

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

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employee's Name _____		Email Address _____		Employer's Name _____		Email Address _____		() Telephone Number _____	
Address _____				Employer's Address _____		City _____		State _____ Zip _____	
City _____		State _____ Zip _____		Insurance Carrier _____					
()		()		Carrier's Address _____		City _____		State _____ Zip _____	
Home Telephone _____		Work Telephone _____		()					
XXX-XX- _____		☐ M ☐ F		/ /					
Last 4 Digits of SSN _____		Sex _____		Date of Birth _____		Carrier's Telephone Number _____		Adjuster's Name _____ Email Address _____	

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 11 NCAC 23A .0404A(g)], 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
[HTTPS://WWW.IC.NC.GOV/DOCFILING.HTML](https://www.ic.nc.gov/docfiling.html)