

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DIANA CASTILLO-BORRERO, : CIVIL ACTION  
 :  
 Plaintiff :  
 :  
 v. :  
 :  
 JO ANNE BARNHART, :  
 Commissioner of :  
 Social Security, :  
 :  
 Defendant : NO. 02-588

MEMORANDUM

Padova, J.

September 27, 2004

I. BACKGROUND

Plaintiff Diana Castillo-Borrero seeks judicial review of the final decision of Defendant, Social Security Commissioner Jo Anne Barnhart, who denied her claim for Social Security benefits. Both Plaintiff and Defendant have filed motions for summary judgment. Pursuant to 28 U.S.C. § 636(b)(1)(B) and Local Rule 72.1(d)(1)(C), the Court referred this matter to Magistrate Judge M. Faith Angell for a Report and Recommendation. Judge Angell recommended that Plaintiff's motion for summary judgment be denied and that Defendant's motion for summary judgment be granted. Plaintiff filed timely objections to the Report and Recommendation. For the reasons which follow, the Court overrules Plaintiff's objections and grants Defendant's motion for summary judgment in its entirety.

II. STANDARD OF REVIEW

A district court judge makes a *de novo* determination of those portions of a magistrate judge's report and recommendation to which

objection is made. 28 U.S.C. § 636(b)(1)(C). The judge may accept, reject or modify, in whole or in part, the magistrate judge's findings or recommendations. Id.

Under the Social Security Act, a claimant is disabled if he is unable to engage in "any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to . . . last for a continuous period of not less than twelve (12) months." 42 U.S.C. §423(d)(1)(A); 20 C.F.R. §404.1505. Under the medical-vocational regulations, as promulgated by the Commissioner, the Commissioner uses a five-step sequential evaluation to evaluate disability claims.<sup>1</sup> The burden to prove the

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<sup>1</sup>The five steps are:

1. If you are working and the work you are doing is substantial gainful activity, we will find that you are not disabled regardless of your medical condition or your age, education, and work experience.
2. You must have a severe impairment. If you do not have any impairment or combination of impairments which significantly limits your physical or mental ability to do basic work activities, we will find that you do not have a severe impairment and are, therefore, not disabled. We will not consider your age, education, and work experience. However, it is possible for you to have a period of disability for a time in the past even though you do not now have a severe impairment.
3. If you have an impairment(s) which meets the duration requirement and is listed in Appendix 1 or is equal to a listed impairment(s), we will find you disabled without considering your age, education, and work experience.
4. Your impairment(s) must prevent you from doing past relevant work. If we cannot make a decision based on your current work activity or on medical facts alone, and you have a severe impairment(s), we then review your residual functional capacity and the physical and mental demands of the work you have done in the past. If you can still do this kind of work, we will find that you are not

existence of a disability rests initially upon the claimant. 42 U.S.C. §423(d)(5). To satisfy this burden, the claimant must show an inability to return to his former work. Once the claimant makes this showing, the burden of proof then shifts to the Commissioner to show that the claimant, given his age, education and work experience, has the ability to perform specific jobs that exist in the economy. Rossi v. Califano, 602 F.2d 55, 57 (3d Cir. 1979).

Judicial review of the Commissioner's final decision is limited, and this Court is bound by the factual findings of the Commissioner if they are supported by substantial evidence and decided according to correct legal standards. Allen v. Brown, 881 F.2d 37, 39 (3d Cir. 1989); Coria v. Heckler, 750 F.2d 245, 247 (3d Cir. 1984). "Substantial evidence" is deemed to be such relevant evidence as a reasonable mind might accept as adequate to support a decision. Richardson v. Perales, 402 U.S. 389, 407 (1971); Cotter v. Harris, 642 F.2d 700, 704 (3d Cir. 1981). Substantial evidence is more than a mere scintilla, but may be somewhat less

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disabled.

5. Your impairment(s) must prevent you from doing any other work. (1) If you cannot do any work you have done in the past because you have a severe impairment(s), we will consider your residual functional capacity and your age, education, and past work experience to see if you can do other work. If you cannot, we will find you disabled. (2) If you have only a marginal education, and long work experience (i.e., 35 years or more) where you only did arduous unskilled physical labor, and you can no longer do this kind of work, we use a different rule. 20 C.F.R. §§ 404.1520(b)-(f).

than a preponderance. Dobrowolsky v. Califano, 606 F.2d 403, 406 (3d Cir. 1979).

