

**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 # \_\_\_\_\_  
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 _____		
						City _____	State _____	Zip _____
Social Security Number _____			<input type="checkbox"/> M <input type="checkbox"/> F	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 maybe 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 404A(7)], Form 28 must be used.

EMPLOYER: COMPLETE THE FOLLOWING.

- Date of injury: \_\_\_\_\_ 2. Date disability began: \_\_\_\_\_
- Date temporary total compensation was/will be terminated: \_\_\_\_\_
- Date the employee returned/will return to work: \_\_\_\_\_  
at the  same or greater wages, than received at the time of injury, or  
at  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: \_\_\_\_\_
- 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.

FORM 28T  
2/01  
PAGE 1 OF 1

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

**FORM 28T**

**MAIL TO:**

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