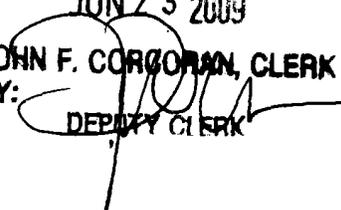


UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
HARRISONBURG DIVISION

JUN 23 2009
JOHN F. CORCORAN, CLERK
BY: 
DEPUTY CLERK

STEPHANIE K. HARVEY,

Plaintiff
v.

MICHAEL J. ASTRUE,
Commissioner of Social Security,

Defendant

Case No. 5:08cv00063

REPORT AND
RECOMMENDATION

By: Hon. James G. Welsh
U. S. Magistrate Judge

The plaintiff, Stephanie K. Harvey, brings this action pursuant to 42 U.S.C. § 405(g) challenging the final decision of the Commissioner of the Social Security Administration (“the agency”) denying her application for Supplemental Security Income (“SSI”) under Title XVI of the Social Security Act, as amended (“the Act”), 42 U.S.C. §§ 1381 *et seq.* Jurisdiction of the court is pursuant to 42 U.S.C. § 405(g) and 42 U.S.C. § 1383(c)(3).

The Commissioner’s Answer was filed on December 5, 2008 along with a certified copy of the administrative record (“R.”) containing the evidentiary basis for the findings and conclusions set forth in the Commissioner’s final decision. By order of referral entered December 15, 2008, this case is before the undersigned magistrate judge for report and recommendation pursuant to 28 U.S.C. § 636(b)(1)(B).

The plaintiff contends that she has been functionally disabled since birth due to the combined effects of mild mental retardation, cerebral palsy, a petit mal seizure disorder, scoliosis, and sleep

apnea. On appeal, she argues that the Commissioner's final decision denying her application was based on multiple decisional "failures" by the administrative law judge ("ALJ"), including failures to consider certain of her mental limitations,¹ the limited potential job base for mentally ill individuals irrespective of other adverse vocational factors,² the "disabling" nature of her petit mal seizure disorder,³ the "severe" nature of her sleep apnea,⁴ and the testimonial evidence given by her and her mother concerning her subjective symptoms.⁵ *Inter alia* in his response the Commissioner, citing 20 C.F.R. § 416.945, argues that the plaintiff's contentions concerning the ALJ's failure to consider her deficiencies in concentration and persistence, her need for a high level of supervision, the eroding impact of her mental capacities on the potential occupational base and her associated testimonial evidence, all represent a general challenge to the ALJ's residual functional assessment "since they relate to what [the] plaintiff is still able to do mentally and intellectually, not withstanding her impairments."

¹ In her brief the plaintiff contends that the ALJ failed to consider her diminished abilities in a work like setting to maintain concentration, persistence and pace.

² It is the plaintiff's contention that the ALJ failed to comply with the mandate of Social Security Ruling ("SSR") 85-15 that his residual functional capacity assessment include (in addition to age, education and work experience) consideration of the eroding impact of her mental capacities on the potential occupational base.

³ On appeal, the plaintiff argues that her evidence shows her to have a non-convulsive seizure disorder which meets or equals listing 11.03's requirements that the condition be documented by a detailed description of its typical seizure pattern, and by evidence of its frequency and the postictal manifestations of significant unconventional behavior or of significant interference with activity during the day. 20 C.F.R. Part 404, Subpart P, Appx. 1, §11.03

⁴ This argument by the plaintiff essentially relies on the Fourth Circuit's decision in *Evans v. Heckler*, 734 F.2d 1012, 1014 (4th Cir. 1984). Quoting *Brady v. Heckler*, 724 F.2d 914, 920 (11th Cir. 1984), the Fourth Circuit in *Evans* held that "an impairment can be considered as 'not severe' only if it is a *slight abnormality* which has such a *minimal effect* on the individual that it would not be expected to interfere with the individual's ability to work, irrespective of age, education, or work experience."

