IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF WISCONSIN

DONALD J. WINTERS,

Petitioner,

v.

JO ANNE B. BARNHART,
Commissioner of Social Security,

Respondent.

REPORT AND
RECOMMENDATION

05-C-0583-C

This civil action brought under 42 U.S.C. § 405(g) seeks judicial review of an adverse decision of the Commissioner of Social Security. Plaintiff Donald J. Winters challenges a final decision of the commissioner denying his applications for Disability Insurance Benefits and Supplemental Security Income payments under sections 216(I) and 223 and 1614(a)(3)(A) of the Social Security Act, codified at 42 U.S.C. §§ 416(I), 423(d) and 1382c. Plaintiff, who is proceeding *pro se*, contends that the administrative law judge (ALJ) who denied his claim at the administrative level failed to give adequate consideration to plaintiff's physical and mental impairments in concluding that plaintiff is not disabled.

Having carefully reviewed the entire record and considered plaintiff's arguments, I conclude that substantial evidence supports the ALJ's determination that plaintiff is not disabled. The ALJ considered all of the important evidence, explained how she weighed that evidence and clearly explained how she arrived at her conclusion that plaintiff is able to perform various jobs despite his impairments. Accordingly, I am recommending that this court affirm the commissioner's decision.

Legal and Statutory Framework

To be entitled to either disability insurance benefits or supplemental security income payments under the Social Security Act, a claimant must establish that he is under a disability. The Act defines "disability" as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). A physical or mental impairment is "an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques." 42 U.S.C. § 1382c(a)(3)(c).

The commissioner has promulgated regulations setting forth the following five-step sequential inquiry to determine whether a claimant is disabled:

(1) Is the claimant currently employed?

(2) Does the claimant have a severe impairment?

(3) Does the claimant's impairment meet or equal one of the impairments listed by the SSA?

(4) Can the claimant perform his or her past work? and

(5) Is the claimant is capable of performing work in the national economy?

See 20 C.F.R. § 404.1520. The inquiry at steps four and five requires assessment of the claimant's "residual functional capacity," which the commissioner has defined as "an

assessment of an individual's ability to do sustained work-related physical and mental activities in a work setting on a regular and continuing basis." Social Security Ruling 96-8p. "A 'regular and continuing basis' means 8 hours a day, for 5 days a week, or an equivalent work schedule." *Id*.

In seeking benefits, the initial burden is on the claimant to prove that a severe impairment prevents him from performing past relevant work. If he can show this, then the burden shifts to the commissioner to show that the claimant was able to perform other work in the national economy despite the severe impairment. *See Stevenson v. Chater*, 105 F.3d 1151, 1154 (7th Cir. 1997); *Brewer v. Chater*, 103 F.3d 1384, 1391 (7th Cir. 1997).

The following facts are drawn from the Administrative Record ("AR"):

FACTS

I. Plaintiff's Background and Hearing Testimony

Plaintiff was born on May 24, 1960, making him 44 years old at the time of the ALJ's decision. He is a high school graduate and a non-combat veteran. Plaintiff has held many jobs, most in factory settings and most only briefly. Some of his past jobs include machine operator, assembler, forklift operator, construction worker and security guard. Plaintiff received social security benefits in 1993 for a substance addiction disorder, but those benefits were terminated in 1997 when Congress passed legislation disqualifying individuals from benefits when alcoholism or drug abuse were material to the issue of disability.

Plaintiff reapplied for benefits on May 15, 2002, alleging that he became disabled on January 16, 2002, as a result of a fractured left ankle. The local disability agency denied his claim. Plaintiff requested reconsideration, alleging that he also suffered from a mental condition, lower back pain and left knee pain. After his application was denied on reconsideration, plaintiff requested a hearing before an ALJ.

