*North Carolina Industrial Commission*

# *RETURN TO WORK REPORT*

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #

Employer FEIN _____

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

| | |
|---|---|
| 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 |
| Social Security Number ☐ M ☐ F Sex / / 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 404A(7) 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.**

**MAIL TO:**

***NCIC - CLAIMS SECTION***
***4335 MAIL SERVICE CENTER***
***RALEIGH, NC 27699-4335***
***MAIN TELEPHONE: (919) 807-2500***
***OMBUDSMAN: (800) 688-8349***



**FORM 28**