Despite the deference to administrative decisions implied by this standard, this Court retains the responsibility to scrutinize the entire record and to reverse or remand if the Commissioner's decision is not supported by substantial evidence. Smith v. Califano, 637 F.2d 968, 970 (3d Cir. 1981). Substantial evidence can only be considered as supporting evidence in relationship to all other evidence in the record. Kent v. Schweiker, 701 F.2d 110, 114 (3d Cir. 1983).

### III. DISCUSSION

Plaintiff applied for supplemental security income benefits ("SSI") on May 31, 2000. (R. at 12.) The application alleged a disability beginning on April 1, 1997, due to depression and anxiety. (R. at 13.) On May 31, 2001, a hearing was held before Jonathan L. Wesner, Administrative Law Judge ("ALJ"). (R. at 12.) At the hearing, the ALJ received testimony from Plaintiff, who was represented by counsel, and from a vocational expert. (R. at 12.)

Plaintiff has a seventh grade education, and was twenty-nine years old at the time of the administrative hearing. (R. at 13, 18.) At the time of the administrative hearing, Plaintiff lived with her boyfriend of four years, who worked each day until 1:30 AM. (R. at 24, 89, 186.) Plaintiff also lived with her two children, ages seven and nine. (R. at 24, 186.) The children have

different fathers and have no contact with them. (R. at 186.) In the summer of 2000, the son of Plaintiff's boyfriend, who was six years old at the time of the administrative hearing, moved in with Plaintiff and her family. (R. at 101.)

In written statements to the Social Security Administration, Plaintiff indicated that she was able to plan each day, get up at a certain time, start meals, finish household chores, and go to appointments. (R. at 61.) During the school year, Plaintiff woke up to an alarm at 7:30 AM, brushed her daughter's hair after washing it, and drove the children to school. (R. at 90.) After school, Plaintiff picked the children up, cleaned the mess they made in the afternoon, and helped them with their homework. (R. at 91-92.) Plaintiff prepared a variety of foods for the children, including rice and beans, soup, spaghetti, and mashed potatoes. (R. at 60.) After dinner, Plaintiff cleaned the children's rooms or the bathroom, which involved sweeping and mopping floors. (R. at 92.)

Plaintiff complained of chronic frontal headaches. (R. at 126.) A brain CT scan revealed minimal calcification of the basal ganglia and no other abnormality. (R. at 126.) Dr. V. Mangesh Kumar, Plaintiff's treating neurologist, reviewed the CT scan and commented that the basal ganglia calcification was an incidental finding. (R. at 156.) Dr. Kumar treated Plaintiff with medication to be taken on an as needed basis. (R. at 156.) Dr. Kumar also

recommended that Plaintiff exercise in order to lose some weight and help her adapt to pain by increasing her endorphin levels. (R. at 156.) On February 23, 2001, Dr. Kumar reported that a brain MRI was negative and that Plaintiff's headaches had become milder. (R. at 203.)

Plaintiff received treatment from Dr. Gladys M. Frye for panic disorder from September 30, 1998 to September 13, 1999. (R. at 187-93.) On May 4, 1999, Dr. Frye reported that while Plaintiff had a history of panic disorder, it was limited to mild anxiousness and agoraphobia and did not require medication at that time. (R. at 190.) Dr. Frye prescribed several medications in the course of treating Plaintiff, including Zoloft, Paxil, and Xanax. (R. at 191-92.) Plaintiff reported that Zoloft made her feel better. (R. at 187.) She stopped taking Zoloft, however, because she was "not a pill taker." (R. at 187.)

Dr. Adam Wilikofsky, a psychologist, treated Plaintiff for panic attacks from February 15, 2000 to June 6, 2000. (R. at 105, 107-10, 113, 118-19, 121-25, 174, 179-86.) Plaintiff reported to Dr. Wilikofsky that, other than receiving medication from her family doctor, she had no past history of being treated for emotional problems. (R. at 124.) Dr. Wilikofsky provided psychotherapy to Plaintiff and recommended relaxation techniques. (R. at 108.)