On May 19, 2004, the ALJ held a hearing at which plaintiff and a vocational expert testified. Plaintiff testified that apart from a brief, unsuccessful work attempt in June 2003, he had not worked since January 2002. Plaintiff reported that he stopped working at that time because he fractured his ankle as a result of his knee giving out. Plaintiff testified that he had a service-related left knee injury for which the Veterans Administration had found him 20 percent disabled. Plaintiff reported constant pain in his left knee and ankle but said that medications lessen the pain. He also reported pain and sporadic spasms in his left lower back and pain in his left shoulder that prevented raising his arm very far above his head.

Plaintiff testified that after his ankle surgery in January 2002, he was in a wheelchair for five months then on crutches for three months. After the crutches he started using a cane, which he still was using at the time of the hearing. Plaintiff testified that he needed the cane to walk to prevent his knee from going out and because he couldn't put all his weight on his ankle. He said that with the cane, he could walk comfortably about half a block. Without the cane he walked with a limp and bent towards one side. Plaintiff estimated that he could stand for about 20-30 minutes at a time, sit about 30 minutes at a time and lift no more than five pounds.

In addition to his physical problems, plaintiff testified that he suffered symptoms of depression, including feelings of hopelessness, nightmares, anxiety attacks and forgetfulness. He also experienced hallucinations or nightmares about twice a month.

Plaintiff was living with a friend at the time of the hearing. He testified that his daily activities consisted mostly of watching television, although he prepared simple meals and washed dishes on occasion. He attended groups at the VA twice weekly.

II. Medical Evidence

The voluminous administrative record contains records documenting plaintiff's medical treatment at the VA medical center in Milwaukee and his efforts to participate in various inpatient and outpatient programs sponsored by the VA. The ALJ summarizes this evidence well at pp. 4-8 of her decision and I incorporate it herein by reference as if set forth herein. I discuss only some of the most salient records.

On January 15, 2002, plaintiff fractured his left ankle after slipping on ice. Plaintiff said at that time that he had been drinking. Plaintiff underwent surgery for repair of the ankle with placement of screws and hardware on January 25, 2002. Thereafter, monthly x-rays showed that the ankle and hardware were in good position and the fracture was healing. Plaintiff progressed from wheelchair to crutches. On May 6, 2002, plaintiff's physical therapist commented that plaintiff was progressing gradually and needed "continued reinforcement that he is not causing any damage by [weight bearing] . . .." AR 459. She

hoped that by the end of two weeks, plaintiff would be able to walk two blocks without an assistive device. *Id*. On May 9, 2002, Dr. Stephen Yao, an orthopedic surgeon, indicated that plaintiff's status was "weight bearing as tolerated." AR 453.

On June 6, 2002, plaintiff was referred again to physical therapy to help him progress to bearing weight on the ankle. The orthopedist's note accompanying that referral stated that plaintiff continued to use crutches but "he no longer needs them." AR 215.

Plaintiff attended physical therapy, including pool therapy, from June to August 2002. Plaintiff progressed from crutches to a cane. On July 3, 2002, plaintiff told his therapist that he did not have pain during ambulation when he was wearing combat boots. AR 209. On July 31, 2002, plaintiff walked 540 feet without an assistive device. AR 567. Although his therapists encouraged him to wean himself off the cane, plaintiff was reluctant and progressed slowly in therapy. *Id*.

On July 30, 2002, William P. McDevitt, M.D., an orthopedic surgeon, saw plaintiff for complaints of ankle pain. Dr. McDevitt noted that plaintiff continued to complain of swelling and pain in the ankle. Dr. McDevitt reported that x-rays showed that plaintiff's ankle had healed, although he had early degenerative changes and limited range of motion. Dr. McDevitt further indicated that plaintiff had moderate swelling in his ankle, but he was able to walk reasonably well. Dr. McDevitt opined that plaintiff would have difficulty returning to heavy construction work for another three to six months.

