North Carolina Industrial Commission

IC File #_____

EMPLOYEE'S REQUEST THAT COMPENSATION BE REINSTATED AFTER UNSUCCESSFUL TRIAL RETURN

Emp. Code #_____

Carrier Code #_____

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
XXX-XX- Last 4 Digits of SSN ☐ M ☐ F Sex / / Date of Birth	( ) 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.

ATTORNEYS/CARRIERS:
FILE VIA ELECTRONIC DOCUMENT FILING PORTAL
HTTP://WWW.IC.NC.GOV/DOCFILING.HTML

EMPLOYEE FILING OPTIONS:
E-MAIL TO EXECSEC@IC.NC.GOV
FAX TO (919) 715-0282
MAIL TO NCIC-EXECUTIVE SECRETARY
1236 MAIL SERVICE CENTER
RALEIGH, NC 27699-1236

HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV

FORM 28U