On December 15, 2000, a Dr. Ahmad completed a form report

entitled, "Medical Source Statement of Ability to do Work-Related Activities (Mental)," for Plaintiff. (R. at 152-53.) On the form, Dr. Ahmad checked off that Plaintiff had no useful ability to perform activities within a schedule, maintain regular attendance, and be punctual; complete a normal workday or workweek; perform at a consistent pace; maintain socially appropriate behavior; travel in unfamiliar places or use public transportation; or set realistic goals or make plans independently of others. (R. at 153.) Although Dr. Ahmad indicated on the form that his findings were supported by a psychological evaluation, the record does not include any such evaluation. (R. at 16.) In Dr. Ahmad's most recent clinical report, which is dated March 16, 2001, he noted that Plaintiff was doing "OK," that her sleep was better, and that her mood was "OK." (R. at 200.) He also noted that Plaintiff denied suicidal thoughts, had no side effects from medication, and had no hallucinations. (R. at 200.)

Laura B. Boll, a family nurse practitioner, treated Plaintiff from January 18, 2000 through May 7, 2001, prescribing her medication for anxiety and headaches and arranging appointments with specialists. (R. at 101-04, 106-07, 109, 111-12, 114-18, 120, 159-64, 170-73, 194-96, 205-15, 218-22.) Ms. Boll encouraged Plaintiff to exercise and diet and recommended that she listen to relaxation tapes. (R. at 109, 114.) According to Ms. Boll, Plaintiff did not utilize the relaxation tapes or other strategies

that Dr. Wilikofsky provided. (R. at 109.) In May 2000, Plaintiff advised Ms. Boll that she was being pressured by the Pennsylvania Department of Public Welfare ("Welfare Department") to return to work or go to school. (R. at 116.) Between May 2000 and May 2001, Ms. Boll completed three employability reassessment forms, on which she indicated that Plaintiff was temporarily disabled, and submitted them to the Welfare Department on Plaintiff's behalf. (R. at 210-15.) Ms. Boll also completed a functional assessment form indicating that Plaintiff had a poor ability to work with or near others, complete a normal workday or workweek, interact with the public, ask simple questions, accept instruction and respond to criticism, get along with co-workers and peers, maintain socially appropriate behavior, travel in unfamiliar places, or set realistic goals. (R. at 205.)

On October 2, 2000, Dr. Roger K. Fretz, a state agency psychologist, completed a functional capacity assessment indicating that Plaintiff had only moderate limitation in her ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; work in coordination with or proximity to others without being distracted by them; get along with coworkers and peers without distracting them or exhibiting behavioral extremes; and respond appropriately to changes in the work setting. (R. at 134-37).

In his decision, the ALJ found that the medical evidence

established that Plaintiff had severe impairments consisting of depression and anxiety disorder, but that she did not have an impairment or combination of impairments listed in, or medically equal to, a listing found in the Commissioner's regulations. (R. at 13.) The ALJ found that "[t]he claimant is not entirely credible concerning her allegation of total disability, as this claim is not supported by the objective medical findings, treatment history and her activities of daily living, which suggest only a moderate degree of limitation." (R. at 14.) The ALJ also found that Plaintiff had no relevant past work and that she retained the residual functional capacity to perform a limited range of light work. (R. at 16-18.) The ALJ further found that Plaintiff was capable of making a successful adjustment to work that exists in significant numbers in the national economy. (R. at 18-19.) The ALJ concluded that Plaintiff was not disabled as defined by the Act and, therefore, denied Plaintiff's claim for SSI benefits in his decision dated September 28, 2001. (R. at 12, 19.)

After Plaintiff's request for review was denied by the Appeals Council, Plaintiff sought judicial review in this Court. The Court then referred the matter to Magistrate Judge M. Faith Angell for a Report and Recommendation. See 28 U.S.C. § 636(b)(1)(B) and Local Rule 72.1(d)(1)(c). The Magistrate Judge recommended that the decision of the ALJ denying Plaintiff's claim for benefits be upheld. Plaintiff filed timely objections to the Magistrate

Judge's Report and Recommendation.

In her objections to the Report and Recommendation, Plaintiff argues that the ALJ erred by (1) engaging in "sit and squirm" jurisprudence; (2) discounting Plaintiff's credibility on the basis of her daily activities; (3) failing to accord proper weight to the opinions of her primary medical treatment providers; and (4) failing to investigate and properly analyze all possible reasons for Plaintiff's alleged noncompliance with a prescribed course of treatment.