⁵ This contention by the plaintiff is based on an alleged failure by the ALJ to comply with the agency's two-step decisional process for the evaluation of subjective symptoms, SSR 96-7p, upon which she relies, directs that the adjudicator first "must consider whether there is an underlying medically determinable physical or mental impairment(s) . . . that could reasonably be expected to produce the individual's pain or other symptoms." and second he "must evaluate the intensity, persistence, and limiting effects of the individual's symptoms to determine the extent to which the symptoms limit the individual's ability to do basic work activities."

Each party has moved for summary judgment; no written request was made for oral argument,⁶ and the case is now before the undersigned for a report and recommended disposition.

I. Summary Recommendation

Based on a thorough review of the administrative record as a whole and for the reasons herein set forth, it is recommended that the plaintiff's motion for summary judgment be denied, the Commissioner's motion for summary judgment be granted, and an appropriate final judgment be entered affirming the Commissioner's decision denying SSI.

II. Standard of Review

The court's review in this case is limited to a determination as to whether there is substantial evidence to support the Commissioner's conclusion that the plaintiff failed to meet the statutory conditions for entitlement to SSI. "Under the . . . Act, [a reviewing court] must uphold the factual findings of the [Commissioner], if they are supported by substantial evidence and were reached through application of the correct legal standard." *Mastro v. Apfel*, 270 F.3^d 171, 176 (4th Cir. 2001) (quoting *Craig v. Chater*, 76 F.3^d 585, 589 (4th Cir. 1996)). This standard of review is more deferential than *de novo*. "It consists of more than a mere scintilla of evidence but may be somewhat less than a preponderance." *Mastro*, 270 F.3^d at 176 (quoting *Laws v. Celebrezze*, 368 F.2^d 640, 642

⁶ Paragraph 2 of the court's Standing Order No. 2005-2 requires that the plaintiff in a Social Security case must request oral argument in writing at the time his or her brief is filed.

(4th Cir. 1966)). "In reviewing for substantial evidence, [the court should not] undertake to re-weigh conflicting evidence, make credibility determinations, or substitute [its] judgment for that of the [Commissioner]." *Id.* (quoting *Craig v. Chater*, 76 F.3^d at 589). Nevertheless, the court "must not abdicate [its] traditional functions," and it "cannot escape [its] duty to scrutinize the record as a whole to determine whether the conclusions reached are rational." *Oppenheim v. Finch*, 495 F.2^d 396, 397 (4th Cir. 1974). The Commissioner's conclusions of law are, however, not subject to the same deferential standard and are subject to plenary review. *See Island Creek Coal Company v. Compton*, 211 F.3^d 203, 208 (4th Cir. 2000); 42 U.S.C. § 405(g).

III. Administrative History

The record shows that on November 5, 2005 the plaintiff filed her SSI application and alleged therein that she had been disabled since her birth in 1987. (R.16,40,62,68-74,82,130.) Administratively, her application was denied both initially and on reconsideration, and a hearing was held on January 30, 2007 before an ALJ. (R.16,29,33,38-39,41-42,45-50,57-61, 586 *et seq.*) The plaintiff was present; she and her mother testified, and she was represented by counsel. (R.16,26-28,41-44,51-54,586,573-621.) David Nichols, a vocational witness was also present and testified. (R.16,35-37,621-633.)

By written decision dated February 28, 2007, the claim was denied. (R.10-20.) After taking into account the plaintiff's age, limited education, "borderline intellectual functioning," "deficits in adaptive behavior," "mild deficits in maintaining concentration, persistence and pace," and the

multiple limitations associated with her decisionally significant physical infirmities,⁷ the ALJ concluded that she retained the ability to perform simple repetitive tasks at a light exertional level.⁸ (R.18-20,23-24.) After requesting Appeals Council review, the plaintiff submitted two “To Whom it May Concern” letters, one from Dr. Thomas Spicuzza (her neurologist in the 1990s) and the other from Sonia Costa (a special education teacher).⁹ After her request for review was denied, the plaintiff instituted this appeal. (R.6-9,13,559-565.)

