

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

IC File # \_\_\_\_\_  
 Emp. Code # \_\_\_\_\_  
 Carrier Code # \_\_\_\_\_  
 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 _____ |             |           |
| Sex <input type="checkbox"/> M <input type="checkbox"/> F |  |  | Date of Birth _____              |  |  | City _____              | State _____ | Zip _____ |
| Social Security Number _____                              |  |  | 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:

- 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 \_\_\_\_\_
- 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 EMPLOYER \_\_\_\_\_ 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.

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

**MAIL TO:**

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