

IC File # \_\_\_\_\_

# NOTICE OF TERMINATION OF COMPENSATION BY REASON OF TRIAL RETURN TO WORK G.S. § 97-18.1(b) AND G.S. § 97-32.1

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

The Use of This Form Is Required Under the Provisions of the Workers' Compensation Act

Employer FEIN \_\_\_\_\_

Employee's Name \_\_\_\_\_

Employer's Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Carrier \_\_\_\_\_

Home Telephone \_\_\_\_\_ Work Telephone \_\_\_\_\_

Carrier's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

XXX-XX- \_\_\_\_\_  M  F / /

( ) ( )

Last 4 Digits of SSN \_\_\_\_\_ Sex \_\_\_\_\_ Date of Birth \_\_\_\_\_

Carrier's Telephone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**Important Notice to Employee:** Your disability compensation has been stopped because you have returned to work. You are entitled to a trial return to work for a period not to exceed nine months, unless you have been released by an authorized treating physician to unrestricted work, in which case your trial return to work may be limited to 45 days. During your trial return to work, you may be entitled to partial disability compensation if, because of your on-the-job injury, you earn less wages now than before your injury. In order to request that your compensation be reinstated if your trial return to work is unsuccessful, you should complete Form 28U, which may be obtained by calling (800) 688-8349. In addition, you should notify an appropriate person at the company named below in order to request that your compensation be reinstated:

NAME OF EMPLOYER OR CARRIER/ADMINISTRATOR \_\_\_\_\_ ADDRESS \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

When an employee returns to work other than on a trial return to work basis [see I.C. Rule 404A(7)], Form 28 must be used.

**EMPLOYER: COMPLETE THE FOLLOWING.**

1. Date of injury: \_\_\_\_\_ 2. Date disability began: \_\_\_\_\_

3. Date temporary total compensation was/will be terminated: \_\_\_\_\_

4. Date the employee returned/will return to work: \_\_\_\_\_

at the  same or greater wages, than received at the time of injury, or  
at  reduced wages which were/are paid at the rate of \$ \_\_\_\_\_ weekly.

If employee has returned to work at reduced wages, is employee entitled to compensation for partial disability pursuant to N.C. Gen. Stat. § 97-30?  yes  no

If "Yes", submit proper Form, such as Form 26 or Form 62

If not, explain: \_\_\_\_\_

5. If different employment has been verified, name of employer: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR \_\_\_\_\_

TITLE \_\_\_\_\_

DATE \_\_\_\_\_

Employer: The original of this form shall be mailed to the address below, and a copy sent to the employee and the employee's attorney of record, if any. Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL  
HTTP://WWW.IC.NC.GOV/DOCFLILING.HTML