A. "Sit and Squirm" Jurisprudence

Plaintiff argues that the ALJ impermissibly engaged in "sit and squirm" jurisprudence in evaluating the credibility of her allegations of total disability. "[S]it and squirm" jurisprudence occurs when 'an ALJ who is not a medical expert will subjectively arrive at an index of traits which he expects the claimant to manifest at the hearing. If the claimant falls short of the index, the claim is denied.'" Pachilis v. Barnhart, 268 F. Supp. 2d 473, 482 (E.D. Pa. 2003)(quoting Freeman v. Schweiker, 681 F.2d 727, 731 (11th Cir. 1982)). The United States Court of Appeals for the Third Circuit ("Third Circuit") has "refused to permit an ALJ's lay observation that a claimant appears healthy to constitute substantial evidence supporting the ALJ's ultimate finding of physical nondisability." Kelly v. R.R. Ret. Bd., 625 F.2d 486, 494 (3d Cir. 1980).

In his decision, the ALJ opined that “[o]ften a claimant’s physical demeanor will verify the presence of severe impairments. Moreover, he or she will frequently exhibit bonafide symptoms of these impairments spontaneously during the Hearing. Nonetheless, from my careful visual scrutiny, neither of these occurrences were apparent in this particular case.” (R. at 15.) However, the ALJ also based his determination of Plaintiff’s credibility on the objective medical evidence and her treatment history. (R. at 14.) In particular, the ALJ noted that Plaintiff “has not required hospital treatment or aggressive treatment” for her depression and anxiety disorder, and that her tension headaches are “controlled with medications.” (R. at 14.) He also observed that “the claimant was initially authorized ten therapy visits, which suggests her symptoms were expected to improve and did not warrant long-term or aggressive care.” (R. at 14.) Thus, because the ALJ used “his own observations to reinforce, not to supplant, a conclusion drawn from the medical evidence,” he did not engage in “sit and squirm” jurisprudence. DeMarco v. Heckler, 616 F. Supp. 644, 647 (E.D. Pa. 1985). Indeed, “credibility determinations are an important part of an ALJ’s function.” Id. (citations omitted). Accordingly, Plaintiff’s objection to the Report and Recommendation is overruled in this respect.

B. Plaintiff’s Daily Activities

Plaintiff contends that the ALJ erred in discounting her

credibility based on her "activities of daily living." (R. at 14.) In his decision, the ALJ noted that Plaintiff is "not totally housebound," as she "is able to drive herself . . . to her appointments, drive[] and walk[] her children to school, and has gotten out recreationally with her children and boyfriend as part of her psychotherapy homework." (R. at 14.) The ALJ further concluded that Plaintiff "has no significant difficulty taking care of personal needs, caring for her children, cooking, cleaning or driving." (R. at 16.)

In support of her contention, Plaintiff cites Smith v. Califano, 637 F.2d 968 (3d Cir. 1981). In Smith, the claimant suffered from a chronic duodenal ulcer disease and spastic irritable colon. Id. at 970-71. The ALJ relied on the claimant's testimony that "he had full use of his hands, arms and legs, does shopping and last fall went hunting twice" in denying his claim for disability insurance benefits. Id. at 971. The Third Circuit concluded that the ALJ's decision was not supported by substantial evidence because "[i]t is well established that sporadic or transitory activity does not disprove disability." Id. at 971-72. The court noted that "shopping for the necessities of life is not a negation of disability and even two sporadic occurrences such as hunting might indicate merely that the claimant was partially functional on two days." Id. at 971. The court further stated that "[t]he ALJ's error in drawing an inference from sporadic

activities to a lack of disabling pain is compounded by the absence of corroborating medical testimony." Id. at 972.

The Court concludes that Smith is distinguishable from the instant case. In this case, the ALJ weighed the relevance of Plaintiff's daily activities only after carefully reviewing the medical record, which, as discussed above, corroborated the finding of non-disability. See Lozada v. Barnhart, Civ. A. No. 02-3666, 2004 WL 1801751, at \*10-\*11 (E.D. Pa. July 27, 2004) (distinguishing Smith on basis of ALJ's review of medical record); Witmer v. Barnhart, Civ. A. No. 01-3061, 2002 WL 485663, at \*3-\*4 (E.D. Pa. March 28, 2002) (same). Furthermore, Plaintiff's daily activities are not "sporadic or transitory." Indeed, the record reflects that Plaintiff maintains her home and cares for three young children on a daily basis. See Wright v. Sullivan, 900 F.2d 675, 682 (3d Cir. 1990) (distinguishing Smith on basis of claimant's more extensive activity); Lozada, 2004 WL 1801751, at \*12 n.21 (distinguishing Smith where claimant cared for three young children and maintained home). Accordingly, Plaintiff's objection to the Report and Recommendation is overruled in this respect.