IV. Facts and Analysis

The administrative record in this case shows that the plaintiff was nineteen years of age¹⁰ at the time of the hearing. (R.23,82,68,130,136,137,593.) Early in her life she was determined to have significant developmental delays and has been followed for this condition continuously since age one. (R.135,137-138,148-172,406-408,409,412, 419,434,444-449,457-458,480,483.) In June

⁷ The significant physical infirmities identified by the ALJ included a petit mal seizure / “mild” hypotonic cerebral palsy disorder and a scoliotic deformity of the spine which had been surgically improved by a spinal fusion in 1999; neither condition , however, had required any medical or pharmacological treatment for a number of years. (R.18,23,79,89.)

⁸ “*Light work*” is defined in 20 C.F.R. § 404.1567(b) to involve lifting no more than 20 pounds at a time with frequent lifting or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be very little, a job is in this category generally it requires a good deal of walking or standing, or when it involves sitting most of the time generally involve some pushing and pulling of arm or leg controls. To be considered capable of performing a full or wide range of light work, an individual must have the ability to do substantially all of these activities. A job may also be considered light work if it requires “standing or walking, off and on, for a total of approximately 6 hours of an 8-hour workday” with intermittent sitting. Social Security Ruling (“SSR”) 83-10.

⁹ Dr. Spicuzza’s letter referenced a “normal” EEG study dated December 11, 1995 (R.481) and opined that it was not unusual for a patient to have a “normal study” when not experiencing any current seizure activity, and Ms. Costa’s letter restated information in the plaintiff’s school records, including her cognitive limitations, her inability meet the mental demand of the school’s general curriculum, her individualized education plan, and her need for one-on-one assistance both to keep on task and to complete tasks in a timely manner.

¹⁰ Under the agency’s regulations, the plaintiff is classified as a “younger person” and age is generally not considered to affect seriously such an individual’s ability to adjust to other work. 20 C.F.R. § 404.1563(c).

2006 she received her high school Special Diploma after completing her individualized education plan, and at the time of the hearing she was continuing to attend classes and was scheduled to start training at Vector Industries.¹¹ (R.575,593-594.)

The plaintiff's childhood medical records include treatment records from Waynesboro Community Hospital, Kluge Children's Rehabilitation Center, the University of Virginia Medical Center's pediatric medicine department, Augusta Pediatrics (Dr. Fred Costello), Augusta Medical Center, and Augusta Neurological (Dr. Thomas Spicuzza). Although her hospital course as a new born was normal (R.139-144), before age two she evidenced persistent developmental delays and by age four was diagnosed at the Kluge Center to have mild hypotonic cerebral palsy, to exhibit cognitive skills that ranged from average to borderline, and to exhibit sporadic oppositional behaviors. (R.409-458,474-476.)

Consistent with her previously diagnosed neurological condition, an EEG at age seven suggested that she might be experiencing some epileptic seizure activity, and she was started on Depakote as an "anticonvulsant prophylaxis." (R.483,484,486.) Laboratory studies at the time, however, were generally in the range of normal, and an MRI on the same day demonstrated no abnormality. (R.494-485,488.) A neurological examination two weeks later was also normal, and it was noted at the time that no clinical seizure activity had been observed either by her parents or by the school system. (R.484-485,488.) Anti-convulsive medication was, therefore, discontinued. (R.479.) A subsequent 24-hour ambulatory EEG in December 1994 similarly demonstrated no

¹¹ Vector Industries is a sheltered workshop located in Waynesboro, Virginia.

seizure activity (R.479,481), and since age nine she has had no follow-up neurologist care. (R.89).

The plaintiff's pre-adolescent medical records also verify her development of a significantly abnormal curvature of the spine which was surgically improved at age eleven by a lower thoracic-upper lumbar fusion with stabilizing rods that reduced the physical abnormality from under fifty degrees to thirty degrees centered at T6. (R.358,471,498,517.)

