

NOTICE OF REINSTATEMENT OR MODIFICATION OF COMPENSATION (G.S. § 97-32.1 OR § 97-18(b))

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	Policy Number	
() - Home Telephone	() - Work Telephone	Carrier's Address		City	State Zip
XXX-XX- Last 4 Digits of SSN	<input type="checkbox"/> M <input type="checkbox"/> F Sex	/ / Date of Birth	() - Carrier's Telephone Number	() - Fax Number	
Date of Injury: _____					

Compensation in the amount of \$ _____ per week was reinstated or modified on _____ pursuant to N.C. Gen. Stat. § 97-32.1 or N.C. Gen. Stat. § 97-18(b).

Give reason for reinstatement:

The employee's average weekly wage, including overtime and all allowances, was \$ _____, which results in a weekly compensation rate of \$ _____.

a. Temporary total compensation is being paid at the compensation rate above.

b. Temporary partial compensation is being paid in the amount of \$ _____.

c. Other: _____

SIGNATURE EMPLOYER OR CARRIER/ADMINISTRATOR	TITLE	DATE / /
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Employer: The original of this form must be sent to the Industrial Commission at the address below. A copy shall be provided to the employee and the employee's attorney of record, if any.