

RETURN TO WORK REPORT

IC File # _____
 Emp. Code # _____
 Carrier Code # _____
 Carrier File # _____
 Employer FEIN _____

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 _____			Work Telephone _____			Carrier's Address _____			
Social Security Number _____			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____			City _____	State _____	Zip _____
			Carrier's Telephone Number _____			Fax Number _____			

Employer: The use of this form is not appropriate when an employee has returned to work on a trial return to work basis pursuant to N.C. Gen. Stat. 97-32.1, in which case Form 28T must be used. By using this form you are stating that this case is not a trial return to work and that one of the exclusions contained in NCIC Rule 404A(7) applies.

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. If your trial return to work is unsuccessful, you should complete form 28U in order to request that your compensation be reinstated.

THE EMPLOYER OR CARRIER/ADMINISTRATOR MUST COMPLETE THE FOLLOWING WHEN EMPLOYEE RETURNS TO WORK OTHER THAN ON A TRIAL RETURN TO WORK BASIS.

SECTION A. COMPLETE THE FOLLOWING:

1. Date of injury: _____
2. Date disability began: _____
3. Date returned to work: _____

SECTION B. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR REDUCED WAGES

Employee is being paid at the rate of \$ _____ weekly.

SECTION C. COMPLETE IF EMPLOYEE RETURNED TO WORK FOR A DIFFERENT EMPLOYER:

1. Name of that employer: _____
2. Address: _____
3. Telephone: _____

SIGNATURE OF EMPLOYER OR CARRIER/ADMINISTRATOR _____ TITLE _____ DATE _____

Employer: The original of this form shall be sent to the address below, and a copy sent to the employee and the employee's attorney of record, if any. A Form 28B must be filed to report the amount and last date compensation and/or medical compensation were paid.

For IC use ONLY	
Nature _____	
Body _____	
Cause _____	
SIC _____	
Coder _____	

FORM 28

MAIL TO:

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