The plaintiff's medical record indicates that she required medical treatment on only one occasion after age eleven. In November and December 2004 she was treated by her pediatrician for persistent cold and flu symptoms (R.556-557), and in early 2005 she was referred to the University of Virginia Medical Center's pediatric respiratory medicine division for a consultive follow-up. (R.467-473.) On that occasion she was noted to be well-appearing and in no distress. (R.471.) Her physical examination was normal; she was found to have no obstructive lung disease, and no functional deficits were noted. (R.472-473.) It was, however, noted that she experienced "choking episodes" two or three times per night during sleep, had an "insufficient sleep syndrome," and was thought to have "post-sigh central apnea." (R.467-468.)

A more current consultive physical and neurological examination by Korin Hudson, M.D., in February 2006 disclosed no significant functional deficits. (R.5176-524.) Dr. Hudson found that the plaintiff could sit, stand, and walk without limitation. (R.520,522.) He determined that she could lift and carry without difficulty, had no dexterity deficit, was able to answer simple questions, and was physically capable of performing simple repetitive tasks. (*Id.*)

Due to the plaintiff's significantly delayed physical, speech and language development, at age two she was found to be eligible for the Shenandoah Valley Regional pre-school program for the handicapped. (R.459-466.) Her school records similarly document the plaintiff's significant special education needs throughout her primary and secondary school years. She exhibited persistent cognitive limitations, a "mentally deficient" "level of functioning, borderline" reading and writing language skills, mentally-deficient math skills, low average visual-motor skills, difficulty staying on task, and persistent organization and comprehension limitations. (R.145-408.)

The results of intelligence, achievement, visual retention, adaptive behavior and other testing by Gerald Showalter, Ph.D., in December 2005 additionally demonstrated the plaintiff's "mild" mental retardation, borderline or low normal functioning, and the various cognitive, memory, attention, concentration, and learning deficits identified throughout her school years. (R.498-502.) His neurological examination also disclosed a mild finger-to-nose coordination abnormality, some mild upper and lower extremity weakness, and some minimal limitation in right upper and lower extremity motion. (R.505-510.) Based on his neuropsychological assessment, Dr. Showalter concluded that the plaintiff would benefit from a period of vocational training at Woodrow Wilson Rehabilitation Center. (R.502-503.)

Based on a consultive assessment in January 2006 which included similar (albeit less extensive) psychological testing (R.511-516), Joseph Cianciolo, Ph.D., concluded that the plaintiff "possessed the intellectual capacity necessary to perform simple and repetitive tasks." (R.513.) In his opinion her ability to maintain regular attendance and complete an ordinary work week was "relatively unimpaired," and her ability to interact with others was "moderately compromised." (*Id.*)

Additionally, Dr. Cianciolo concluded that she would likely require extra supervision and would not be able to perform tasks requiring simple calculations. (*Id.*)

In October 2005 the plaintiff's pediatrician, Dr. Fred Costello, wrote a short one-page letter in which he opined on the plaintiff's behalf that she was incapable of either supporting herself or fully caring for herself. (R.504.) Other than a general references to the plaintiff's medical history, Dr. Costello's opinion makes no reference to any clinical evidence or other objective basis for his opinion. For this reason, as well as its conclusory nature and her "unremarkable" recent treatment, Dr. Costello's disability opinion was "reject[ed]" by the ALJ (R.23). *See Craig v. Chater*, 76 F.3^d 585, 590 (4th Cir. 1995); 20 C.F.R. § 416.927; SSR 96-5p.

The administrative record in this case also contains assessments by state agency psychological and medical reviewers. Based on reviews of the record in February and May 2006, including a detailed explanation of findings, the state agency psychological reviewers concluded that the plaintiff's condition did not meet the mental retardation criteria of listing 12.05 and that she possessed the mental ability to do light work of a simple repetitive nature. (R.525-541.) In March 2006, the state agency medical reviewer similarly concluded that the record contained no physical signs or symptoms of a listed physical impairment and that the plaintiff was physically able to do work at a light exertional level. (R.542-549.)

