

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

IC File # \_\_\_\_\_

Emp. Code # \_\_\_\_\_

Carrier Code # \_\_\_\_\_

Carrier File # \_\_\_\_\_

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			Policy Number			
( ) - Home Telephone	<input type="checkbox"/> M <input type="checkbox"/> F		( ) - Work Telephone	Carrier's Address			City	State	Zip
XXX-XX- Last 4 Digits of SSN	Sex	Date of Birth	Carrier's Telephone Number			( ) - Fax Number			
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

**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.**