In addition to plaintiff's ankle injury, plaintiff was evaluated for complaints of left knee pain and left lower back pain. On June 26, 2002, plaintiff reported to his physical therapist that his knee was hurting him more than anything else. AR 587. On September 13, 2002, he reported that he still used his cane because his left knee hurt and he didn't trust it. AR 713. Plaintiff underwent various diagnostic studies, including x-rays, MRI scan and a nerve conduction study and EMG of the left leg. No knee abnormalities were detected apart from an undersurface tear of the medial meniscus and mild degenerative deficits in the left knee. No back abnormalities were found. Plaintiff's doctor said he would not recommend knee surgery.

On September 6, 2002, plaintiff had a physical exam for the purposes of admission to the VA Domiciliary. Musculoskeletal exam found no joint swelling, crepitation or limitation of motion; deep tendon reflexes were full and symmetric and plaintiff had no sensory deficits. AR 729-30. In November 2002, M.J. Baumblatt, M.D., a state agency physician, reviewed the record evidence and concluded that plaintiff could lift or carry 20 pounds occasionally and 10 pounds frequently; stand or walk about 6 hours in an 8-hour workday; and sit for about 6 hours in an 8-hour workday. AR 822.

A year later, on September 15, 2003, a physical therapist noted that plaintiff had a normal gait. That same month, a nurse encouraged plaintiff to walk at least 4 times a week. AR 921. On December 22, 2003, Timothy Wittwer, a nurse practitioner who saw plaintiff regularly, indicated that plaintiff should be re-trained to perform a sedentary job which

involved minimal lifting, reaching, and bending. AR 874. Wittwer stated that plaintiff "is able to work but due to his skills is forced to work in temp labor jobs which are not suitable for him." *Id*. A physical therapist noted in February 2004 that plaintiff had a normal gait but limped when he knew the therapist was watching. AR 995.

On February 24, 2004, plaintiff saw Dr. Collopy about his ankle and knee pain and to complete forms for his disability application. Examination showed a well-healed surgical scar on plaintiff's left ankle and good range of motion of both the left knee and ankle. Plaintiff indicated that he did not want to undergo surgery to remove the hardware in his ankle at that time because he was attempting to enter a job retraining program. AR 991.

In March 2004, Dr. Collopy completed a medical assessment form in which he reported that Plaintiff's impairment met section 1.03 of the Listing of Impairments. Dr. Collopy did not answer the question asking how plaintiff's impairment met the listing. Dr. Collopy completed another form indicating that plaintiff had "moderate" pain resulting from his left ankle injury, and could not stand or walk for extended periods of time. Dr. Collopy reported that plaintiff could walk 2 blocks, stand or walk for less than 2 hours in an 8-hour workday, and sit for at least 6 hours in an 8-hour workday. Dr. Collopy opined that plaintiff could lift and carry 50 pounds rarely, but could lift and carry under 10 pounds frequently. Dr. Collopy concluded that plaintiff would need to take 8 unscheduled breaks during an average 8-hour workday and would be absent about once or twice a month. AR 966-71.

In addition to his physical impairments, plaintiff had mental health concerns for which he obtained treatment from Dr. William Anderson. On April 4, 2002, Dr. Anderson conducted a psychiatric assessment of plaintiff. Plaintiff reported that he had been treated with Zoloft in the past but stopped when he relapsed with alcohol. Plaintiff reported symptoms of depression and anxiety, including poor sleep, poor memory and concentration, and visual hallucinations of a black cat following him. Dr. Anderson did not record any mental status findings. He diagnosed plaintiff with major depression with anxiety symptoms and possibly a panic disorder, for which he prescribed serzone. AR 494.

On June 28, 2002, Dr. Anderson reported that plaintiff was having slight difficulty with concentration and auditory hallucinations about 3 times a month in the form of a rough voice with derogatory themes. Dr. Anderson reported that plaintiff had "full insight into the fact that [the voice] is not real" and was not too upset with it. AR 768. He increased plaintiff's dosage of serzone. A social worker in June 2002 noted that plaintiff enjoyed shooting pool, reading and playing chess. AR 774. In August 2002, plaintiff told Dr. Anderson that the serzone was sufficient for his depression. AR 625.