Additionally, the record shows that the plaintiff participated in a significant range of activities. Her social activities included bowling, playing tennis, participating in Special Olympics sports, swimming, and visiting with friends. (R.93,97,102-103,117,121,597-598.) Her household

activities included feeding pets, setting the table, doing dishes, dusting, fixing simple meals, changing the bed linens, and working in the flower beds. (R.91-92,100-101,117,119.) She entertained herself by doing jig saw puzzles, doing word searches, and playing computer games. (R.93,98,121,592,596.) At the time of the hearing she was learning to drive, to handle a checkbook, to count change, and to touch-type. (R.594-596,599-600.) She reported no difficulties getting-along with others, no problem taking the school bus, and no problem staying home alone for an hour or so. (R.91,98,120,574.) She reported that she was able to care for her personal hygiene; however, her mother testified that this and any other activity requiring multiple instructions needed to be monitored. (R.94,104,590-591,610-611.)

A.

As the defendant noted in his brief, at its core the plaintiff's appeal centers on her contention that the ALJ committed clear error by making the determination that she had the ability to perform simple, repetitive tasks in a work environment, despite her borderline intellectual functioning, her documented deficiencies in concentration and persistence and her need for significant supervision. The existence of these non-exertional impairments in combination with her underlying borderline mental functioning are disabling, she argues, and are all well-documented in her school and medical records and by her testimonial evidence.

This argument, however, demonstrates only the first prong of the two-step process used by the agency to determine disability on the basis of non-exertional limitations. *See* 20 C.F.R. § 416.929(b); SSR 96-7p; *Craig v. Chater*, F.3^d 585, 594 (4th Cir. 1996).

It is only *after* [an individual] has met her threshold obligation of showing by objective medical evidence a medical impairment reasonably likely to cause the [non-

exertional impairment] claimed, that the intensity and persistence of the [plaintiff's non-exertional impairment], and the extent to which it affects her ability to work, must be evaluated. *See* 20 C.F.R. §§ 416.929(c)(1) & 404.1529(c)(1). Under the regulations, this evaluation must take into account not only the claimant's statements about her [non-exertional impairment], but also "all the available evidence," including the [plaintiff's] medical history, medical signs, . . . laboratory findings, . . . and any other evidence relevant to the severity of the impairment, such as evidence of the [plaintiff's] daily activities, specific descriptions of the [non-exertional impairment], and any medical treatment taken to alleviate it.

Craig, at 595.

Consistent with *Craig*, with SSR 96-2p and with the agency's underlying regulations, the ALJ in the instant case took into account the entire record, including the plaintiff's medical evidence, her educational records, and her testimonial evidence. (R.18-23.) He considered all of her symptoms which were "reasonably . . . consistent with the objective medical evidence;" he noted the "generally routine, conservative and unremarkable" nature of her treatment, and he evaluated the "intensity, persistence and limiting effects" of her symptoms on her ability to do basic work activity. (R.20-21,23.) *See* 20 C.F.R. § 416.929(c). Grounded on this consideration of the evidence, the ALJ reasoned that the functional assessments (R.525-528,529-541,542-549) by the state agency physician and psychologists were consistent "with the other credible evidence in the record." (R.23.) And based on the vocational testimony, he then concluded that the plaintiff possessed the ability to perform a range of simple, repetitive tasks, including jobs such as usher/ticket taker and fast food worker at a light exertional level, as well as ticket taker, surveillance monitor and order clerk at a sedentary level. (R.20-24.)

In short, contrary to the plaintiff's contention, the ALJ did not err by "selective[ly] accept[ing] her evidence, including her testimony and that of her mother concerning what were described as "debilitating seizures," "depression," "diminished mental capacity," and "deficits" in thought processing, concentration and persistence. The record amply demonstrates that the ALJ fairly and appropriately weighed this evidence in keeping with the applicable regulations, case law, and Rulings, and his findings are well-supported by substantial evidence. 20 C.F.R. § 416.929(b)-(d); *Craig v. Chater*, 76 F.3^d at 594; SSR 96-7p.

B.

The plaintiff's contention that the ALJ erred in failing to find her sleep apnea to be a "severe" abnormality is similarly without merit. There is not a shred of decisionally significant evidence in the medical record to suggest that this condition even minimally impairs her ability to perform work activity. *See* 20 C.F.R. §§ 416.920c and 416.921(b); SSR 85-28; *see Hunter v. Sullivan*, 993 F.2^d 31, 35 (4th Cir. 1992).

