

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

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: _____
- The employee **MUST** obtain the following from an authorized treating physician:

<u>TREATING PHYSICIAN'S STATEMENT</u>			
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.

**MAIL TO: OFFICE OF THE EXECUTIVE SECRETARY
4333 MAIL SERVICE CENTER
RALEIGH, NC 27699-4333
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/**