Reason	Response

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Physician Questionnaire (Continued)

Current and proposed treatment – include type, frequency and duration:

_____

_____

Has a referral for physiotherapy been made? Yes ☐ No ☐ Start date for Physiotherapy: MM / DD / YYYY

Compliance – Is your patient compliant with the recommended treatment program? Yes ☐ No ☐

Functional Capacity

PLEASE PROVIDE CURRENT CAPABILITIES Estimated Duration of limitations: _____

MOBILITY	OCCASIONAL (1-33%)	FREQUENT (34-66%)	CONSTANT (67-100%)	FULL ABILITY
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Continuous Bending / Twisting	☐	☐	☐	☐
Kneeling / Crouching / Squatting	☐	☐	☐	☐
LIFTING FLOOR TO WAIST				
Sedentary (up to 4.5 kgs)	☐	☐	☐	☐
Light (4.6 - 9.0 kgs)	☐	☐	☐	☐
Medium (9.1 – 22 kgs)	☐	☐	☐	☐
LIFTING WAIST TO SHOULDER				
Sedentary (up to 4.5 kgs)	☐	☐	☐	☐
Light (4.6 - 9.0 kgs)	☐	☐	☐	☐
Medium (9.1 – 22 kgs)	☐	☐	☐	☐

UPPER BODY	Right	Left	Both	Right	Left	Both	Right	Left	Both	Right	Left	Both
Pushing / Pulling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Carrying	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gripping / Grasping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reaching forward (over 45 cm)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reaching overhead (over 178 cm)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Is your patient able to operate a motor vehicle?: Yes ☐ No ☐

If no, has inability to operate a motor vehicle been reported to Minstry of Transportation?: Yes ☐ No ☐ Date: MM / DD / YYYY

Prognosis

To the best of my knowledge, this Employee is completely unable to work from: Date: MM / DD / YYYY to Date: MM / DD / YYYY

What is the prognosis for return to regular unrestricted work?: _____

What are the factors affecting your patient's progress?: _____

Is complete recovery expected? Yes ☐ No ☐

Notice to Physician Any information provided by me to OSI regarding this claim may be disclosed to the Employee and / or those authorized by him / her to receive such disclosure unless I notify OSI in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect to the health of the Employee or result in harm to a third party.

Physician Signature: _____ **Print Physician name:** _____ **Date:** MM / DD / YYYY

Specialty: _____ **Street:** _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Telephone Number: _____ **Fax Number:** _____ **License Number:** _____

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Attending Physician Statement (APS)

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4 Complete this section if diagnosis is PSYCHIATRIC in nature

Psychiatric Diagnosis / Reason for visit per DSM 5: _____
Secondary diagnosis (if applicable): _____

Are patient's symptoms due to drug or alcohol abuse?: Yes ☐ No ☐ If yes, details: _____
Hospital admission or substance abuse program?: Yes ☐ No ☐ If yes, details: _____

Signs and Symptoms: _____
_____

DSM-5 Code(s):_____ Current Global Assessment of Function score (GAF): _____
Severity: Mild ☐ Moderate ☐ Severe ☐ Date of Onset: ___ / ___ / _____

PLEASE PROVIDE CURRENT CAPABILITIES:

COGNITIVE CAPABILITIES	OCCASIONAL (1-33%)	FREQUENT (34-66%)	CONSTANT (67-100%)	FULL ABILITY
Verbal Communication	☐	☐	☐	☐
Attention to Detail	☐	☐	☐	☐
Concentration	☐	☐	☐	☐
Able to follow and provide instructions	☐	☐	☐	☐

Functional limitations that apply to diagnosis?: _____
_____
Is your patient able to perform their normal Activities of Daily Living (ADL)?: Yes ☐ No ☐
If no, please provide details as to how your patient's medical condition impacts their ability to perform their ADLs:
_____

How often is your patient being evaluated?: _____

Please confirm if any other medical conditions have been ruled out as contributing to or causing the current mental health condition(s): _____

Medication (attach page if required):

Name	Dose	Date Begun	Date Changed and Reason	Response

Referral to therapy / counselling?: Yes ☐ No ☐ If yes, provide name and details: _____
_____
Referral to Psychiatrist?: Yes ☐ No ☐ If yes, provide name and details: _____
_____
If yes, provide next appointment date: ___ / ___ / _____ Date referral was made: ___ / ___ / _____
If no, provide rationale: _____

Are there any psychological stressors that may affect return to work? Yes ☐ No ☐
Psychosocial and environmental problems: Yes ☐ No ☐ Workplace Issues: Yes ☐ No ☐
Comments: _____
Please provide recommendations to assist your patient in a safe and suitable return to work: _____
_____

Physician, please complete prognosis and sign on page 3.