She argues in her brief that in combination the "sleep apnea" diagnosis in 2004 and her testimony about being "constantly fatigued" compel a finding that the condition is "severe" and adversely impacts her functional abilities. Her evidence, however, fails to demonstrate that this condition limits, in any significant way, her ability to engage in basic work activity. *See* 20 C.F.R. §§ 416.909, 416.920(c), and 416.921. The condition has required no treatment or medical management. *See e.g., Pleasant v. Astrue*, 2009 U.S. Dist. LEXIS 17615, *13-14 (SDWVa, 2009) (claimant's sleep apnea responded well with the use of a C-PAP machine); *Kiser v. Barnhart*, 2005 U.S. Dist. LEXIS 14766, *19-21, 105 Soc. Sec. Rep. Services 125, ____ (WDVa, 2005) (no ongoing

treatment or counseling required). In addition, the plaintiff points to nothing in the administrative record to suggest that her sleep apnea has interfered or otherwise had a negative effect on her school work or other activities. *See Evans v. Heckler*, 734 F.2^d 1012, 1014 (4th Cir. 1984).

C.

Likewise, the plaintiff's claim that the ALJ erred in failing to find her non-convulsive "seizure disorder" to be of listing-level severity¹² is equally flawed. In recognition of her burden to show that she has an impairment that meets or equals the severity of a listed impairment,¹³ the plaintiff cites the court to several evidentiary items which she contends demonstrate a seizure condition which meets the requirements of Listing 11.03. It is her contention that her "two"¹⁴ abnormal EEGs in the mid-1990s (R.480,486) in combination with the testimony of her and her mother about experiencing a couple of altered awareness "spells each week since age three" (R.581,583,615, 619-620) serve to meet both the listing's requirement for a "detailed description of a typical seizure" and its "frequency" requirement.

In stark contrast to this argument, the plaintiff's medical record demonstrates only a single abnormal EEG at age seven; it shows that she has taken no seizure control medication since that age; it documents no need for any seizure-related medical care since that age; it discloses no abnormality

¹² Listing 11.03 provides: "*Epilepsy— nonconvulsive epilepsy (petit mal, psychomotor, or focal), documented by detailed description of a typical seizure pattern, including all associated phenomena; occurring more frequently than once weekly in spite of at least 3 months of prescribed treatment. With alteration of awareness or loss of consciousness and transient postictal manifestations of unconventional behavior or significant interference with activity during the day.*" 20 C.F.R. Part 404, Subpart P, Appx. 1.

¹³ *See e.g., Hall v. Harris*, 658 F.2^d 260, 264 (4th Cir. 1981).

¹⁴ In her brief the plaintiff erroneously characterizes the results of Dr. Spicuzza's October 24, 1995 EEG study (R.586) and his later reference to it in a September 26, 1995 letter as "two abnormal EEG studies." The medical record, however, contains the results of only a single abnormal study in October 1994.

on neurologic examination; it records no report of seizure activity by the plaintiff's parents or the school system, and it contains no suggestion which would either substantiate or confirm the plaintiff's and her mother's testimony about a high frequency of seizure activity. (*E.g.*, R.479,483-486,488, 586.)

Accordingly, the ALJ properly found that this testimony lacked credibility, and the record fully supports this decision. *Inter alia*, the absence of any objective medical evidence of seizure activity during the relevant time period¹⁵ (or even during the eleven years prior thereto), the absence of any school record suggesting that the plaintiff had experienced seizure activity, the absence of any evidence of related functional limitations, and the inconsistency between the hearing testimony and the parents' statements in 1994-1995, all serve amply to demonstrate that the plaintiff's condition does not meet Listing 11.03.

