North Carolina Industrial Commission

IC File #_____

Emp. Code #_____

Carrier Code #_____

Carrier File #_____

Employer FEIN _____

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

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

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.

FORM 28T
2/01
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MAIL TO: ***NCIC CLAIMS SECTION***
4335 MAIL SERVICE CENTER
RALEIGH, NC 27699-4335
MAIN TELEPHONE: (919) 807-2500
OMBUDSMAN: (800) 688-8349

FORM 28T