On September 6, 2002, during a health screening for admission to the VA domiciliary, plaintiff denied having any psychiatric symptoms. AR 729. On November 29, 2002, a nurse who conducted a mental health intake assessment of plaintiff noted that he was alert and oriented, neatly dressed with good hygiene, had normal speech and motor activity, related pleasantly and cooperatively, demonstrated a stable mood with full affect,

but appeared to have poor judgment and insight. Plaintiff denied auditory or visual hallucinations, memory or concentration problems or suicidal or homicidal ideations. AR 833-34.

In September 2003, Dr. Anderson adjusted plaintiff's medications because plaintiff complained that the serzone was causing alertness problems and he was having more anxiety and auditory hallucinations. In November 2003, Dr. Anderson noted on mental status examination that plaintiff was alert and fully oriented, had no psychosis, and denied any suicidal or homicidal ideations. Dr. Anderson indicated that plaintiff was participating in pool therapy, physical therapy, drawing and was taking classes in the Outward Bound program with the goal of going to school. Plaintiff tolerated his medications but had "some" sedating side-effects and dry mouth. Dr. Anderson increased one of plaintiff's medications and discontinued another medication. AR 893.

On January 21, 2004, Dr. Anderson noted that plaintiff had not been filling his medications and had been out of all of them for two weeks. On mental status exam, plaintiff was logical, linear and goal directed with no delusions or distractions. Dr. Anderson discussed with plaintiff his need to resume his medications and his propensity toward self sabotage. AR 999.

Dr. Anderson completed an assessment form in April 2004. AR 1013-16. He stated that plaintiff suffered from major depression and cocaine and alcohol dependence in early remission. Dr. Anderson indicated that plaintiff had "mild" restriction of activities of daily

living; "marked" difficulties in maintaining social functioning; "moderate" difficulties in maintaining concentration, persistence or pace; and three episodes of decompensation. He found that plaintiff was either "seriously limited but not precluded" or "unable to meet competitive standards" in 11 mental work areas as a result of his impairments.

III. Vocational Expert Testimony

The vocational expert testified that plaintiff's past work history consisted of various temporary jobs that were generally light-to-medium unskilled work. AR 64. The ALJ asked the vocational expert to consider a hypothetical individual with plaintiff's vocational profile who could perform sedentary work that entailed occasional climbing, stooping, kneeling, crawling, balancing, and crouching; routine, repetitive, simple, non-complex work; no overhead reaching of the left arm; no public contact and limited interaction with coworkers; and the option to alternate between sitting and standing. AR 65-66. The vocational expert testified that the hypothetical individual could perform work as a bench assembler (5,000 jobs) and office clerk (35,000 jobs). AR 66. Plaintiff's attorney asked the vocational expert to consider the impact of a cane on the jobs identified, and the vocational expert testified that the hypothetical individual still could perform the jobs identified because the individual could perform the work in a seated position, so that use of a cane would not be a factor in the workplace. AR 69. The vocational expert further testified that an employer would allow an individual to be absent no more than 2 days a month. AR 70.

IV. ALJ's Decision

In her written decision, the ALJ followed the commissioner's five-step process for evaluating disability claims. At step one, she found that plaintiff had not engaged in substantial gainful activity following his alleged onset date. At step two, the ALJ found that plaintiff had the following "severe" impairments: status post left ankle fracture; low back and knee pains; depression; and a history of alcohol and cocaine abuse. At step three, she found that none of plaintiff's impairments, either singly or in combination, were severe enough to meet or medically equal the criteria of any "listed" impairment. In reaching this conclusion, the ALJ rejected Dr. Collopy's opinion that plaintiff met the criteria of Listing 1.03. The ALJ found that plaintiff was able to ambulate effectively within 12 months following his ankle surgery, and noted that plaintiff had told a physical therapist "that he had no ankle pain when he wore combat boots and that he needed a cane for only longer distances." The ALJ also pointed out that by the latter part of 2002, plaintiff was focused primarily on his knee, not the ankle.

