

RETURN TO WORK REPORT

IC File # _____

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- _____ Sex M F Date of Birth _____

Carrier's Telephone Number _____ Fax Number _____

Employer: The use of this form is not appropriate when an employee has returned to work on a trial return to work basis pursuant to N.C. Gen. Stat. § 97-32.1, in which case Form 28T must be used. By using this form, you are stating that this case is not a trial return to work and that one of the exclusions contained in NCIC Rule 11 NCAC 23A .0404A(g) applies.

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. If your trial return to work is unsuccessful, you should complete form 28U in order to request that your compensation be reinstated.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING:

1. Date of injury: _____
2. Date disability began: _____
3. Date returned to work: _____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES:

Employee is being paid at the rate of \$ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer: _____
2. Address: _____
3. Telephone: _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	DATE
--	-------	------

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

EMAIL TO FORMS@IC.NC.GOV

CONTACT INFORMATION:
NCIC-CLAIMS ADMINISTRATION
TELEPHONE: (919) 807-2502
HELPLINE: (800) 688-8349
WEBSITE: [HTTP://WWW.IC.NC.GOV](http://WWW.IC.NC.GOV)