EMPLOYEE'S REQUEST THAT COMPENSATION BE REINSTATED AFTER UNSUCCESSFUL TRIAL RETURN TO WORK (G.S. 97-32.1)

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

Address

City State Zip

( ) ( )
Home Telephone Work Telephone

☐ M ☐ F / /
Social Security Number Sex Date of Birth

Employer's Name ( ) Telephone Number

Employer's Address City State Zip

Insurance Carrier

Carrier's Address City State Zip

( ) ( )
Carrier's Telephone Number Fax Number

SECTION A.

EMPLOYEE: COMPLETE AND MAIL TO EMPLOYER AND CARRIER/ADMINISTRATOR, AND TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW:

1. I request that my total disability compensation be resumed immediately. I had a trial return to work with _____ (name of employer) from _____ (date first worked) until _____ (date last worked).
   The date of my injury by accident or the date of disability from my occupational disease was _____
2. Explain in detail the reasons you are no longer working: _____
3. The employee **MUST** obtain the following from an authorized treating physician:

TREATING PHYSICIAN'S STATEMENT

This is to certify that the employee is unable to continue the trial return to work due to the employee's injury for which Compensation has been paid. My medical specialty is: _____

SIGNATURE OF AUTHORIZED TREATING PHYSICIAN PRINTED NAME DATE

ADDRESS CITY STATE ZIP

IF RETURN TO WORK WAS WITH THE EMPLOYER FROM WHOM YOU HAVE RECEIVED WORKERS' COMPENSATION, SIGN HERE AND DO NOT COMPLETE THE REMAINDER OF THIS FORM. IF RETURN TO WORK WAS WITH A DIFFERENT EMPLOYER, COMPLETE SECTION B BELOW.

SIGNATURE OF EMPLOYEE DATE

SECTION B.

EMPLOYEE'S RELEASE OF EMPLOYMENT INFORMATION

I hereby request and authorize my last employer, _____
(Name and address of last employer)
to release to my prior employer and carrier/administrator listed above, or their attorney of record, the following information relating to my trial return to work: first and last date worked, total wages earned, and the reasons this employee is no longer so employed.

READ BEFORE SIGNING

SIGNATURE OF EMPLOYEE DATE

SEND A COPY OF THIS FORM TO THE EMPLOYER AND CARRIER/ADMINISTRATOR FROM WHOM YOU WERE RECEIVING WORKERS'COMPENSATION. SEND THE ORIGINAL TO THE INDUSTRIAL COMMISSION AT THE ADDRESS BELOW.

FORM 28U

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