In connection with her step four analysis, the ALJ assessed plaintiff's residual functional capacity and determined that he retained the capacity for simple, routine, unskilled sedentary work. The ALJ noted that plaintiff's ankle had healed well with no complications. As for the knee, the ALJ noted that plaintiff's knee condition was minor and did not affect its stability and plaintiff had been able to work for many years in spite of it. In addition, the ALJ noted that plaintiff's own physicians had concluded that plaintiff was

capable of performing sedentary work. The ALJ noted that both Dr. Collopy and a nurse practitioner had opined that plaintiff could meet the demands of sedentary work.

The ALJ found that plaintiff's allegations of disabling limitations were not credible, pointing out that the record was replete with evidence that plaintiff was motivated by secondary gain and prone to exaggeration. In particular, the ALJ noted that one physical therapist had noted that plaintiff appeared to be faking a limp and that plaintiff's social workers at the VA had noted instances in which plaintiff had been manipulative or dishonest in order to gain admission to various VA facilities where he could receive room and board. The ALJ stated: "This case comes down to credibility and simply stated claimant has none."

As for mental limitations, the ALJ gave little weight to Dr. Anderson's mental residual functional capacity assessment, noting that the extreme limitations he endorsed on that form were not supported by his contemporaneous progress notes. The ALJ pointed out that Dr. Anderson's progress notes "intimate that claimant's primary problem is noncompliance, both with medications and regarding abstinence from alcohol and drugs." The ALJ found that absent plaintiff's substance abuse, there was no reason he could not handle the demands of unskilled work, pointing out that plaintiff was able to attend college preparatory classes through the Outward Bound program and that plaintiff was able to attend to activities of daily living and function socially when he chose to do so.

At step four, the ALJ found that plaintiff was unable to meet the exertional demands of his past work. On the basis of the vocational expert's testimony, however, the ALJ found

at step five that there was a significant number of jobs in the national economy within plaintiff's residual functional capacity that he could perform, namely, bench assembly and office clerk jobs. The ALJ pointed out that even if plaintiff required a cane (a "questionable" premise), the vocational expert had stated that it would not affect plaintiff's ability to perform those jobs. Accordingly, the ALJ determined that plaintiff was not disabled.

The ALJ's decision became the final decision of the commissioner when the Appeals Council declined to review plaintiff's claim.

ANALYSIS

In a social security appeal brought under 42 U.S.C. § 405(g), this court does not re-evaluate the case but instead reviews the final decision of the commissioner. This review is deferential: under § 405(g), the commissioner's findings are conclusive if they are supported by "substantial evidence." *Clifford v. Apfel*, 227 F.3d 863, 869 (7th Cir. 2000). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971). When reviewing the commissioner's findings under § 405(g), this court cannot reconsider facts, reweigh the evidence, decide questions of credibility, or otherwise substitute its own judgment for that of the ALJ regarding what the outcome should be. *Clifford*, 227 F.3d at 869. Thus, where conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled, the responsibility for that decision falls on the commissioner. *Edwards v. Sullivan*, 985 F.2d

334, 336 (7th Cir. 1993). Nevertheless, the court must conduct a "critical review of the evidence" before affirming the commissioner's decision, *id.*, and the decision cannot stand if it lacks evidentiary support or "is so poorly articulated as to prevent meaningful review." *Steele v. Barnhart*, 290 F.3d 936, 940 (7th Cir. 2002). When an ALJ denies benefits, she must build a logical and accurate bridge from the evidence to his conclusion. *Zurawski v. Halter*, 245 F.3d 881, 887 (7th Cir. 2001).

In this case, the record amply supports the ALJ's conclusion that plaintiff is not disabled. As the ALJ pointed out, in spite of plaintiff's repeated complaints of left leg, ankle and lower back pain, his doctors detected only minor abnormalities, and physical examinations were largely normal except for some limited range of motion and slight weakness. Although plaintiff's doctors indicated that he likely would have difficulty returning to the physically demanding work he had performed in the past, they were of the opinion that plaintiff could perform sedentary work. The ALJ reasonably relied on these opinions in fashioning her residual functional capacity assessment.