C. Plaintiff's Primary Medical Treatment Providers

Plaintiff argues that the ALJ erred by failing to accord proper weight to the opinions of her primary medical treatment providers. In giving "little weight" to the medical opinion of Dr. Ahmad, Plaintiff's treating psychiatrist, the ALJ stated as

follows:

Dr. Ahmad, a treating psychiatrist, completed a functional assessment that is inconsistent with the ability to perform substantial gainful activity. Dr. Ahmad indicated that his assessment was supported by a psychological evaluation. However, such evaluation was never provided despite several written requests after the Hearing, and the legible portion of Dr. Ahmad's handwritten notes do not reflect findings that would support the degree of limitation indicated in his assessment. Furthermore, this assessment is not supported by the objective findings or treatment history and is inconsistent with the other medical opinion evidence.

(R. at 16.) In refusing to give "any weight" to the medical opinion of Laura Boll, Plaintiff's treating nurse practitioner, the ALJ stated as follows:

Laura Boll, the claimant's treating nurse practitioner, completed employability assessments for the Pennsylvania Department of Welfare indicating that claimant is temporarily disabled. These statements do not provide specific functional limitations that could be useful in determining an individual's functional capacity for Social Security disability. Ms. Boll also completed a functional assessment that reflects the claimant has poor ability in the following areas: work with or near others, complete a normal workday or workweek, interact with the public, ask simple questions, accept instruction and respond to criticism, get along with coworkers and peers, maintain socially appropriate behavior, travel in unfamiliar places, or set realistic goals. These limitations, which would preclude the performance of substantial gainful activity, are not supported by the objective findings, the statements contained in Ms. Boll's treatment notes or the treatment history, and are outside of her area of expertise.

Furthermore, Ms. Boll is not an acceptable medical source whose opinion is entitled to any weight under the Regulations.

(R. at 16.)

A treating physician's opinion is entitled to controlling weight if it is well-supported by clinical and laboratory diagnostic techniques and is not inconsistent with other substantial medical evidence in the record. 20 C.F.R. § 416.927(d)(2). As noted by the ALJ, Dr. Ahmad did not submit the psychological evaluation on which his form report was purportedly based. The Third Circuit has recognized that "[f]orm reports in which a physician's obligation is only to check a box or fill in a blank are weak evidence at best . . . . [W]here these [form] reports are unaccompanied by thorough written reports, their reliability is suspect.'" Mason v. Shalala, 994 F.2d 1058, 1065 (3d Cir. 1993) (quoting Brewster v. Heckler, 786 F.2d 581, 585 (3d Cir. 1986)). Furthermore, Dr. Ahmad's opinion regarding Plaintiff's functional limitations is inconsistent with other substantial medical evidence in the record, including the conservative treatment prescribed by Plaintiff's treating physicians and the functional capacity assessment completed by Dr. Roger K. Fretz. Dr. Fretz indicated that Plaintiff has only moderate limitation in her ability to understand, remember, and carry out detailed instructions; maintain attention and concentration for extended periods; work in coordination with or

proximity to others without being distracted by them; get along with coworkers and peers without distracting them or exhibiting behavioral extremes; and respond appropriately to changes in the work setting. (R. at 134-35.) Dr. Fretz's assessment was accompanied by a written narrative that explained his findings in greater detail. (R. at 136-37.) Dr. Ahmad's functional assessment is also inconsistent with his own findings from a March 16, 2001 clinical report. In the report, Dr. Ahmad noted that Plaintiff was doing "OK," that her sleep was better, and that her mood was "OK." (R. at 200.) He also noted that Plaintiff denied suicidal thoughts, had no side effects from medication, and had no hallucinations. (R. at 200.) As the medical opinion contained in Dr. Ahmad's form report is neither well-supported by clinical and laboratory diagnostic techniques nor consistent with other substantial medical evidence in the record, the ALJ's decision to accord "little weight" to Dr. Ahmad's opinion is supported by substantial evidence.

