

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

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		Policy Number			
() - Home Telephone		() - Work Telephone		Carrier's Address		City		State Zip	
XXX-XX- Last 4 Digits of SSN		☐ M ☐ F Sex		/ / Date of Birth		() - Carrier's Telephone Number		Adjuster's Name Email Address	
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 or modification:

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.