Insofar as Dr. Collopy and Dr. Anderson offered opinions suggesting that plaintiff was disabled, the ALJ was not required to afford them controlling weight unless they were well supported and "not inconsistent with the other substantial evidence in the case record." 20 C.F.R. § 404.1527(d)(2); *Gudgel v. Barnhart*, 345 F.3d 467, 470 (7th Cir. 2003). With respect to Dr. Collopy's opinion that plaintiff met Listing 1.03, substantial evidence supports the ALJ's conclusion that the evidence failed to support a finding that plaintiff

could not ambulate effectively within 12 months of his ankle surgery, as required by the listing. *See* 20 C.F.R., Pt. 404, Subpt. P, App. 1, 1.03. As the ALJ pointed out, plaintiff told a therapist six months after the surgery that he did not have pain when he walked in his combat boots and shortly thereafter reported that the primary reason he continued to use the cane was because he felt that his knee was unstable. Dr. McDevitt noted in July 2002 that the fracture had healed and that plaintiff was able to walk "reasonably well;" other orthopedists and physical therapists opined that plaintiff did not need the cane. This evidence reasonably supports the ALJ's conclusion that plaintiff was ambulatory and did not require assistive devices within 12 months of his surgery.

Worth noting is that even if plaintiff did require the use of one cane, this would not amount to an "inability to ambulate effectively" under the listing. *See* Listing 1.00B2b (defining ineffective ambulation as "the inability to walk without the use of a walker, two crutches or two canes . . .") Because Dr. Collopy's opinion that plaintiff met Listing 1.03 was inconsistent with other substantial evidence in the record, the ALJ was entitled to reject it.

The same goes for the ALJ's assessment of Dr. Anderson's opinion. The ALJ accorded little weight to the extreme mental restrictions endorsed by Dr. Anderson on his mental RFC form because they were inconsistent with his contemporaneous progress notes which indicated that plaintiff's primary problem was noncompliance, both with medications and with abstaining from alcohol and drugs. The record amply supports the ALJ's decision not

to credit Dr. Anderson's report of disabling mental limitations. As the ALJ pointed out in the body of her decision, Dr. Anderson noted minimal abnormal limitations during his office visits and attributed most of plaintiff's difficulties maintaining shelter and employment to self-sabotage. Dr. Anderson's notes indicate that plaintiff's medications ameliorated his mental condition when he took them as prescribed. Moreover, Dr. Anderson did not indicate whether the extreme limitations he endorsed would be present if plaintiff refrained from using drugs and alcohol. In light of plaintiff's ability to attend college preparatory classes through the Outward Bound program, the absence of evidence that plaintiff had difficulties with daily activities or social functioning and the absence of clinical findings documenting mental limitations, the ALJ properly gave little weight to Dr. Anderson's mental RFC form.

The ALJ also reasonably concluded that, to the extent plaintiff alleged that his physical and mental problems were so severe as to prevent him from performing any job, his allegations were not credible. This court must defer to the ALJ's credibility determination unless it is "patently wrong." *Zurawski*, 245 F.3d at 887 (7th Cir. 2001) (citing *Powers v. Apfel*, 207 F.3d 431, 435 (7th Cir. 2000)). Credibility determinations are entitled to special deference because the ALJ is in a better position than the reviewing court to observe a witness. *Shramek v. Apfel*, 226 F.3d 809, 811 (7th Cir. 2003). However, credibility determinations are not immune from review: "[a] court has greater freedom to review credibility determinations based on objective factors or fundamental implausibilities, rather

than subjective considerations." *Briscoe ex rel. Taylor v. Barnhart*, 425 F.3d 345, 354 (7th Cir. 2005) (citation omitted). In addition, SSR 96-7p requires ALJs to articulate the reasons behind credibility evaluations:

> The reasons for the credibility finding must be grounded in the evidence and articulated in the determination or decision. It is not sufficient to make a conclusory statement that "the individual's allegations have been considered" or that "the allegations are (or are not) credible." . . . The determination or decision must contain specific reasons for the finding on credibility, supported by the evidence in the case record, and must be sufficiently specific to make clear to the individual and to any subsequent reviewers the weight the adjudicator gave to the individual's statements and the reasons for that weight.