The ALJ's decision to reject the medical opinion of Ms. Boll is also supported by substantial evidence. A nurse practitioner's opinion is not an "acceptable medical source" entitled to controlling weight. See 20 C.F.R. § 416.913(a) (defining "acceptable medical source"). A hearing examiner may, however, consider the opinion of a nurse practitioner "insofar as it is deemed relevant to assessing a claimant's disability." Hartranft

v. Apfel, 181 F.3d 358, 361 (3d Cir. 1999); see 20 C.F.R. § 404.913(d)(1) (“[W]e may also use evidence from other sources to show the severity of your impairment(s) and how it affects your ability to work. Other sources include . . . (1) medical sources not listed in paragraph (a) of this section (for example, nurse-practitioners . . . .)”). The boilerplate forms completed by Ms. Boll are not corroborated by any written reports. Moreover, Ms. Boll’s findings are inconsistent with both the treatment that she prescribed for Plaintiff, which included exercising, dieting, and listening to relaxation tapes, and other substantial medical evidence in the record. Accordingly, Plaintiff’s objection to the Report and Recommendation is overruled in this respect.

D. Noncompliance with Prescribed Course of Treatment

Plaintiff argues that the ALJ erred by failing to afford her a full opportunity to justify her noncompliance with the treatment prescribed by her physicians. In discounting Plaintiff’s credibility, the ALJ relied in part upon her failure to follow the prescribed course of treatment:

Although the claimant has required changes and/or adjustments to medications with little improvement in her symptoms, the Record shows that she has not always been compliant with them, has discontinued taking them, or has gone weeks without medication due to insurance or pharmacy problems. She has also not followed through with relaxation techniques recommended by Ms. Boll and her therapist to help her symptoms. It would seem that if the claimant’s symptoms were as severe or functionally limiting as alleged, she would

take a more active role in her treatment.

(R. at 15.) Plaintiff argues that, pursuant to Social Security Ruling 82-59, the hearing examiner was obligated to provide the claimant "an opportunity to fully express the specific reason(s) for not following the prescribed treatment." SSR 82-59 (S.S.A. 1982). The Court notes, however, that Social Security Ruling 82-59 "only applies where the ALJ has determined that an individual's impairments preclude her from engaging in substantial gainful activity, i.e., an individual who would otherwise be found to be disabled under the Act." Lozada, 2004 WL 1801751, at \*11; see also Thomas v. Barnhart, Civ. A. No. 02-2958, 2003 WL 21419154, at \*5 (E.D. Pa. June 11, 2003); Rothrock v. Massanari, Civ. A. No. 00-4912, 2001 WL 881450, at \*5 (E.D. Pa. June 12, 2001). The ALJ did not otherwise err in relying in part on Plaintiff's non-compliance with her prescribed medical treatment in rejecting her disability claim. See Lanzaro, 2004 WL 1801751, at \*12 n.23 (citing SSR 96-7p). Accordingly, Plaintiff's objection to the Report and Recommendation is overruled in this respect.

#### IV. CONCLUSION

For the foregoing reasons, the Court overrules Plaintiff's objections to the Report and Recommendation of Magistrate Judge Angell. Defendant's Motion for Summary Judgment is granted in its entirety. Plaintiff's Motion for Summary Judgment is denied in its entirety.

An appropriate Order follows.



IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

DIANE CASTILLO-BORRERO,	:	CIVIL ACTION
	:	
Plaintiff	:	
	:	
v.	:	
	:	
JO ANNE BARNHART,	:	
Commissioner of	:	
Social Security,	:	
	:	
Defendant	:	NO. 02-588

**JUDGMENT**

**AND NOW**, this 27th day of September, 2004, in accordance with the Court's separate Order dated this same date, granting Defendant's Motion for Summary Judgment, pursuant to Kadelski v. Sullivan, 30 F.3d 399 (3d Cir. 1994) and Federal Rule of Civil Procedure 58, **IT IS HEREBY ORDERED** that **JUDGMENT IS ENTERED** in favor of Defendant, Jo Anne Barnhart, Commissioner of the Social Security Administration, and against Plaintiff, Diana Castillo-Borrero.

BY THE COURT:

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John R. Padova, J.