

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

IC File # _____

Emp. Code # _____

Carrier Code # _____

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

Carrier File # _____

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- _____ M F / /

() _____ () _____

Last 4 Digits of SSN _____ 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 11 NCAC 23A .0404A(g)], 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, orat ☐ **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.

FILE VIA ELECTRONIC DOCUMENT FILING PORTAL

HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

FORM 28T

03/2020

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FORM 28T**CONTACT INFORMATION:**

NCIC-CLAIMS ADMINISTRATION

TELEPHONE: (919) 807-2502

HELPLINE: (800) 688-8349

WEBSITE: HTTP://WWW.IC.NC.GOV