1996 WL 374186, at *4 (S.S.A. July 2, 1996). *Accord Zurawski*, 245 F.3d at 887 (ALJ must explain bases for credibility determination sufficiently to permit meaningful appellate review).

Here, the ALJ followed the commissioner's regulations and considered plaintiff's subjective complaints as part of her analysis of his residual functional capacity. The ALJ expressly found that plaintiff's claim of disability was not credible. First, there was the lack of objective medical evidence supporting plaintiff's claim. Also, the ALJ cited to records documenting that plaintiff was prone to exaggeration and manipulation, such as faking a limp, falsely claiming suicidal ideation in a failed attempt to gain hospital admission, and the various tales he spun to explain his AWOL status from VA treatment programs. The ALJ's decision demonstrates a clear and logical foundation for her credibility determination, and the record adequately supports it.

Plaintiff states in his brief that he has problems standing for long periods of time, walking long distances, bending over and lifting things. His statements leave the impression that he thinks he is entitled to disability benefits because he cannot perform the work he used to do, such as forklift or machine operation. However, to be entitled to disability benefits under the Social Security Act, it is not enough that the claimant cannot perform his or her past work; rather, a claimant must be unable to engage in *any* substantial gainful activity. In denying plaintiff's application for benefits, the ALJ accepted that plaintiff has various impairments that prevent him from returning to his past work. Nevertheless, she concluded that plaintiff still had adequate physical and mental abilities to perform unskilled jobs that required minimal physical effort. (Sedentary work is defined as work requiring lifting no more than 10 pounds and primarily sitting, with only limited walking or standing. 20 C.F.R. § 404.1567(a)).

Although it is true that plaintiff has no training or background performing sedentary jobs, the ALJ limited plaintiff to those that were unskilled, meaning that they can be learned on the job in a short period of time. 20 C.F.R. § 404.1568(a). Indeed, plaintiff's attempts to enroll in a compensated work program through the VA shows that even he thinks he can perform some types of jobs. Because the vocational expert testified that a significant number of jobs exist in the national economy that can be performed by a person with plaintiff's vocational profile and limitations, the ALJ properly found that plaintiff is not disabled under the commissioner's regulations. The commissioner's decision should be affirmed.

RECOMMENDATION

Pursuant to 28 U.S.C. § 636(b)(1)(B), I respectfully recommend that the decision of the commissioner denying plaintiff Donald Winters's applications for Disability Insurance Benefits and Supplemental Security Income payments be AFFIRMED.

Entered this 11th day of April, 2006.

BY THE COURT:

/s/

STEPHEN L. CROCKER
Magistrate Judge

April 11, 2006

Donald James Winters
322-1/2 Superior Avenue, Apt. #6
Tomah, WI 54660

Richard D. Humphrey
Assistant United States Attorney
660 West Washington Avenue
Madison, WI 53703

Re: Winters v. Barnhart
Case No. 05-C-583-C

Dear Mr. Winters and Attorney Humphrey:

The attached Report and Recommendation has been filed with the court by the United States Magistrate Judge.

The court will delay consideration of the Report in order to give the parties an opportunity to comment on the magistrate judge's recommendations.

In accordance with the provisions set forth in the memorandum of the Clerk of Court for this district which is also enclosed, objections to any portion of the report may be raised by either party on or before May 1, 2006, by filing a memorandum with the court with a copy to opposing counsel.

If no memorandum is received by May 1, 2006, the court will proceed to consider the magistrate judge's Report and Recommendation.

Sincerely,

/s/

Connie A. Korth
Secretary to Magistrate Judge Crocker

Enclosures
cc: Honorable Barbara B. Crabb, District Judge