As a part of this same contention by the plaintiff, she also argues that the ALJ's decisional reliance on the normal results of the 24-hour ambulatory EEG in December 1994 was misplaced in the face of the treating source opinions of Dr. Spicuzza that it is "a rather common occurrence" for a person with a seizure disorder to have a normal EEG and that this normal study "would likely be affected" by the plaintiff's use of Depakote until about one week before the study. (*See* Plaintiff's Brief and attachment dated 04/10/2007.) This reliance is also not decisionally warranted. These opinions are patently speculative. They are inconsistent with the plaintiff's more than twelve year history of non-treatment for the condition. They are inconsistent with her entire school system

¹⁵ As the Commissioner notes in his brief, in this SSI claim the plaintiff must establish the existence of a disabling condition which persisted during the time relevant to her claim — between November 1, 2005 (her protected filing date) and February 23, 2007 (the date of the ALJ's decision).

record. And they are not otherwise supported by any treatment notes, by any objective assessments, or by any other objective medical basis. *E.g., Craig v. Chater*, 76 F.3^d at 590; *Mastro v. Apfel*, 270 F.3^d 171, 178 (4th Cir. 2001).

D.

As set forth in detail in Section II above, it is not the province of the court to make the disability determination. The court's role is limited to determining whether the Commissioner's final decision is supported by substantial evidence. In this case, substantial evidence supports that decision. This recommendation that the decision of the Commissioner be affirmed is not intended to suggest in any way that the plaintiff does not have both significant mental limitations and significant attendant functional limitations. In combination, however, the objective medical evidence and her school system records fail to demonstrate the existence of a condition that has resulted in her total disability during the relevant period covered by the ALJ's decision. Moreover, the administrative record in this case demonstrates that the plaintiff's claim and her evidence, both objective and subjective, were properly considered and were fully and fairly assessed by the ALJ.

V. Proposed Findings of Fact

As supplemented by the above summary and analysis and on the basis of a careful examination of the full administrative record, the undersigned submits the following formal findings, conclusions and recommendations:

1. All facets of the Commissioner's final decision are supported by substantial evidence;

2. Substantial evidence supports the finding that the plaintiff's sleep apnea was not a "severe" disorder within the meaning of the Social Security Act and applicable regulations;
3. Substantial evidence supports the finding that the plaintiff had no condition, either singularly or in combination, that met nor medically equaled an impairment listed in 20 C.F.R. Part 404, Subpart P, Appx. 1;
4. The ALJ did not err in his review of the plaintiff's mental impairments and associated functional limitations;
5. The ALJ did not err in his review of the plaintiff's physical impairments and associated functional limitations;
6. In accordance with SSR 85-15, the ALJ's residual functional capacity assessment included consideration of the impact of the plaintiff's mental capacities on the potential occupational base;
7. Substantial evidence supports the finding that during the relevant period covered by the ALJ's decision that the plaintiff had the functional ability to perform a range of light and sedentary work as described by the vocational witnesses;
8. The ALJ's decision demonstrates his proper evaluation of the plaintiff's testimony and the testimony of her mother;
9. The ALJ's decision demonstrates his evaluation of the plaintiff's subjective symptoms in accordance with SSR 96-7p;
10. The plaintiff has not met her burden of proving her disability; and
11. The final decision of the Commissioner should be affirmed.

VI. Recommended Disposition

For the foregoing reasons, it is RECOMMENDED that an order be entered AFFIRMING the final decision of the Commissioner, GRANTING SUMMARY JUDGMENT to the defendant, DENYING plaintiff's claim, and DISMISSING this case from the docket of the court.

The clerk is directed to transmit the record in this case immediately to the presiding district judge and to transmit a copy of this Report and Recommendation to all counsel of record.

VIII. Notice to the Parties

Both sides are reminded that, pursuant to Rule 72(b) of the Federal Rules of Civil Procedure, they are entitled to note objections, if any they may have, to this Report and Recommendation within ten (10) days hereof. **Any adjudication of fact or conclusion of law rendered herein by the undersigned to which an objection is not specifically made within the period prescribed by law may become conclusive upon the parties.** Failure to file specific objections pursuant to 28 U.S.C. § 636(b)(1) as to factual recitals or findings as well as to the conclusions reached by the undersigned may be construed by any reviewing court as a waiver of such objections.

Dated: this 22^d day of June 2009.

 /s/ James G. Welsh
United States Magistrate Judge