TRADEMARK ASSIGNMENT

Electronic Version v1.1
Stylesheet Version v1.1

SUBMISSION TYPE:	NEW ASSIGNMENT
NATURE OF CONVEYANCE:	CHANGE OF NAME

CONVEYING PARTY DATA

Name	Formerly	Execution Date	Entity Type
Professional Association of Treatment Homes		01/06/2011	Non-Profit Corporation: MINNESOTA

RECEIVING PARTY DATA

Name:	PATH, Inc.
Street Address:	2021 East Hennepin Avenue, Suite 320
City:	Minneapolis
State/Country:	MINNESOTA
Postal Code:	55413
Entity Type:	Non-Profit Corporation: MINNESOTA

PROPERTY NUMBERS Total: 1

Property Type	Number	Word Mark
Registration Number:	2429251	PATH

CH $40.00 2429251

CORRESPONDENCE DATA

Fax Number: (612)455-3801
Correspondence will be sent via US Mail when the fax attempt is unsuccessful.
Phone: 612.455.3800
Email: mail@hsml.com
Correspondent Name: Curtis B. Hamre
Address Line 1: P.O. Box 2902
Address Line 4: Minneapolis, MINNESOTA 55402

ATTORNEY DOCKET NUMBER:	90553.1US01
NAME OF SUBMITTER:	Curtis B. Hamre
Signature:	/Curtis B. Hamre/
Date:	02/03/2011

Total Attachments: 1
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MINNESOTA SECRETARY OF STATE

CERTIFICATE OF ASSUMED NAME

Minnesota Statutes, Chapter 333

Read the instructions before completing this form. **Filing fee: $25.00**

The filing of an assumed name does not provide a user with exclusive rights to that name. The filing is required for consumer protection in order to enable consumers to be able to identify the true owner of a business.

1. State the exact assumed name under which the business is or will be conducted: (one business name per application)

PATH, Inc.

2. State the address of the principal place of business. A complete street address or rural route and rural route box number is required; the address cannot be a P.O. Box.

2021 East Hennepin Avenue, Suite 320	Minneapolis	MN	55413
Street	City	State	Zip

3. List the name and complete street address of all persons conducting business under the above Assumed Name, OR if an entity, provide the legal corporate, LLC, or Limited Partnership name and registered office address. Attach additional sheet(s) if necessary.

Name (please print)	Street	City	State	Zip
Professional Association of Treatment Homes	2021 East Hennepin Avenue, Suite 320	Minneapolis	MN	55413

4. I, the undersigned, certify that I am signing this document as the person whose signature is required, or as agent of the person(s) whose signature would be required who has authorized me to sign this document on his/her behalf, or in both capacities. I further certify that I have completed all required fields, and that the information in this document is true and correct and in compliance with the applicable chapter of Minnesota Statutes. I understand that by signing this document I am subject to the penalties of perjury as set forth in Section 609.48 as if I had signed this document under oath.

Signature (ONLY one person listed in #3 or an authorized agent is required to sign.)

01/06/11
Date

Christine Weflen, Authorized Agent, Attorney
Print Name and Title

Christine Weflen
Contact Person

612-305-7557
Daytime Phone Number

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JAN 06 2011
Mark Ritchie
Secretary of State

AssumedNameRegistrationRev.08-10-10